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The Next Step in Integrated Care: Universal Primary Mental Health Providers

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Abstract
Current models of mental health care often do not address three barriers to mental health: the binary view of mental illness (healthy vs. mentally ill), stigma, and prevention. Care models where some patients are selected for referral or consultation with a mental health professional can reinforce this binary view and the stigma associated with seeing mental health services. By only selecting patients who currently are experiencing mental health problems, current integrated care models do not offer sufficient avenues for prevention. To address these barriers, this article proposes building on current models through the development of primary mental health providers (PMHPs). PMHPs—like primary care providers—would provide regular check-ups, assessments, prevention interventions, first-line treatment, or referral to more specialized professionals. This universal approach will help decrease the binary view of mental health, decrease the stigma of seeing a mental health professional through universal access, and improve prevention efforts.

Keywords Integrated care · Mental health · Prevention · Stigma · Behavioral health

The spring 2018 special issue of *Journal of Clinical Psychology in Medicals Settings* on "The Primary Care Behavioral Health Model of Integration" featured articles summarizing the Primary Care Behavioral Health (PCBH) model and research surrounding it (Hunter, Reiter, & Dobmeyer, 2018). The PCBH model expands on other integrated models—such as Screening, Brief Intervention and Referral to Treatment (SBIRT), which focuses on substance use (Babor et al., 2007); and the Collaborative Care Model, which focuses on depression and anxiety (Hunter, Dobmeyer, & Reiter, 2018)—to reach a wider range of patients and conditions. However, the PCBH model and other integrated care models maintain some fundamental elements of mental health care models that continue to serve as barriers to population mental health. This article highlights how current integrated care models can maintain several fundamental barriers to mental health, and proposes steps to build on current integrated care models to address these barriers.

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Current Integrated Care Models

Current integrated care models, such as those described in the spring 2018 special issue of *Journal of Clinical Psychology in Medicals Settings* (Hunter et al., 2018) and the May–June 2014 special issue of *American Psychologist* (Anderson, 2014) share the idea that there is a significant subset of patients who present to physical health care providers who could benefit from also meeting with a mental health professional (MHP), and having a psychologist or other MHP to collaborate in care would improve health outcomes for these patients (Anderson, 2014; Reiter, Dobmeyer, & Hunter, 2018). Physical health care providers (e.g. primary care physicians, obstetrician/gynecologists, oncologists, etc.) may refer this subset of patients to an on-site MHP for further discussion, support, assessment, and/or treatment of a variety of conditions (McDaniel & deGruy, 2014; Poleshuck & Woods, 2014). Mental health concerns, such as depression or anxiety, are often detected through screening questionnaires, which can trigger the physician to refer to the MHP (Poleshuck & Woods, 2014; Reiter et al., 2018). In addition to mental health concerns, physicians may consult with the on-site MHP to discuss behaviors such as eating patterns, substance use, sexual behaviors, and sleep hygiene that may address other medical conditions

(Poleshuck & Woods, 2014). Common physical conditions such as pain, chronic illness, pregnancy, and sexual dysfunctions impact, and are impacted by, mental health and patients with these conditions may also be referred to the on-site MHP (Poleshuck & Woods, 2014).

Integrated practices are now found among family physicians, internists, pediatricians, OB/GYNs, and at VA medical centers (Kearney, Post, Pomerantz, & Zeiss, 2014; McDaniel & deGruy, 2014; Poleshuck & Woods, 2014; Stancin & Perrin, 2014). When mental health providers are in the same location as physical health care providers, patients are more likely to attend mental health appointments (Basu, Stevens, & Phillip, 2012). Integrated care models such as those at Montefiore Health System, the Department of Veteran Affairs Health Care System, Cherokee Health Systems, and the U.S. Air Force have demonstrated the wide-ranging impact and feasibility of integrated care (Briggs, Hershberg, & Germán, 2016; Germán et al., 2017; Khatri, Perry, & deGruy, 2017; Rowan & Runyan, 2005; Zeiss & Karlin, 2008).

