Integrating Behavioral Health into Primary Care

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A Problem: Behavioral health care, an enormous unmet need

More than 20% of American adults suffer from behavioral health problems.[1] Without treatment, the consequences of behavioral health disorders for the individual and for society are staggering including unnecessary suffering, disability, unemployment, homelessness, inappropriate incarceration, and suicide. In the US, the economic cost of untreated behavioral health problems is more than 100 billion dollars each year.[2]

In general, patients with behavioral health problems are sicker and use more services than people without them. Seventy percent of those with significant behavioral health problems have at least one chronic condition, 45% have two, and 30% have three or more. Common illnesses that often co-occur with, or are exacerbated by behavioral health problems, include cardio-vascular and pulmonary disease, diabetes, and arthritis. The health care costs of individuals with dual-diagnoses are 2-3 times higher than individuals without these disorders.[3]

Given the above statistics it is not surprising that individuals suffering from behavioral health disorders (e.g. insomnia, depression, anxiety, obsessive compulsive disorder, and substance use) make up a remarkably high percentage of patients seen in primary care clinics and practices. The primary care setting provides the initial, and often only, opportunity for access to behavioral health services, with more than 40% of patients with behavioral health problems initially seeking care in primary care settings.[4] The most frequently encountered include insomnia, depression and anxiety.

Insomnia

Ten percent of patients in primary care and 40% of patients in behavioral health clinics suffer from insomnia. Research shows that lack of sleep can have a significant impact on recovery from and control of a variety of illnesses including de-pression, heart disease, and diabetes. Today, most patients with a sleep problem are treated with a medication (on or off label), even though guide-

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lines recommend cognitive behavioral therapy (CBT), a type of talk therapy, as the first line of treatment.

"It is important for families to have a health care home and to have a team that is working together to address the whole spectrum of their needs, behavioral and physical. That is your right." –Parinda Khatri, Ph.D., Cherokee Health Systems

Depression

A national survey of primary care clinicians that addressed current practices in depression recognition and management found that while many physicians feel responsible for recognizing depression in their patients, a substantial proportion lack essential knowledge about the diagnostic assessment of depression and few provide the follow-up recommended in management guidelines.[5] The over-diagnosis of depression and over-treatment with prescriptions and psychiatric medications, especially antidepressants, is a growing trend. A recent study found that more than 70% of patients prescribed antidepressants did not meet the criteria for a major depressive episode.[6] Many of these patients suffer from mild to moderate depression and there is little evidence supporting the benefits of anti-depressants in these cases. Moreover, antidepressants come with an array of side effects (e.g. nausea, dry mouth, headache, decreased libido, increased sweating, weight gain, drowsiness, fall-risk, and insomnia). CBT, on the other hand, has been proven to work in this population and has no side effects.[7]

Anxiety

Anxiety disorders are among the most prevalent behavioral problems in US adults. They last at least 6 months and can get worse if they are not treated. Anxiety disorders often accompany other behavioral problems or medical illnesses, including alcohol or substance abuse, which may exacerbate the symptoms of anxiety or make them harder for primary care physicians to detect. Studies show that approximately 80% of primary care patients with anxiety disorders do not receive appropriate treatment.[8] When treatment is received it is most often medication instead of psychotherapy such as CBT, despite the empirical support for CBT as efficacious treatment for anxiety disorders and its recommendation by the American Psychiatric Association that it should be offered first.[9]

The reasons for the less than optimal treatment of behavioral disorders in primary care settings are obvious. Primary care clinicians are not trained in the diagnosis and care of patients with these problems. In addition, they are already maxed out in terms of available time, often able to only spend 10 to 15 minutes per patient. However, if a diagnosis (e.g. anxiety) is made, they are obligated to provide some form of treatment and medication is the fastest option.

1. Kessler RC, Chiu WT, Demler O, Walters EE. Prevalence, severity, and comorbidity of twelve-month DSM-IV disorders in the National Comorbidity Survey Replication (NCS-R). Archives of General Psychiatry, 2005 Jun;62(6):617-27.
2. National Alliance for Behavioral Illness. www.nami.org. Retrieved May 15, 2013.
3. Urban Institute for the Medicaid Institute at the United Hospital Fund. Coughlin and Shang, 2011.
4. Chapa, T. (September, 2004). Mental health services in primary care settings for racial and ethnic minority populations. Draft issue brief. Rockville, MD: Office of Minority Health
5. Williams, J. W. J., Rost, K., Dietrich, A. J., Ciotti, M. C., Zyzanski, S. J., & Cornell, J. (January 01, 1999). Primary care physicians' approach to depressive disorders. Effects of physician specialty and practice structure. Archives of Family Medicine, 8, 1.
6. Mojtabai, R. (January 01, 2013). Clinician-identified depression in community settings: concordance with structured-interview diagnoses. Psychotherapy and Psychosomatics, 82, 3, 161-9.
7. Butler, A. The Clinical Psychologist, (1995); vol 48: pp 3-5.
8. Demertzis, K. H., & Craske, M. G. (January 01, 2006). Anxiety in primary care. Current Psychiatry Reports, 8, 4, 291-7.
9. [American Psychiatric Association. (2006). American Psychiatric Association practice guidelines. Arlington, VA: American Psychiatric Pub.

