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BRIEF REPORT

Outlining the Scope of Behavioral Health Practice in Integrated Primary Care: Dispelling the Myth of the One-Trick Mental Health Pony

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Patient presentation in primary care ranges from psychosocial considerations to physical and mental health concerns including serious mental illness. To best prepare for addressing all aspects of health, integrated primary care practices should be equipped with the expertise and resources to appropriately treat the range of presentations. We conducted a literature review of research articles to determine the span of service types provided by behavioral health providers in primary care settings. Among 675 articles retrieved, only 17 addressed health behaviors, 64 examined both health behaviors and mental health, and 160 included only mental health topics. Within these groups, depression was the dominant screening, assessment, and treatment target, and only 42% of all studies included Method and Results sections. Literature supports that integrating behavioral health providers and services into primary care settings benefits patients, primary care providers, and the practice at large, resulting in improved care experiences. However, primary care practices appear to not use the full range of services behavioral health providers can offer. Increased health policy efforts and payment reform are needed to enable a more expansive view of what behavioral health providers could do in a primary care context.

Keywords: behavioral health primary care, integrated care, health policy, mental health

Fragmentation in health care perpetuates high costs, poorer outcomes, and lower patient satisfaction (Lurie, Manheim, & Dunlop, 2009). A primary driver of fragmentation is the separation of mental health from the physical health system (deGruy, 1996). This false dichotomy has led to treating one condition at a time, which impedes patient-centered health care and achievement of the Triple Aim (Berwick, Nolan, & Whittington, 2008; Brown-Levey, Miller, & deGruy, 2012).

The benefits of integrating behavioral health providers (i.e., psychologists, family therapists, psychiatrists, social workers, licensed professional counselors, or case managers) into the U.S. primary care system is empirically supported (Kwan & Nease, 2013; Miller, Kessler, Peek, & Kallenberg, 2011). Integration adds comprehensiveness and continuity to primary care (PC), enhances team-based care, and creates opportunities for collaboration to improve outcomes (deGruy & Etz, 2010; Dickenson & Vineis, 2002).

Behavioral health providers (BHPs) can provide many services in PC, and outlining the scope of services is important for policymakers, payers, and practices working to integrate. For example, does the evidence suggest that integrated BHPs only tackle mental health issues or other patient needs such as

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health behavior change? In this paper we describe services provided by BHPs based on the available peer-reviewed literature. We then describe the full range of services that can be provided in PC by BHPs and provide policy recommendations to better support this range of services.

Method

A research librarian conducted a literature search of Ovid Medline (1946 to present) and PsycINFO 1806 to June, week 1, 2013 using the search terms in Table 1. We limited the search to English language articles published between 2000 and 2013 with adult samples in the U.S. In Medline, the search terms were exploded as MeSH terms and combined. We included explanatory and pragmatic studies and excluded articles specifically addressing medication, prescribing psychologists, other medical professionals only, telemedicine, editorials, and reviews of articles, books, or books chapters.

We categorized the references into three topics: (a) mental health only, (b) health behavior only, or (c) mental health AND health behavior. We define "mental health only" as the delivery of mental health services, and "health behavior only" is service delivery related to chronic conditions like obesity, insomnia, COPD, and diabetes. The third category includes the delivery of both mental health and behavioral health services (e.g., depression and HIV+). For all three groups, a BHP must have provided these services to PC patients. Lastly, we identified references that included Methodology and Results sections. To assess interrater agreement of these categories, two raters reviewed 20% of the 241 total citations.

Results

Search terms produced 675 references. The following were excluded because of the predetermined criteria: editorials ($n = 29$); medication-focused ($n = 31$); telemedicine ($n = 17$); pediatrics ($n = 50$); other medical professionals only ($n = 19$); and international PC settings ($n = 233$). An additional 17 were excluded, because their focus was not in PC or integrated PC settings; 22 were reviews or introductions to special journal topics; and 16 were not relevant to the search terms. This resulted in 160 mental health only, 17 health behavior only, and 64 mental health AND health behavior references (see Figure 1). Interrater agreement was .79 among all three groups. According to established guidelines on interrater reliability, numbers above .70 are considered acceptable (Stemler, 2004).