Reiter et al. (2018) have provided an operational definition of the PCBH model of integrated care used at multiple successful integrated care sites:

> The PCBH model is a team-based primary care approach to managing behavioral health problems and biopsychosocially influenced health conditions. The model's main goal is to enhance the primary care team's ability to manage and treat such problems/conditions, with resulting improvements in primary care services for the entire clinic population. The model incorporates into the primary care team a behavioral health consultant (BHC)… to extend and support the primary care provider (PCP) and team. The BHC … assists in the care of patients of any age and with any health condition (Generalist); strives to intervene with all patients on the day they are referred (Accessible); shares clinic space and resources and assists the team in various ways (Team-based); engages with a large percentage of the clinic population (High volume); helps improve the team's biopsychosocial assessment and intervention skills and processes (Educator); and is a routine part of biopsychosocial care (Routine). To accomplish these goals, BHCs use focused (15–30 min) visits to assist with specific symptoms or functional improvement. Follow-up is based in a consultant approach in which patients are followed by the BHC and PCP until functioning or symptoms begin improving; at that point, the PCP resumes sole oversight of care but re-engages the BHC at any time, as needed. Patients not improving are referred to a higher intensity of care, though if that is not possible, the BHC may continue to assist until improvements are noted. This consultant approach also aims to improve the PCP's biopsychosocial management of health conditions in general. (Reiter et al., 2018, p. 112)

While integrated primary care sites have demonstrated that having MHPs on-site to be necessary for improved patient mental health, simply having co-located MHPs has not been found to be sufficient to fully integrate mental health care (Kathol, Butler, McAlpine, & Kane, 2010). The current integrated care models have provided great advances in mental health care and improved access, however, these models still do not meet population needs. Importantly, these models maintain some of the primary barriers to general mental health, including: the binary view of mental health, stigma, and lack of prevention.

Binary View of Mental Health

Current integrated care models function on the idea that a *subset* of patients who present to physical health care providers could also benefit from meeting with an MHP (Briggs et al., 2016; Germán et al., 2017; Khatri et al., 2017; Reiter et al., 2018; Rowan & Runyan, 2005; Zeiss & Karlin, 2008). In these models, a primary care provider (PCP) decides who is going to be referred to the MHP (Briggs et al., 2016; Germán et al., 2017; Khatri et al., 2017; Reiter et al., 2018; Rowan & Runyan, 2005; Zeiss & Karlin, 2008). Reliance on PCPs deciding who will be referred to the MHP presents several problems. The first problem is that patients are not being screened for all mental health conditions that may need treatment, and even among conditions that do commonly receive screening, many cases are missed or not referred to mental health providers. For example, many clinics use the first two questions of the Patient Health Questionnaire (PHQ-2) to screen for depression and do not screen for suicidality if the PHQ-2 screen is negative for depression, which has been found to miss many patients who are experiencing suicidality (Dueweke, Marin, Sparkman, & Bridges, 2018). Failure to screen for suicidality is thought to play a role in findings that greater than two-thirds of people who suicide saw a primary care provider in the 90 days before their death (Ahmedani et al., 2014; De Leo, Draper, Snowdon, & Kõlves, 2013). Similarly, among people who were known to have experienced a trauma (i.e. presenting to a trauma center with significant injuries from a physical trauma) physicians only discussed mental health services in 19% of cases in the subsequent 6 months (Wong et al., 2009). Among patients who presented for medical care following physical trauma and who had PTSD or depressive symptoms detectable by screens, only 28% were referred to an MHP in the 6 months after the traumatic event (Wong et al., 2009). In fact, PCPs have been found to

leave more than half of cases of PTSD undetected, missing valuable opportunities to refer for psychotherapy, which is the first-line treatment (Greene, Neria, & Gross, 2016; Williams, 2017).

The second problem of having a PCP decide who will and will not be referred to the MHP is how this bifurcation reinforces the binary view of mental health: a person is either mentally unhealthy and needs an MHP, or mentally healthy and does not need an MHP. This dichotomous view is known to be inaccurate, with mental health symptoms increasingly being referred to as multiple spectra (Lobo & Agius, 2012). Similar to physical health, all people experience periods when they are in better mental health and times when they are suffering, and experience symptoms ranging from mild to severe, common to rare, and acute to chronic.

Models of behavioral health integration still largely focus on identifying people who are already experiencing symptoms of mental illness (SAMHSA-HRSA Center for Integrated Health Solutions, 2014) or who have certain medical conditions (Fisher & Dickinson, 2014; Poleshuck & Woods, 2014; Reiter et al., 2018). This approach can leave many people with subclinical or prodromal symptoms without treatment. Additionally, the binary approach reinforces the idea that only those individuals with severe enough symptoms would need or benefit from mental health treatment.