"Patients should be informed about the advantages, limitations and potential harm of all evidence-based treatments for their condition so they can make an informed choice. Too often, psychotropic medication is the only option that is offered." – Suzanne Bennett Johnson, Ph.D., ABPP, Florida State University College of Medicine

Another Problem: The separation of behavioral and primary care in our health care systems

Historically the provision of behavioral health services has been separated from traditional health care delivery systems. This is especially true for poor and low-income individuals who receive behavioral services through state run programs, which often include psychiatric hospitals and clinics. Many states even have separate systems for mental health and substance abuse treatment.

Physical health services (primary and specialty care) are often provided for the poor through Federally Qualified Health Centers (FQHCs), and community mental health centers and by a variety of other mechanisms including private practices for those with insurance. However, it is increasingly recognized that the practice of separating health care into physical and behavioral health silos is misguided and results in poor quality care and higher costs. Policymakers in New Jersey and across the country now recognize that there is a better way, that is, to connect, coordinate, and ultimately integrate behavioral health care with primary care. This improves treatment of the "whole person" and studies have shown also enhances clinical outcomes and reduces over all health care utilization and costs.[1] The impetus for change comes in large part from the passage of the Affordable Care Act. Beginning in 2014 under the law, all new small group and individual plans will be required to cover mental health and substance use disorder services, and will be required to cover them at parity with medical and surgical benefits.[2] Research has shown that the provision of frontline behavioral health services in primary care settings has many positive aspects. These include: the improvement of patient, practitioner and provider satisfaction; overall health care cost efficiency, including primary and specialty costs for physical health care; improved clinical and functional patient outcomes; and enhanced adherence to treatment.[3] Given all of the above it is not surprising that efforts are underway in New Jersey and throughout the country to move toward integration.

1. Substance Abuse and Mental Health Services Administration, Results from the 2005 National Survey on Drug Use and Health: National Findings, Office of Applied Studies, NSDUH Series H-30, DHHS Publication No. SMA 06-4194, Rockville, Md., (2007).
2. Beronio, K., Po, R., Skopec, L., & Gleid, S. (February 20, 2013). Affordable Care Act Expands Mental Health and Substance Use Disorder Benefits and Federal Parity Protections for 62 Million Americans. ASPE Office of Health Policy. US Department of Health and Human Services. http://aspe.hhs.gov/health/reports/2013/mental/rb_mental.pdf
3. Mauch, D., Kautz, C., & Smith, S. (February, 2008). Reimbursement of Mental Health Services in Primary Care Settings. US

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(held on May 13th, 2013)

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What is Integration?

The integration of behavioral health into primary care provides primary and behavioral health care in the same setting. Integration can take many forms and often includes adding mental health professionals such as psychologists, psychiatrists, social workers, counselors, nurses and/or care managers, to primary care facilities. Their role is to focus on the mental health needs of patients and ranges from helping with diagnosis to providing treatment. Integration can be made easier by new technologies such as web-based software, phone contact centers, and other tools which are designed to allow clinicians to be more efficient and effective. For example, research has shown that using tools offered over the Internet, such as computerized CBT, a single clinician can provide care to 4 – 5 times more patients with the same clinical results as face-to-face therapy.

Identification of patients with behavioral health problems in primary care has long been recognized as inadequate so many models of integration include systematic screening as one element to improve care. Preliminary data shows that Screening, Brief Intervention and Referral to Treatment (SBIRT) in the primary care or emergency setting can reduce high-risk drug and alcohol use by up to 74%.[1] The use of well-validated screens such as the PHQ-9 for depression and the GAD-7 for anxiety identify clients who have behavioral problems. Once screening identifies a need the patient is then referred to various types of care depending on the severity of the behavioral problem. As mentioned earlier, guidelines suggest that the first step for insomnia and anxiety (including panic attacks and phobias) should be CBT. When computerized CBT programs are accessed over the Internet they can be overseen by a wide variety of different clinicians none of whom needs to be trained in CBT. The face-to-face time needed to be spent with the patient is determined by the clinician depending on the type of disorder and its severity. The average is approximately 10 min/week.