Across all groups, 42% of the references included methods and results sections. Of the 160 mental health-only publications, 84 included these sections. None were found in the 17 health behavior–only group and 18 of the 64 health behavior AND mental health references included them. The majority of references without methods/results were either explanatory, policy-based, commentaries, or provided recommendations. Among the 84 in the mental health–only group, depression was most widely covered ($n = 45$), followed by anxiety ($n = 14$), comor-

Table 1
Search Terms Used

General search terms	Mental health terms	Health behavior terms
Psychiatrist	Mental disorders	Pain management
Mental health professional	Depression	Insomnia
Psychologist	Anxiety	Tobacco dependence
Primary care clinic/setting/office	PTSD/posttraumatic stress disorder	Medication treatment/adherence/compliance
	Bipolar	Smoking
	Schizophrenia	Illness behavior
	ADHD/attention deficit hyperactivity disorder	Adjustment to illness
		Coping/coping behavior
	Eating disorder	Hypertension
	Dementia or Alzheimer	Diabetes
	Substance/alcohol/drug abuse	Weight management/control
		Health care psychology

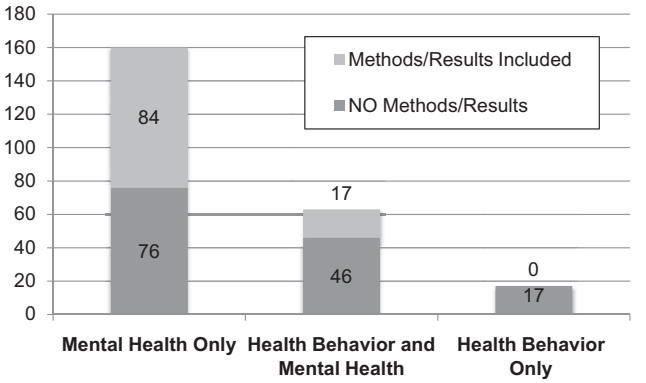

Figure 1. Literature search results by topic type and inclusion of methods/results.

bid depression and anxiety, bipolar, and general mental health (each $n = 4$), and PTSD, borderline personality, schizophrenia, eating disorders, and ADHD (each $n = 2$). There was one reference each for severe mental illness, substance abuse, and depression with PTSD. Of the 18 health behavior AND mental health references, 11 pertained to depression within chronic illness samples (i.e., chronic pain, cancer, COPD, diabetes or HIV), and the remaining addressed specific medical illnesses and either anxiety ($n = 3$) or general psychiatric comorbidity.

Discussion

Based on our review, it is clear that BHPs are most often utilized and known for delivering mental health services in integrated settings (160 mental health-only vs. 80 behavioral-health-inclusive references). Depression is the dominant screening, assessment, and treatment focus. Although addressing depression is important, it is also clear that a range of other mental and behavioral health concerns are prevalent and eligible for BHP's varied expertise. Research on the integration of behavioral health in primary care would also benefit from (a) increasing scientific rigor as only 42% of all retrieved references included Method and Results sections, and (b) further study on the impact of BHP interventions in PC so that efforts can be provided accordingly.

Although we do not summarize this literature through a more formal systematic review or meta-analysis, we identified key topics that have been published in integrated PC, and synthesize the literature to describe a range of needs and services that could be provided by behavioral health in PC. The goal of our review is to identify the role of BHPs in the literature and list role functions, thus extending the practice, policy, and research discourse for the field. This review suggests there is an opportunity for BHPs to provide services for a range of need in PC (Brown Levey et al., 2012). However, the literature supporting integration tends to segment services, and fragmented care underestimates the potential impact of integrated care on a broad range of health conditions.

The Range

Based on the reviewed literature, clinical practice, and integrated care practice facilitation/coaching, we propose that integrated BHPs are well suited to address a range of behavioral health needs of PC patients (Kessler, 2012). The potential functions of integrated BHPs are described in Figure 2 and below.

Addressing psychosocial barriers to care. As the literature suggests, a significant proportion of PC visits include psychosocial components, which directly and indirectly affect health outcomes. Barriers include social, cognitive, and behavioral factors that influence patient engagement and health status (Martikainen et al., 2002). Therefore, addressing these barriers and social determinants of health is critical.