This binary view has colored how people approach treatment for mental health. Common screening instruments that are often used in integrated care, such as the Patient Health Questionnaire for Depression (PHQ) and the 7-item questionnaire for Generalized Anxiety Disorder (GAD-7), were designed to screen for people who are currently experiencing significant symptoms that are likely diagnosable as Major Depressive Disorder or Generalized Anxiety Disorder (Kroenke & Spitzer, 2002; Spitzer, Kroenke, Williams, & Löwe, 2006). In fact, in same-day consultation models, since patients are generally not expecting to meet with an MHP, and they rather are "worked-in," the appointment may not occur if the patient is unable to stay for the extra appointment (Reiter et al., 2018) and thus may not see an MHP at all.

The World Health Organization defines health as "a state of complete physical, mental and social well-being and not merely the absence of disease or infirmity" (World Health Organization, 2005). Given this definition, it is impossible for any individual to be mentally healthy for their entire lifespan. In fact, psychological suffering is considered a universal experience for all people (Hayes, Strosahl, & Wilson, 2012). Thus, the referral of only a subset of patients misses opportunities to address mental health in the remaining population.

The binary view leads to the other two primary barriers to mental health: stigma and lack of prevention.

Stigma

The oversimplification of complex characteristics into distinct groups—such as the binary view of those who need mental health care and those who do not—is the foundation upon which stigma develops (Link & Phelan, 2001). Once separation into simplified, distinct groups has occurred, people begin to divide "us" from "them", and to associate "them" with undesirable characteristics and stereotypes. As a result, there is an effort to distance oneself from the group associated with undesirable characteristics, which, in turn, creates stigma (Link & Phelan, 2001).

The current models of integrated care use the separation into two distinct groups to prioritize patients for referral to a limited number of MHPs. While prioritization is important given the limited mental health resources currently available, it does reinforce the simplification of characteristics into two distinct groups that can maintain the stigma of the group that gets referred to the MHP.

There has been a call to decrease stigma as a means to increase care-seeking among those with mental health symptoms (Corrigan, 2004). While proposed approaches to decreasing stigma would involve reducing fundamental components of stigma, such as decreasing dichotomous labeling that separates the stigmatized group from another group (Link & Phelan, 2001), the flagging of a specific subset of patients who should meet with the MHP actually serves to strengthen, rather than ameliorate, these factors among both patients and providers.

Integrated care models try to decrease the stigma of seeing MHPs by changing the location from mental health clinics, which are associated with stigma, to the primary care office, where there is not the same stigma (Kenkel, Deleon, Mantell, & Steep, 2005). While this change in location allows some patients access to MHPs that they would not have agreed to meet with before, reserving mental health clinics for those who need specialty care reinforces stigma of going to mental health clinics by continuing to allow people to separate patients into simplified groups (i.e. Those who have to go to a mental health clinic and those who do not). In fact, as many people belonging to stigmatized groups try to hide their stigmatized identity from others (Goffman, 1963), the message conveyed by telling patients they can avoid going to mental health clinics maintains the stigma of mental illness by reinforcing the idea of "hiding" mental health care in primary care.

Intervention efforts that focus on identifying high risk individuals, especially among groups that are already stigmatized in other ways, may bring ethical concerns (American Psychological Association, 2014) that could be avoided if interventions were universal instead. Since contact with people with mental illness has been proposed as a promising avenue for decreasing stigma surrounding mental illness

(Corrigan & O'Shaughnessy, 2007), a more universal, rather than binary, approach is likely to both improve mental health and decrease stigma.

Prevention

The binary view of mental illness has also interfered with prevention efforts as current integrated care models focus on those who are already experiencing significant symptoms.

There are four main approaches to prevention: universal or primary prevention—where all people are targeted to reduce the incidence of disorder;—selective prevention—where people who are deemed at risk are provided prevention interventions; indicated interventions or secondary prevention—where people who already have subclinical symptoms are targeted for intervention; and tertiary prevention—where people who already have diagnosable syndromes are provided interventions to prevent future episodes or problems (Katz & Ali, 2009; Leavell & Clark, 1965; Reisinger, Hunt, Burgo-Black, & Agarwal, 2012).

Primary care medicine has enjoyed great successes with primary, selective, and secondary prevention of a wide range of conditions. For example, the national effort to vaccinate all children to prevent poliovirus resulted in the elimination of polio by 1979 in the United States (Centers for Disease Control and Prevention (CDC), 2013). Similarly, cervical cancer—which was previously the leading cause of cancer deaths among women – has been dramatically reduced through screening all women for precancer cells through Pap tests (CDC, 2014).