1. http://www.samhsa.gov/SAMHSA_News/VolumeXIV_1/index2.htm. Retrieved May 15, 2013.

What are some reasons for integrating?

Behavioral and physical health problems are intertwined. Integrated primary care services help ensure that people are treated in a holistic manner, meeting the behavioral health needs of people with physical disorders, as well as the physical health needs of people with behavioral problems.

"It is important for families to have a health care home and to have a team that is working together to address the whole spectrum of their needs, behavioral and physical. That is your right." – (Parinda Khatri, Ph.D., Cherokee Health Systems)[1]

Inappropriate prescribing. The great majority of behavioral health problems (depression, anxiety, insomnia), seen by primary care physicians are treated with medication, many of which have never been shown to work for the disorder they're treating (e.g. Seroquel for insomnia), and have serious side effects. Psychotropic drugs can be tools in treating many mental health disorders but inappropriate prescribing can cause serious harm especially in older adults who are prone to drug-drug interactions.

"Patients should be informed about the advantages, limitations and potential harm of all evidence-based treatments for their condition so they can make an informed choice. Too often, psychotropic medication is the only option that is offered." (Suzanne Bennett Johnson, Ph.D., ABPP, Florida State University College of Medicine)[2]

Enormous treatment gap for behavioral health. There is a significant gap between the prevalence of behavioral health problems, on one

hand, and the number of people receiving treatment and care, on the other hand. Primary care for behavioral health helps close this gap.

"More mental health interventions occur in primary care than in specialty mental health settings." – (MaryClare Champion, Ph.D. Cherokee Health Systems) [3]

Primary care for behavioral health enhances access. Primary care clinics are often easier to access than mental health facilities. When behavioral health is integrated into primary care, people can often access behavioral health services closer to their homes, which can mean having to take less time off from their daily activities.

"Health care reform is about making sure that everyone who needs it has access to whatever kind of health care he or she needs – including mental health care." – (Jeremy A. Lazarus, M.D., American Medical Association). [4]

Primary care for behavioral health helps reduce stigma. Behavioral health services delivered in primary care minimize stigma and discrimination.

"One approach to increase effectiveness and access to mental health care, and potentially reduce stigma, is integration of mental health services into the primary care setting" – (National Institutes of Health). [5]

Primary care for behavioral health is cost effective. Integrating behavioral health with primary care allows for improving health outcomes and reducing medical costs. One way to bridge the behavioral health and primary care systems is through the use of technology in primary care clinics. For example, computerized CBT programs for a variety of disorders have been shown to be just as effective as traditional CBT delivered face-to-face by a clinician and the cost per patient (with the same outcome) is up to 90% lower depending on the disorder. [6]

"Providing behavioral health care in a primary medical care setting can be cost effective and lead to improved patient outcomes." – (Health Resources and Services Administration). [7]

In summary, there is a serious deficit in our health care system when it comes to providing care to people with behavioral health disorders. Patients with behavioral health problems are both under detected and over diagnosed, especially depression. When diagnosed and treated in primary care settings they are often given inappropriate treatment in the form of medication even though CBT is recommended to be the first treatment tried. In addition, even when treated appropriately, their care is less than optimal because it is separated from their physical care. The Affordable Care Act is correcting this latter problem by providing incentives for the integration of behavioral and primary care. Technology in the form of web-based programs (e.g. CBT) is available as tools to facilitate the integration of behavioral health care into primary care settings.

1. A Family Guide: Integrating Mental Health and Pediatric Primary Care (2011). National Alliance on Mental Illness.
2. Smith, B. (2012, June) Inappropriate prescribing. Research shows that all too often, Americans are taking medications that may not work or may be inappropriate for their mental health problems, 43 (6), 36.
3. Collins, C., & Milbank Memorial Fund. (2010). Evolving models of behavioral health integration in primary care. New York, NY: Milbank Memorial Fund.
4. Lazarus, J. (October 29, 2012) Treating the whole person includes mental health care. American Medical News. Retrieved from amednews.com on May 15, 2013.
5. Funk, Michelle, Saraceno, Benedetto, Drew, Natalie, & Faydi, Edwige. (n.d.). Integrating mental health into primary healthcare. Radcliffe Publishing Ltd.
6. National Institute for Health and Clinical Excellence (NICE) (2006). Depression and Anxiety:computerised cognitive behavioural therapy (Review of Technology Appraisal 51). Retrieved on 13 May 2013 from www.nice.org.uk
7. Integrating Behavioral Health with Primary Medical Care (2013). Health Resources and Services Administration. Retrieved from http://www.hrsa.gov/publichealth/clinical/BehavioralHealth/ on May 13, 2013.