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networks

Practical Information for State Mental Health Agency Professionals

BUILDING BRIDGES: A Status Report on the Integration of Public Health and Public Mental Health

A growing number of health and mental health professionals have been working for decades to promote the benefits of a more integrated system of care. The proponents argue—with decreasing opposition—that since mental and physical illnesses often manifest themselves in conjunction, treating those ills in conjunction is the best prescription for consumer improvement. In fact, the relationship between mind and body has never been more scrutinized, and has even reached society’s mainstream by gracing the cover of *TIME*’s annual special report on health (January 20, 2003).

The challenge rests in achieving this more integrated system of care within the public sector. At the state and local levels in particular, the fundamental issues of implementation, staffing, and training continue to hamper progress while overriding challenges like funding and competing priorities have thwarted otherwise encouraging efforts.

With a special emphasis on the primary care level (where the potential benefits of integration may be the most critically needed), this double issue of *networks* is intended to re-visit the discussion on integration, illustrate current examples of successful integration measures, and offer counsel, examples, and resources for those interested in further integrating systems.

At a recent conference on integration, SAMHSA Administrator Charles G. Curie, M.A., A.C.S.W., shared his position on the subject: "Whether we mend broken bones, broken spirits, broken hearts, or broken promises, we are all in the same business—helping people become and stay healthy." We at NTAC agree, and believe that regardless of your field, you will find the information contained herein encouraging, and—more importantly—useful. ◆

The Big Picture View: An Executive Panel on the Philosophy of Integration

To capture a cross-section of opinion on the integration of public health and public mental health, *networks* recently interviewed five executive-level officials on the topic. From the field of mental health, the panel participants include Junius J. Gonzales, M.D., branch chief of the Services Research and Clinical Epidemiology Branch, Division of Services and Intervention Research, National Institute of Mental Health, and Charles G. Ray, president and CEO of the National Council for Community Behavioral Healthcare. From the field of public health, the participants include Georges C. Benjamin, M.D., executive director, American Public Health Association (interviewed while secretary of the Maryland Department of

Health and Mental Hygiene), George E. Hardy, Jr., M.D., M.P.H., executive director of the Association of State and Territorial Health Officials, and Deborah Klein Walker, Ed.D., associate commissioner for Programs & Prevention, Bureau of Substance Abuse Services, Massachusetts Department of Public Health.

1 Do you believe public mental health and public health should be more integrated? If so, why?

Gonzales: At a global level, the concept is appealing for both practical and financial

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 ALSO AVAILABLE ONLINE AT
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MESSAGE FROM NTAC

In this double issue of *networks*, we illustrate the ongoing conversation on the delivery of integrated public mental health and primary care services. This topic is certainly not new, yet the lack of progress in this area has begun to create a new crisis in front line health care. People who require both medical and mental health services find our delivery systems fragmented, difficult to access, and, at times, redundant, a situation that is leaving more and more primary care customers without even the most basic mental health treatment options.

Policy makers and administrators wrestle with funding barriers, conflicting priorities, differing missions, and scarce resources. Providers struggle with incompatible billing regulations, workforce resource gaps and training issues, and responsibilities for specific and different service outcomes. Service recipients face multiple providers, lack of service coordination, transportation and time constraints, and the lack of single point accountability for quality, access, and outcomes.

An example of the difficulties inherent in providing for both health and mental health services has emerged as our country improves our homeland security status. Recent events in our country have led to a new and significant focus on disaster planning and response preparation. Through the investigation of how to meet both the physical health and safety needs, as well as the mental health needs of our citizens, policy makers on the national, state, and local level have become well aware of the problems associated with the delivery of both primary care and mental health services in planning for a comprehensive response. However, even the preliminary task of ensuring a seat at the table for representatives of key health stakeholders has proven to be difficult to achieve.

The great challenges to the improvement of mental health and primary health care service delivery systems will need to be addressed by our health care leadership at all organizational levels. Commitment, energy, and quid pro quo compromises will be required to work through the barriers and find solutions. Only in such a coordinated environment will words like “seamless services” and “equal access” become more than just phraseology.