The focus on primary and secondary prevention contributed to the international 1978 Alma-Ata Declaration, which established the model for health policy (Magnussen, Ehiri, & Jolly, 2004) and asserted that primary health care is essential for global public health (World Health Organization, 2014). This declaration defined primary health care as including promotion of health, prevention of illness, education about health problems, and controlling, rehabilitating, and curing illness (World Health Organization, 1978). This focus on primary and secondary prevention is in contrast to countries that follow tertiary prevention models that only provide health care to those who have an illness. These countries have been found to have poorer health outcomes compared to countries that utilize primary care, which is universal and preventative (Magnussen et al., 2004). In fact, the Alma-Ata Declaration specified that primary health care should be accessible to all people (World Health Organization, 1978).

Despite the successes of the primary care model on prevention of physical health problems, mental health care has maintained a partial and reactionary model. Mental health prevention efforts have focused on secondary or tertiary prevention rather than primary prevention or mental health promotion (Clark & Leavell, 1965). Since primary prevention includes both protecting people from the onset of illness and promoting health (Clark & Leavell, 1965), the current provision of mental health care does not meet criteria for primary health care. Even wide selective interventions of individuals at highest risk for developing specific mental health conditions are not thought to impact enough people to have a significant effect on the prevalence of common disorders (Barrera, Torres, & Muñoz, 2007). To truly impact the prevalence of mental health problems, it is necessary to address the incidence among all people, not only the duration or severity in select groups or among those already experiencing symptoms (Barrera et al., 2007).

The Next Step: Primary Mental Health Providers

It is time for the next step in mental health care that can address a number of the current problems by changing the way that we conceptualize mental illness and mental health care. In contrast to the binary view, where some people are seen as needing an MHP and others do not, this model would be similar to the primary care model of health and would involve development of primary mental health providers (PMHPs). These PMHPs would be to mental health care what primary care physicians (PCPs) are to physical health care. In physical health care, it is the norm for all people to have a PCP whom they see at least annually for a yearly "physical," for screenings and prevention when in good health, and whom they also see when they experience symptoms. Similarly, it could become the norm for *all* people to have a PMHP whom they see at least annually when in good mental health for screenings and prevention, and whom they also see when they experience stressful life events or have a change in their mental health. Like PCPs, PMHPs would be able to provide in-office treatment for some disorders, while referring to specialists for others.

Thus, in the PMHP model, all patients would have two primary care clinicians instead of just one: a PCP and a PMHP. With the growing amount of research, general knowledge, and treatments available in health care, the role of primary care clinician needs to expand beyond a single person. These two clinicians would be in the same clinic with other members of a primary care team (e.g. pharmacists, case managers, social work). By having two primary care clinicians, the health care system will be moving toward true mental health parity: where half of primary care has a focus on physical health and wellness and the other half of primary care has a focus on mental health and wellness, with appropriate overlap. Mental health cannot achieve parity with physical health if the vast majority of primary care is focused on physical health. The PMHP model would allow

a more equal and balanced approach to physical and mental health.

Ideally, PMHPs would work in conjunction with PCPs at one all-inclusive primary health care office. As most common medical problems have behavioral components (Hunter, Goodie, Oordt, & Dobmeyer, 2009), collaboration on these issues is essential. This collaboration would allow integrated care and a team approach on the vast range of disorders that are common in both fields, such as diabetes, hypertension, autism, risky sexual behaviors, disordered eating, and somaticized symptoms, as is currently done at many integrated care sites.

In addition to parity, the PMHP model would replace the binary model by offering universal care for mental health and help cultivate an understanding of mental health as widely varied rather than dichotomous, which can aid in normalizing the experience of mental health symptoms. Additionally, it would normalize seeing a mental health provider, as all people would be expected to see a PMHP.

The PMHP model would help to address stigma of seeking treatment. Anti-stigma campaigns for mental illness have been largely unsuccessful (Lovett, Tamkin, & Fletcher, 2011). However, when conditions are seen as common, they are less likely to be labeled as a stigmatized group (Lovett et al., 2011). Thus, a more universal approach can reduce stigma, and therefore, have greater participation than approaches that only select high risk individuals (Barrera et al., 2007), as is the focus of current integrated care models (see Table 1).

The effects of moving from high risk screening to universal screening on stigma has been demonstrated in HIV detection. Underdiagnosis occurs when only those at risk are tested, as many people either do not know they are at risk or may not disclose risk factors to health care providers (Branson et al., 2006). In contrast, when HIV screening is offered universally, the stigma around getting tested declines, and a higher proportion of people are tested (Branson et al., 2006). In fact, the CDC now recommends universal testing for HIV because offering routine testing, rather than just testing people who were thought to be at risk, reduces the stigma of getting tested (Branson et al., 2006). Similarly, universal mental health screening can decrease the stigma of mental health assessment.