Evidence-based interventions for lifestyle changes to improve physical health. Our review and clinical experience also indicate that

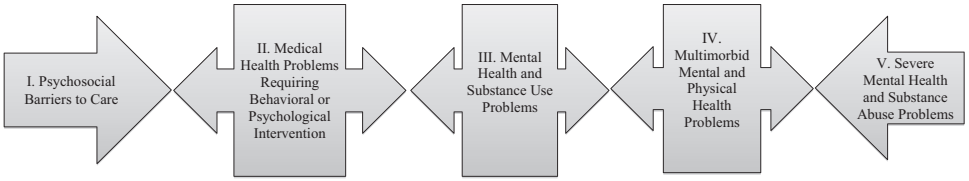

Figure 2. A range of behavioral health issues and needs in primary care.

medical problems requiring behavioral or psychological intervention often result from challenging behavioral changes patients are asked to make to improve their health (i.e., diet, exercise, stress reduction, medication adherence). A robust literature for redesigning PC to better address health behavior change exists as people die prematurely secondary to lifestyle choices (40%) more than anything else (Petterson et al., 2008). First-line interventions include cognitive–behavioral treatments for insomnia (Morin, 2006) and irritable bowel syndrome (Toner, 2005), and motivational interviewing for weight management, exercise, smoking cessation, medication adherence, and safer sex practices (Hunter, Goodie, Oordt, & Dobmeyer, 2009; Rollnick et al., 2007).

Addressing mental health and substance use problems. Our findings also suggest that mental health and substance use concerns, from identification to active treatment, represent the primary domain of need addressed by integrated BHPs. PC providers often underrecognize (Hirschfeld et al., 1997), misdiagnose (Mitchell, Vaze, & Rao, 2009), or neither diagnose nor treat (Baik, Bowers, Oakley, & Susman, 2005) mental health and substance abuse issues. When BHPs work within fully integrated systems, patients have a higher probability of receiving behavioral health care than with external referrals (Agency for Healthcare Research & Quality, 2013; Edlund, Unützer, & Wells, 2004; Unützer et al., 2002).

Addressing the needs of patients with multiple chronic conditions (i.e., mental health and physical health concerns). Multiple chronic conditions contribute to poor health behaviors (Fortin et al., 2006; LeRoy et al., 2014). Multidimensional treatment plans often involve several collaborating providers and interventions involving multiple health behavior change and/or psychotherapy with pharmacotherapy (Koike, Unutzer, & Wells, 2002). Treatment plans must address the whole person complexity of multiple chronic conditions. Although single behavioral interventions (e.g., exercise, stress reduction) or pharmacological treatments (e.g., buproprion for depression and tobacco dependence) have known efficacy, treatment coordination can further reduce patient and provider burden. The range of application for integrated care includes interacting conditions such as physical symptoms without medical cause and psychosomatic symptoms, which often result from a complex constellation of conditions, social situations, and the inability of care systems to orient well to such presentations. This contributes to overutilization, misutilization, and failed services, which are often the result of a care system that is poorly prepared for complex presentations. Attention to behavioral and social factors is required and BHPs can play a larger role in this aspect of care.

Addressing the needs of persons with severe mental illness. Patients with severe mental illness (SMI; e.g., schizophrenia, bipolar disorder) have higher rates of mortality and greater prevalence of chronic disease when compared with the general population (Parks, Svendsen, Singer, Foti, & Mauer, 2006). Our review suggests that identifying mental health conditions, treating comorbid physical health diagnoses, monitoring medications and side effects, and communicating with other providers is critical and should occur within PC. The SMI population has lower no-show rates for behavioral health services provided in PC compared with community mental health settings (Reynolds et al., 2006). Integrated PC services are essential to improve health outcomes in the SMI population.

Policy Implications

If integration is to advance, be population-based, and impact aspirational goals like the

Triple Aim, integrated PC efforts must address the range of health services possible with BHPs, and not be limited to mental health interventions. For policymakers, conceptualizing integration on a range illuminates the full complement of interventions that could be available within true integration. Policies should include all facets of the integration team, not just one function. This new approach increases the likelihood that whole person care can be thoroughly addressed and improve whole person outcomes. This review suggests that the use of BHPs for mental health conditions is the most visible and studied dimension; however, health behavior change, multimorbidity, and interactions commonly considered complex are an important and relatively newer, less empirically studied aspect. Likewise, researchers and program evaluators have a responsibility to examine the full spectrum of behavioral health services in PC, beyond the "one trick pony" of mental health provision. A timely example of this includes studies that examine behavioral health interventions for patients with multiple chronic conditions (LeRoy et al., 2014).