As with all NTAC products, this issue features a variety of viewpoints and opinions to ensure we address the main points of a discussion. Beginning on our front cover, a panel of national experts on integration gives an overview of the topic from the “big picture” perspective. This issue’s *Focus on the States* feature (Page 10) provides a more specialized discussion on recent progress and promising practices at the state mental health agency level. The primary care view is

captured in two articles. The first, beginning on Page 3, outlines the argument in favor of increasing primary care integration and offers tools and funding opportunities for implementation. The second, beginning on Page 5, presents anecdotes of challenges and success stories from the front lines within a case study of integrated primary care sites. There is also a first-person account (Page 15) on navigating the stormy seas of integration from a consumer point of view.

This special edition issue would not have been possible without the time, expertise, and commitment of more than two-dozen contributors. In particular, we would like to note the tremendous assistance, time, and effort contributed by M. Carolyn Aoyama, C.N.M., M.P.H., R.N., coordinator of the Mental Health/Substance Abuse Service Expansion Grant Program for federally funded community health centers within the Health Resources and Services Administration, Bureau of Primary Health Care. Her first-hand knowledge and insight on the issue of integration is unparalleled.

On behalf of NTAC, I would like to also thank the participants in our expert panel, the dedicated professionals interviewed for the articles and features within this issue, as well as those who helped in the editorial review process. In addition, our appreciation is noted to those who helped facilitate this issue from behind-the-scenes, including Mohammed Akhter, M.D., M.P.H.; Robert DeMartino, M.D.; Kana Enomoto, M.A.; Gail P. Hutchings, M.P.A.; Grayson Norquist, M.D., M.S.P.H.; Steven J. Karp, D.O.; and Alan Radke, M.D.

Finally, I would like to note the efforts of NTAC, NASMHPD, and NASMHPD Research Institute, Inc. staff in producing this issue of *networks*, including Robert W. Glover, Ph.D.; Ieshia Haynie; Robert Hennessy; Catherine Huynh, M.S.W.; Andrew Hyman, J.D.; and Theodore Lutterman. ♦

—Kevin Ann Huckshorn, R.N., M.S.N., I.C.A.D.C., NTAC Director

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Analysis:

Integrating Primary Care Benefits All Involved

By M. Carolyn Aoyama,
C.N.M., M.P.H., R.N.

Ms. Aoyama is the coordinator of the Mental Health/Substance Abuse Service Expansion Grant Program for federally funded health centers within the Health Resources and Services Administration, Bureau of Primary Health Care.

Focusing specifically on the important role of the specialty mental health/substance abuse (MH/SA) provider on patient¹ management and clinical outcomes, this article will provide an overview on the integration of mental health and substance abuse services in federally funded Consolidated Health Centers (CHCs). In particular, I will focus on the belief that the specialty provider, working as a member of an interdisciplinary team, can increase the confidence of primary providers to address existing mental health needs among health center patients, improve patient care, and increase productivity of other health care providers.

HEALTH CENTERS HISTORY

Consolidated health centers, commonly called “community health centers,” were first authorized by the federal government in the mid-to-late 1960s and are located in every state and territory of the United States. The Health Resources and Services Administration’s (HRSA) Bureau of Primary Health Care (BPHC) is the federal agency that administers the funding for the Consolidated Health Center Program.

HRSA/BPHC programs increase access to comprehensive primary and preventive health care and improve the health status of underserved and vulnerable populations.

BPHC is dedicated to guaranteeing

access to health care for all and to reducing disparities in health status. In 2001, HRSA/BPHC health center grantees served over 10.3 million patients in over 3,300 service delivery sites. Patient characteristics include: 67% at or below 100% of the poverty level; 64% racial and ethnic minorities; 33% Medicaid beneficiaries; and 40% uninsured. The patients included all age groups from birth to over 65 years of age. The average funding for HRSA/BPHC to health centers is 25% of a center’s total budget (HRSA/BPHC, 1999, 2000, 2001).

MENTAL HEALTH NEEDS IN HEALTH CENTERS

There is a well-documented association between mental health disorders, alcohol and other drug problems, and the utilization of medical resources. In 1991, nearly 8 million people (5% of the U.S. population at that time) between the ages of 15 and 54 years had a co-existing mental and substance abuse/dependence disorder (Rouse, 1998). Alcohol dependence and alcohol-related disorders occur in up to 26% of general medical patients (Fleming et al., 1997; Schmidt & Weisner, 1995). Alcohol problems are frequently implicated in many health conditions and alcohol use can exacerbate symptoms and complicate treatment compliance. In addition, up to 25% of individuals with certain medical conditions (e.g. diabetes, myocardial infarction, carcinomas, strokes) develop Major Depressive Disorder (American Psychiatric Association, 1994).