Table 1 Similarities and differences between the PCBH Model and PMHP Model

Component	PCBH model[a]	PMHP model
Main objectives		
Main goal	Enhance primary care team	Enhance patient access, skills, prevention, and treatment
MHP role	Specialist/consultant	Primary care provider
Maximization aim	Allows physician to work to the top of their license and improves PCP's management of health conditions	Allows each professional to work to the top of their license and improves or prevents patient health conditions
Patients		
Location	Primary care clinic	Primary care clinic
Patients	People with a health condition referred by physician/team	All people
Ages served	All ages	All ages
Volume	Goal is to serve a high number of referred people per day	Goal is to serve a high percentage of the total population
Roles		
Team members	PCP, MHP, and others (e.g. nurses, social work, pharmacists)	PCP, MHP, and others (e.g. nurses, social work, pharmacists)
Screening	Conducted by PCP/medical assistant	Conducted by PCP/medical assistant and PMHP
Patient Oversight	Physician oversees the patient, refers to other team members as conditions arise. MHP sees patient as a part of the PCP's team, and patient returns to PCP sole oversight after brief treatment with MHP	Patient oversees their own care and has a direct relationship with each team member. Team collaboratively directs patient when needed
Visit focus	Specific symptoms or functional improvement	Screening, prevention, skill enhancement, specific symptoms, or functional improvement
MHP approach	Generalist and biopsychosocial	Generalist and biopsychosocial
Education	Focus on educating the team	Focus on educating the patient; Team all educates each other
Referrals		
Referrals	PCP determines referrals	Both PCP and PMHP make referrals
Specialists	Refer to specialists for higher intensity care	Refer to specialists for higher intensity care

PCBH Primary Care Behavioral Health, *PMHP* primary mental health provider, *PCP* primary care physician, *MHP* mental health provider

[a]Reiter et al. (2018)

Universal contact with mental health providers, and the consequent decrease in stigma, would open the door to prevention efforts. Prevention has become increasingly important in addressing the burden of mental health problems and climbing cost of treatment (Petersen, Barry, Lund, & Bhana, 2014). Primary prevention of mental health problems is now thought to be a reasonable goal (Barrera et al., 2007). In 2014, the American Psychological Association published its Guidelines for Prevention in Psychology, which specifically call on psychologists to develop, research, and implement preventative interventions (Guideline 3) (American Psychological Association, 2014).

Ideally, people would start having a PMHP during childhood, to begin prevention early and stigma surrounding seeking mental health care would not form (Corrigan & O'Shaughnessy, 2007), and children would see the integration of mind and body as standard. Starting PMHP annual exams during childhood would mean illnesses with early onset would be caught earlier and developmental challenges could be addressed before they advanced further (Kaltiala-Heino & Rimpelä, 1999). While over 90% of children see a primary care provider (Stancin & Perrin, 2014), which allows for screening most children for both risk factors for negative health outcomes and illness, mental health issues are often not addressed among pediatric primary care patients. In fact, although anxiety is the most common mental health problem among pediatric patients (Teubert & Pinquart, 2011), primary care often does not evaluate for risk factors or engage in prevention efforts for anxiety disorders. Similarly, the U.S. Food and Drug Administration has declared that childhood depression should not be permitted to progress untreated, particularly due to the potential long-term educational and social consequences (U.S. Food and Drug Administration, 2014), but often little time is devoted to depressive symptoms or risks.

Montefiore Health Systems has demonstrated the effectiveness of a pediatric screening schedule that leads to a subset of patients being referred to the MHPs (Briggs et al., 2016). However, even in this successful model, only a small set of conditions are screened, and only higher risk children are referred, maintaining the mental health binary. In contrast, with PMHPs, additional screening measures at each age would be added, plus preventative interventions and skills training would be implemented for all patients, not just those at high risk.

Developmental and behavioral evaluation and early intervention by a PMHP would be possible if children were consistently evaluated for developmental and neurodevelopmental disorders, allowing for interventions early when they can have strong effects (Stancin & Perrin, 2014). A number of preventative interventions, often beginning in child and adolescent populations, have already been developed, implemented, and found to be effective for depressive and anxiety disorders (Barrera et al., 2007; Feldner, Zvolensky, & Schmidt, 2004; Teubert & Pinquart, 2011).