From a payment perspective, systems must support the full range of services described to improve population health. Rather than limiting mental health dollars to support mental health interventions in PC, global payments will allow BHPs to address patients as they present. Integration thrives on a team-based care approach, which is more accessible to patients than fragmented, referral-based care (Collins, Hewson, Munger, & Wade, 2010; Croghan & Brown, 2010; Cunningham, 2009). The future of health care must better integrate behavioral health with primary care. In this context, if BHPs cannot fully utilize their skill set across the range of needs in PC, we will inadvertently limit the full potential of what integration has to offer, thus hindering our progress toward achieving the Triple Aim.

References

Agency for Healthcare Research and Quality. (2013). *Lexicon for behavioral health and primary care integration: Concepts and definitions developed by expert consensus* (AHRQ 13-IP001-EF). Rockville, MD: Agency for Healthcare Research and Quality.

Baik, S.-Y., Bowers, B. J., Oakley, L. D., & Susman, J. L. (2005). The recognition of depression: The primary care clinician's perspective. *Annals of Family Medicine, 3,* 31–37. doi:10.1370/afm.239

Berwick, D. M., Nolan, T. W., & Whittington, J. (2008). The triple aim: Care, health, and cost. *Health Affairs, 27,* 759–769. doi:10.1377/hlthaff.27.3.759

Brown Levey, S., Miller, B. F., & deGruy, F. V. (2012). Behavioral health integration: An essential element of population-based healthcare redesign. *Translational Behavioral Medicine, 2,* 364–371. doi:10.1007/s13142-012-0152-5

Collins, C., Hewson, D. L., Munger, R., & Wade, T. (2010). *Evolving models of behavioral health integration in primary care.* New York, NY: Milbank Memorial Fund.

Croghan, T. W., & Brown, J. D. (2010). *Integrating mental health treatment into the patient-centered medical home* (prepared by Mathematica Policy Research under contract No. HHSA290200900019I TO2; AHRQ Publication No. 10–0084-EF). Rockville, MD: Agency for Healthcare Research and Quality.

Cunningham, P. J. (2009). Beyond parity: Primary care physicians' perspectives on access to mental health care. *Health Affairs, 28,* w490–w501. doi:10.1377/hlthaff.28.3.w490

deGruy, F. (1996). Mental health care in the primary care setting. In M. S. Donaldson, K. D. Yordy, K. N. Lohr, & N. A. Vanselow (Eds.), *Primary care: America's health in a new era*. Washington, DC: Institute of Medicine.

deGruy, F., & Etz, R. S. (2010). Attending to the whole person in the patient-centered medical home: The case for incorporating mental healthcare, substance abuse care, and health behavior change. *Families, Systems, & Health, 28,* 298–307. doi:10.1037/a0022049

Dickenson, D., & Vineis, P. (2002). Evidence-based medicine and quality of care. *Health Care Analysis, 10,* 243–259. doi:10.1023/A:1022995623172

Edlund, M. J., Unützer, J., & Wells, K. B. (2004). Clinician screening and treatment of alcohol, drug, and mental problems in primary care: Results from healthcare for communities. *Medical Care, 42,* 1158–1166. doi:10.1097/00005650-200412000-00002

Fortin, M., Bravo, G., Hudon, C., Lapointe, L., Dubois, M.-F., & Almirall, J. (2006). Psychological distress and multimorbidity in primary care. *Annals of Family Medicine, 4,* 417–422. doi:10.1370/afm.528

Hirschfeld, R. M. A., Keller, M. B., Panico, S., Arons, B. S., Barlow, D., Davidoff, F., . . . Wyatt, R. J. (1997). The National Depressive and Manic-Depressive Association consensus statement on the undertreatment of depression. *JAMA: Journal*

of the American Medical Association, 277, 333–340. doi:10.1001/jama.1997.03540280071036

Hunter, C. L., Goodie, J. L., Oordt, M. S., & Dobmeyer, A. C. (2009). *Common behavioral and cognitive interventions in primary care: Moving out of the specialty mental health clinic*. Washington, DC: American Psychological Association.