Data collected annually from each HRSA/BPHC health center grantee indicates that mental and substance abuse disorders are common primary diagnoses in health centers. When the ICD-9 codes for selected mental health conditions are combined with substance abuse

conditions, this larger category of MH/SA conditions constitutes the second most common primary diagnosis after hypertension for health center patients (HRSA/BPHC, 1999, 2000, 2001). Because many health centers do not yet screen for or manage common MH/SA problems (e.g., depression, anxiety disorders, panic attack, ADHD, or alcohol and other drug use), the BPHC data are probably a significant under-representation of the true incidence of mental health and substance abuse disorders among health center user populations. In this environment, the integration of MH/SA services is clearly needed to provide care to patients with existing mental health needs.

THE CASE FOR INTEGRATION

On-site services of specialty providers can increase access to needed MH/SA services. A health center’s ability to refer their patients to the local public mental health agency has always been a key element in the ability of health centers to serve their patients and provide comprehensive primary health care. However, many health centers report that referring patients off-site for MH/SA care is problematic: 1) health center patients are often unwilling to accept such a referral because of stigma, and 2) as eligibility for public MH/SA services has become more restricted due to reduction in local budgets, access barriers have increased.

Some public MH/SA service agencies serve only insured patients, leaving the uninsured without a source of care. Other agencies may serve the entire population of underserved, but may have long waiting lists of patients who desire and can pay for services. When the public system either doesn’t serve the uninsured or the wait for service delivery is long—sometimes weeks in length—developing MH/SA

¹ For the purposes of this article, mental health consumers and all other users of health center services are referred to as patients.

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Analysis

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capacity within the health center is a good way to ensure patient access to primary mental health and substance abuse services. When referral to specialty services is needed, specialty providers can be utilized to share knowledge of specialty networks that can support a patient's care and recovery.

On-site services of specialty mental health providers are needed to address a wide range of health care issues that do not have an organic basis. This is critical to overall care when you consider that psychosocial stress often drives medical service use, and increases the cost of medical care. Research documents that nearly 70% of all health care visits have a primarily psychosocial basis (Fries et al., 1993). Research has also reported the top 10% of medical utilizers consume approximately 33% of ambulatory medical services and nearly 50% of hospital services (Henk, et al., 1996). Health care costs for depressed, older adults are up to 50% higher than for older adults without depression (Unutzer et al., 2002).

The health problems of many of these patients do not explain their rate of health care utilization. What explains the high utilization of this group of people is that the most frequent psychosocial drivers of medical utilization are mental disorders, alcoholism/drug addiction, low social support, lack of coping skills, and a stressful home/work environment (Friedman et al., 1995). These factors frequently occur in combination among the highest utilizers of medical services (Simon, Von Korff, & Barlow, 1995).

Effective treatments exist for both alcohol-related problems (CSAT TIP #28; NIAAA, 1995) and depression (AHCPR, 1993), however, fewer than

half of those who need treatment actually receive it. Given the prevalence of MH/SA problems in primary care populations and the co-morbidity of MH/SA problems with other primary care medical problems, primary care clinicians are in an ideal position to screen for mental health and substance abuse issues, initiate treatment, and monitor progress. Specialty providers bring with them knowledge of effective treatments. They bring this knowledge to bear as members of a collaborative MH/SA service team. The presence of a specialty mental health/substance abuse provider on the team supports primary care providers (PCPs) who may be reluctant to initiate MH/SA screening and treatment in the absence of a MH/SA provider on staff.

Placing a mental health/substance abuse provider on-site within a health center will ensure that the specialty provider is immediately available to the primary care provider as he/she is seeing patients, which will improve service delivery. Because the MH/SA provider's expertise is considered central to optimal clinical care, some health centers are adopting an "integrated

behavioral health model" in which the mental health provider is made a member of the primary care team and they are located in the immediate area of the medical clinic. As a member of the primary care team, the MH/SA provider serves as a

consultant to the PCP, providing quick consultations, diagnostic patient interviews, MH/SA interventions, individual and group therapy, and specialty referral arrangements. In addition, the mental health provider can assist the PCP in taking on an expanded role in managing a patient's mental health problems. The presence of the MH/SA provider on staff at the health center gives the Primary Care Providers the confidence to begin screening and managing their patients for uncomplicated MH/SA conditions that would otherwise go unrecognized and untreated.