As prevention efforts should focus on identifying and addressing risks, as well as developing strengths, resilience, and coping mechanisms (American Psychological Association, 2014), pediatric screening could include topics such as: bullying (victimization and perpetration), social skills, social support, exposure to violence/abuse, and exposure to substance abuse in the home, in addition to screening for developmental and mental health disorders. As children grow to adolescence, screening and prevention could include areas such as peer relationships, listening skills, self-esteem, body image, sexual health, sexual assault prevention, and substance use in addition to screening for mood and anxiety disorders, which is often the current practice. PMHPs would also be a great opportunity to keep adolescents and young adults engaged in their health care during a time when they are often physically healthy and therefore may not present to a PCP (Lau, Adams, Boscardin, & Irwin, 2014), but are experiencing many transitions, stressors, and risk factors, offering opportunities for intervention and early treatment.

Beyond pediatrics and adolescents, PMHPs would offer opportunities for interventions for cognitive, social, emotional, and interpersonal concerns across the life span. Life stressors, changes in relationship status, or entering new careers could trigger brief interventions for improving listening skills, conflict resolution skills, decreasing performance anxiety, or improving coping skills. By working with people as they become parents, PMHPs could not only provide screening, prevention, and treatment of conditions in new parents, but working with symptomatic parents may be a particularly effective way of preventing similar symptoms in children (Bienvenu & Ginsburg, 2007). Conditions that can be behaviorally passed down across generations (e.g. substance abuse, physical and sexual abuse, some depressive and anxiety conditions) could be identified and addressed so the cycle is broken. Thus, every appointment with a PMHP would be an opportunity to promote health, as well as treat illness (Clark & Leavell, 1965).

In addition to the effects on stigma and prevention, PMHPs could also have a positive impact on diagnosis and treatment. Universal screening at yearly mental health care visits could cut down on underdiagnosis, as all people with a PMHP would be evaluated annually. It could also cut down on overdiagnosis by following positive screens with more thorough evaluations of symptoms and severity. All people could receive appropriate evaluation for their developmental level, such as evaluation for learning or developmental disabilities during childhood and dementia in older adults.

Role of Psychologists

While a number of different types of professionals may provide behavioral health care within a primary care setting, psychologists would be particularly well-suited to fulfill the role of PMHPs. Psychologists have the knowledge, skills, and expertise to provide primary health care—providing prevention, accurate diagnosis, and first-line treatment. Psychologists are trained as experts in development and mental health, as well as assessment, treatment, and working with families (Stancin & Perrin, 2014). Health psychologists would be particularly well-suited as they have training in both mental and physical health conditions and are already members of many integrated care teams. Additionally, psychologists are trained in many non-mental illness topics such as lifespan development, interpersonal relationships, cognition, behavior, and social interactions that make them well-rounded to address many topics. Psychiatrists and psychiatric nurse practitioners would serve as a vital part of the team for the subset of conditions that would benefit from medications, since it would be important for PMHPs to focus on behaviors, social interactions, and address prevention, which cannot be addressed through medication (U.S. Food and Drug Administration, 2014).

It has already been proposed that psychologists could be the leaders of primary care teams (McDaniel & deGruy, 2014), rather than behavioral health consultants, where the mental health professional is there to offer an opinion but is not an equal provider of health care as primary care providers (Hunter et al., 2009; Reiter et al., 2018). In contrast to the PCBH model, where the MHP's role is to take on certain tasks "so that the PCP may reach as many patients as possible and work to the top of their license" (Reiter et al., 2018), the PMHP model allows psychologists to reach as many patients as possible and work to the top of *their* license as well. When psychologists work only as PCP "extenders," to allow physicians to fulfill their role, it reinforces the idea that psychologists are not equal providers, thus contributing to the devaluing of psychologists and MHPs and reinforcing the idea that physical health providers are more important than mental health providers.

Psychologists can also play an important role in the development and implementation of the PMHP model in their role as researchers. Psychologists have already played a strong role in demonstrating the effectiveness, financial viability, and value of collaborative care models (e.g., Bryan et al., 2012; Chaffee, 2009). Thus, psychologists would be uniquely qualified to not only serve as PMHPs, but also to conduct research to evaluate, further develop, and revise the next steps in moving toward primary mental health care.

Potential Barriers

There are a number of barriers that have prevented this type of model from being implemented before. Many of these barriers have already started to diminish, and further steps can be taken to continue to reduce these barriers.

Financial

Financial barriers are likely to be the primary obstacle in implementing the PMHP model as finances have been a barrier to mental health care for decades, but have been gradually improving. The binary view of mental health—that some people need mental health treatment while everyone else does not—was clear in health insurance coverage in which mental health treatment often was not covered, or could only be purchased separately for the proportion of the population who was thought to need it, such as in some mental health carve-outs (Grazier & Eselius, 1999). When mental health services were covered, they were often not covered to the same extent as physical health services, leaving many people without mental health coverage or with inadequate coverage (Beronio, Po, Skopec, & Glied, 2013).