Kessler, R. (2012). An outcome and clinical research focus in an integrated care patient-centered medical home. In R. Curtis & E. Christian (Eds.), *Integrated care: Applying theory to practice* (pp. 297–310). New York, NY: Routledge.

Koike, A. K., Unutzer, J., & Wells, K. B. (2002). Improving the care for depression in patients with comorbid medical illness. *The American Journal of Psychiatry, 159,* 1738–1745. doi:10.1176/appi.ajp.159.10.1738

Kwan, B. M., & Nease, D. (2013). The state of the evidence for integrated behavioral health. In M. R. Talen & A. B. Valeras (Eds.), *Essentials of integrated care: Connecting systems of care, clinical practice and evidence-based approaches* (pp. 65–98). New York, NY: Springer Science+Business Media.

LeRoy, L., Bayliss, E., Domino, M., Miller, B. F., Rust, G., Gerteis, J., & Miller, T. (2014). The agency for healthcare research and quality multiple chronic conditions research network: Overview of research contributions and future priorities. *Medical Care, 52,* S15–S22. doi:10.1097/MLR.0000000000000095

Lurie, I. Z., Manheim, L. M., & Dunlop, D. D. (2009). Differences in medical care expenditures for adults with depression compared to adults with major chronic conditions. *Journal of Mental Health Policy and Economics, 12,* 87–95.

Martikainen, P., Bartley, M., & Lahelma, E. (2002). Psychosocial determinants of health in social epidemiology. *International Journal of Epidemiology, 31,* 1091–1093. doi:10.1093/ije/31.6.1091

Miller, B. F., Kessler, R., Peek, C. J., & Kallenberg, G. A. (2011). *A national research agenda for research in collaborative care: Papers from the collaborative care research network research development conference* (AHRQ Publication No. 11–0067). Rockville, MD: Agency for Healthcare Research and Quality. Retrieved from http://www.ahrq.gov/research/collaborativecare/

Mitchell, A. J., Vaze, A., & Rao, S. (2009). Clinical diagnosis of depression in primary care: A meta-analysis. *The Lancet, 374,* 609–619. doi:10.1016/S0140-6736(09)60879-5

Morin, C. M. (2006). Combined therapeutics for insomnia: Should our first approach be behavioral or pharmacological? *Sleep Medicine, 7,* S15–S19. doi:10.1016/j.sleep.2006.03.005

Parks, J., Svendsen, D., Singer, P., Foti, M. E., & Mauer, B. (2006). *Morbidity and mortality in people with serious mental illness*. Alexandria, VA: National Association of State Mental Health Program Directors.

Petterson, S., Phillips, B., Bazemore, A., Dodoo, M., Zhang, X., & Green, L. A. (2008). Why there must be room for mental health in the medical home. *American Family Physician, 77,* 757.

Reynolds, K. M., Chesney, B. K., & Capobianco, J. (2006). A collaborative model for integrated mental and physical health care for the individual who is seriously and persistently mentally ill: The Wastenaw Community Health Organization. *Families, Systems, & Health, 24,* 19–27. doi:10.1037/1091-7527.24.1.19

Rollnick, S., Miller, W. R., & Butler, C. C. (2007). *Motivational interviewing in health care: Helping patients change behavior*. New York, NY: The Guilford Press.

Stemler, S. E. (2004). A comparison of consensus, consistency, and measurement approaches to estimating interrater reliability. *Practical Assessment, Research & Evaluation, 9,* 1–19.

Toner, B. B. (2005). Cognitive-behavioral treatment of irritable bowel syndrome. *CNS Spectrums, 10,* 883–890.

Unützer, J., Katon, W., Callahan, C. M., Williams, J. W., Hunkeler, E., Harpole, L., . . . Langston, C. (2002). Collaborative care management of late-life depression in the primary care setting. *JAMA: Journal of the American Medical Association, 288,* 2836–2845. doi:10.1001/jama.288.22.2836

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