Integrating MH/SA services into primary care can foster better health outcomes for patients. As mentioned earlier, psychosocial issues bring patients into health centers. Locating mental health providers within primary care clinics helps address the current gap between what the patient is seeking (mental health plus medical services) and what is being provided (medical care only). In addition, because the course and outcome of any disease is directly affected by mental health factors, addressing these mental health factors will improve a patient's overall health outcome. The treatment of diabetes for a patient with unrecognized depression is a good example. The diabetic with unrecognized depression may be much less motivated to stick to his diabetic diet, to exercise, or to test his blood sugar. Consequently, his diabetes will escalate and his physical condition will deteriorate. But, in a setting where mental health services are integrated into the primary care clinics, this patient's depression can be identified and managed along with the diabetes.

Integrating mental health providers into primary care can increase the efficiency of the clinic and the primary care provider. Many PCPs have encountered this situation: A patient who breaks down in tears during the medical visit and needs to talk about what is bothering him/her. The 15-minute encounter becomes a 30- to 45-minute encounter, and the primary care provider—who has back-to-back patients to see each day—is now more behind schedule. Patients in the waiting room become unhappy with the delay, and two or three patients have to be rescheduled. This is an everyday reality in ambulatory health care delivery systems including health centers, and it affects the productivity of the primary care provider and therefore the services of the health center.

Leveraging, a strategy that shifts patients with mental health needs to a mental health clinician, can improve the productive capacity of a primary care provider and the health center and improve

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Integration Efforts in Primary Care: **A Case Study of Barriers and Band-Aids at the Front Line**

By Robert Hennessy, Editor

There is little doubt that modern healthcare in the United States is beginning—in varying degrees—to consider the “whole” person in diagnosis and treatment plans. In fact, the word “holistic” has been overused throughout society to the point where it has lost its buzzword status.

However, for state mental health officials, the integration of public health and public mental health in order to treat the whole person remains a daunting and often ambiguous initiative, and questions abound. What does true integration mean? Why should mental health be integrated into public health? If there are so many positives, why isn't integration happening on a much larger scale? How much will it cost systems already impacted by shrinking budgets?

While there may be few across-the-board solutions to these large-scale questions, there are examples of success on a smaller scale—within community health centers—that state mental health agencies (SMHAs) can interpret for their own use. From financial viability to stigma, from reimbursement issues to reinventing primary mental health care, the challenges and achievements reported by the following federally funded community health centers can serve as a case study of the larger issue of integration.

The need for more effective primary care was given national recognition in 1999 within *Mental Health: A Report of the Surgeon General*.

"It is essential for first-line contacts in the community to recognize mental illness and mental health problems, to respond sensitively, to know what resources exist, and to make proper referrals and/or to address problems effectively themselves. For the general public, primary care represents a prime opportunity to obtain mental health treatment or an appropriate

referral. Yet primary health care providers vary in their capacity to recognize and manage mental health problems. Many highly committed primary care providers do not know referral sources or do not have the time to help their patients find services."

SAMHSA Administrator Charles G. Curie, M.A., A.C.S.W., built on these sentiments at a recent conference on the integration of primary care, mental health, and substance abuse services. "If the services delivery systems are not integrated and coordinated and we

Hayes warmed up his calculator and came up with a more specific formula for covering the cost for each mental health provider.

continue to recognize only the disorder or disease we are trained in, we will be failing too many Americans," he said.

Today, a rising tide of health care providers believe that the answer to this dilemma exists in the physical integration of mental health providers into the primary care provider teams and into the primary care clinics. Stephen Hayes, Psy.D., the director of Behavioral Health Services at the Lynn Community Health Center in Lynn, MA, agrees. Hayes believes that an essential formula for achieving a successfully integrated primary care environment is the development of multi-disciplinary provider teams.