The 2008 Paul Wellstone and Pete Domenici Mental Health Parity and Addiction Equity Act (MHPAEA) made advances in mental health coverage by requiring insurance plans that covered mental health to be comparable to medical and surgical coverage (Beronio et al., 2013). The 2014 Affordable Care Act built on the MHPAEA by including mental health as an "Essential Health Benefit" and expanded mental health parity to individual and small group insurers (Beronio et al., 2013). The next step needed in this trajectory would be for mental health parity to be expanded to all plans, including all Medicaid, Medicare, and "grandfathered" plans that are not currently required to meet mental health parity standards (National Alliance on Mental Illness, 2019). Modeling mental health primary care after physical primary care may be successful because primary care for physical medicine also faced resistance, with arguments that it was too idealistic or too expensive (Magnussen et al., 2004), but, it has been found that when disease-focused models are used, they are more expensive and have worse outcomes than primary care models (Magnussen et al., 2004).

As reimbursement systems are beginning to change and new models are being developed and tested (Kathol et al., 2010; Melek, 2012; Schwenk, 2016), it will be important to move towards a model in which primary mental health care billing is also treated the same as primary physical health care billing. Thus, it will be important for financial models to not only measure the costs of implementing PMHP models, but also the savings of the potential decreased prevalence, severity, and

number of exacerbations of mental illness, and the potential decreased societal costs of behaviors from untreated conditions (e.g. violence, DUIs). For primary mental health care billing to reach parity with primary physical health care billing, PMHPs would need to be able to bill for preventive visits and for screening in the same way that PCPs can bill for preventive visits (e.g. well-child, well-adult) and routine screenings (e.g. cancer screenings, HbA1c, lead screening). In some states, developmental-behavioral screening has become required and is a reimbursable service (Stancin & Perrin, 2014), and thus some of the groundwork for this transition has already begun.

Additionally, PCPs can bill for the patient's concern or symptom (e.g. vaginal discharge) even in the absence of diagnosable illness (e.g. bacterial vaginosis). Similarly, it would be important for PMHPs to be able to label and bill for symptoms (e.g. sadness) even in the absence of diagnosable syndromes (e.g. Major Depressive Disorder). The current diagnostic and billing system reinforces the binary view of mental illness with strict cut-offs for diagnosis, and has been criticized for contributing to overdiagnosis and catering to the pharmaceutical industry (Cosgrove & Krimsky, 2012). Billing for symptoms would be essential to reduce the potential for commercialization, overmedication, and pathologizing the normal—concerns that have already surfaced with the release of the DSM 5 (Bolton, 2013; Cassels, 2013). By allowing PMHPs to address symptoms without having to meet criteria for a full diagnosis, patients can be educated about normal range symptoms (e.g. normal sadness, worry), and coping skills can be taught instead of using treatments with higher costs or risks, avoiding pathologizing the normal. Additionally, patients with subclinical symptoms would be able to receive care at earlier stages. By viewing symptoms as spectra, and having a billing system that allows standards and cut-offs for defining diagnoses without risking non-payment if a patient falls below a cut-off can avoid overdiagnosis and maximize early intervention.

Mental health collaboration and prevention have already been found to decrease medical costs, but also decrease physician pay with payment models where physicians are paid more to care for sicker patients (Basu et al., 2017; Melek, 2012; Schwenk, 2016; Silberner, 2017). Therefore, a payment model is needed where integrated care teams are funded for both prevention and care, rather than relying on payments for individual providers in a fee-for-service model (Basu et al., 2017; Melek, 2012; Schwenk, 2016; Silberner, 2017). Additionally, given that prevention models are less expensive and have better outcomes than disease-based models (Magnussen et al., 2004), PCPs and PMHPs can work together to lobby for increased value and funding for primary care overall.

Providers

The second main barrier is a shortage of providers. Current PCBH models have used screening and referrals partly because the limited number of mental health providers are not able to see all of the patients in a primary care clinic. Part of the reason that there are not enough providers is financial. Psychologists are one of the lowest paid professions for number of years of training required (Bureau of Labor Statistics, 2018; Carnevale, Rose, & Cheah, n.d.). This lower salary likely decreases the number of people who choose a psychology career path. If reimbursement and payment models were to change, and more value placed on mental health, then psychologists could see higher salaries, drawing a larger mental health workforce. Additionally, mental health stigma is likely to play a role in provider shortages as people may not be drawn to stigmatized career fields. As mental health stigma decreases and people begin to place more value on mental health care, the number of people who seek professions in mental health care could increase. Thus, the first steps will be demonstrating the added value and decreased costs of primary care mental health to continue to work toward improved financial models and decreased stigma.

Siloed Education

Another barrier that has prevented this type of integration has been siloed education—different health professions training separately, and not learning to work together and collaborate. Co-located care sites have started to break down the barrier of having mental health and physical health practicing in different physical locations, and integrated care sites have allowed mental and physical health professionals to work together on teams (Hunter et al., 2018), however, education of different health professions still often remains separate. It has been proposed that health professionals include "interprofessional collaboration" as one of the groups of competencies which health professionals would have to demonstrate for successful completion of their education (Englander et al., 2013), and some health professional programs are beginning to offer combined training. Even with these initiatives, in the 2017–2018 academic year, only 12% of medical schools had medical students learning alongside psychology students (Association of American Medical Colleges, 2019). Thus, increased interprofessional education is likely to reduce barriers to the PMHP model.

Future Directions

As universal mental health is the key to decreasing the binary view of mental illness, decreasing stigma of mental health care, and creating an avenue for prevention and

health promotion, next steps should involve implementation of components of the PMHP model at select clinics. Small scale and incremental implementation would allow for evaluation of small populations for change in stigma surrounding mental health care, health outcomes, and evaluation of access to, and engagement with, mental health providers. Each component that gains support through incremental implementation can then be used to help address barriers to more wide-spread implementation.

Since one of the main differences between current integrated care models and the PMHP model is the addition of more comprehensive universal screening and prevention, these components should be implemented and tested next. This implementation would involve having an MHP see every patient who comes in for an annual wellness exam for screening, brief interventions, and prevention. As appointments in primary care clinics are often separated into wellness visits or problem-based visits during scheduling, patients who schedule a wellness exam can be told upon making the appointment that the clinic is now offering integrated care and annual exams now involve meeting with two primary care clinicians who work as part of a team and will focus on different aspects of their health. Since one of the barriers to implementation is the number of available PMHPs compared to the overall population, by starting with just well-visits several goals can be accomplished. First, the PMHPs would have a more reasonable number of patients to see per day than if they tried to see every patient. Second, it would allow the PMHP a wide range of patient demographics (e.g. all ages) compared to when patients are referred only for specific conditions. Third, patients are less likely to be acutely ill as they are for problem-based visits, and thus may be more willing to participate in screening and prevention than when they are focused on addressing a specific symptom for which they set up an appointment. Newer billing codes such as 96110 (developmental screening) or 96127 (brief behavioral assessment) may soon be able to be used by psychologists for these types of screenings (American Psychological Association Office of Health Care Financing Staff, 2015). Once patients start experiencing the screening and preventative PMHP appointments, additional research can be done on differences in diagnosis detection and treatment, as well as patients' perceived usefulness, satisfaction, and desire for other services, and on follow-up appointments scheduled with the PMHP separate from the PCP. As research on existing integrated care models is ongoing, each new component (e.g. screening, prevention strategies) can be added on as research demonstrates efficacy and viability, and subsequent research can examine the effects of multiple components on rates of diagnosis, early intervention, and referral for resources.

In addition to future research on the implementation and effects of the PMHP model itself, continued research into components of health care that will be utilized in the PMHP model are also needed. For example, further studies are needed to evaluate the effectiveness of specific universal screening methods, prevention techniques, and early interventions for different conditions. Large samples will be needed to detect changes in the overall incidence of various mental health conditions (Barrera et al., 2007), and there are knowledge gaps in which types of prevention programs are most effective and cost efficient (Kilian, Losert, Park, McDaid, & Knapp, 2010). As the American Psychological Association works to develop clinical practice guidelines (American Psychological Association, 2015), there are already efforts to create standardized treatments for different conditions that could be implemented across practices.

The PMHP model represents a pathway to achieve APA's call for psychologists to develop systemic interventions for prevention of physical and psychological distress (American Psychological Association, 2014). While de-stigmatizing individual mental health diagnoses may be a long-term and complex goal, de-stigmatizing mental health care, decreasing the binary view of mental illness, and introduction of primary mental health providers are all within reach.

Compliance with Ethical Standards

Conflict of interest The author Adrienne A. Williams declares that she has no conflict of interest.

Human and Animal Rights This article does not contain any studies with human participants or animals performed by any of the authors.

Informed Consent This article does not contain any studies with human participants performed by any of the authors.

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