"We have a behavioral psychologist that works with the center's adult medical team, a clinical nurse specialist and a psychiatrist working alongside the center's family practice team, and a child psychologist resides on the pediatric team," Hayes said. "Not only were these

[mental health] providers assigned to medical components, but I moved their offices into the medical spaces," he added. "All their referrals come from these medical teams, they work together, attend the same staff meetings, and basically become available every day to the primary team effort. The medical doctor screens patients first, then makes a referral and introduces the patient to the behavioral health provider right there in the medical examining room."

While the on-site provider integration sounds nice, the cost of this scenario may seem impossible for some systems to overcome. "We had no idea how to do this when we started, but our board of directors and our staff were on board for doing this," said Hayes. "So, we made it possible by being highly specific about the productivity requirements each one of the [mental health] providers had to generate to support their position on this team."

Moving away from his old productivity measure of 1,200 patient visits per year for a full time behavioral health provider, Hayes warmed up his calculator and came up with a more specific formula for covering the cost for each mental health provider.

"I gave each one of the mental health providers a breakout of what it costs the center to support them," he said. Hayes added salary, employee benefits, and overhead, and came up with a figure of \$98,000 in cost for a provider who makes \$50,000 per year. Then, he divided that figure into a 45-week work year (after vacation, sick, and training time). Hayes figured his providers had to generate \$2,178 per week in their 40-hour position. He also reasoned that out of those 40 hours, they had direct clinical time for 30 hours, so they had to generate \$72.60 per hour.

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Case Study

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“Our mental health providers know what the nut is that they have to crunch. By educating our behavioral providers about the fiscal situation, they could see the expenses, and after that, anybody that exceeds productivity can get into a bonus area each month,” said Hayes. “Is this method cost-effective? Yes. We are doing this without any type of subsidy.”

Creativity, such as that used by the Lynn Community Health Center to finance behavioral health integration, is a common theme in those centers that have had success with their integration efforts. The creative mind of Laurie White, Ph.D., director of Behavioral Health Services at Family Health in Greenville, OH, helped create an in-house educational system that not only allows patients to learn more about how to take care of their mental health, but allows the medical center to be reimbursed by insurance for these mental health education sessions.

“Since our mission is to build healthy lives, we really understand that good health is a holistic concept,” said White. The center has developed a variety of courses that offer some of their less seriously ill behavioral health patients an opportunity to learn how to cope with their conditions. For instance, Family Health offers an 8-week course with sessions on the mind-body connection, the power of thought, stress and relaxation techniques, nutrition (including cooking demonstrations), exercise-at-home clinics, communication and relationship skills, and joy and spirituality. Other “one-shot” courses discuss issues such as the “holiday blues,” diabetes management, and marriage tips.

What helps keep this system running is the center’s efforts to achieve

reimbursement for the sessions. After talking with their local HMO, Family Health found that they would not be reimbursed for their holistic education program. But, White didn’t take “no” for an answer. “We found that if our physician first prescribes the sessions, then meets again with the patient after each session, and has the patient fill out a survey on the treatment plan, we would get reimbursed. If the [doctor-patient]

...an in-house educational system that not only allows patients to learn more about their mental health, but allows the medical center to be reimbursed by insurance for the sessions.

meetings and surveys show that there is a diagnosis, some medical data on the progress, and a connection to the sessions, we don’t have problems with getting a reimbursement,” said White.

A particularly difficult obstacle to early treatment is stigma. According to the literature, a primary care clinic carries far less stigma for most patients, so the opportunity for appropriately targeted treatment may actually be greater in primary care than it is in the current mental health clinic setting. The Bridge Program at Manhattan’s Charles B. Wang Community Health Center was created to battle stigma in this largely immigrant Chinese community. According to Bridge Program Director Teddy Chen, C.S.W., most immigrant Chinese have no concept of what a mental health issue is, and those that do have an idea shun treatment in fear of being ostracized by their community. In fact, according to Chen, stigma is a major factor in why the Bridge Program was formed.

This innovative program uses educational radio spots on Chinese American radio stations, bi-lingual literature and staffers at their clinics, and

CD-ROM-based stories about depression geared toward teenagers. The program also encourages patients to write down their immigrant-related depression experiences for publishing in a community newspaper in an effort to battle stigma through education. Chen says that the efforts have helped bolster mental health encounters from a handful in 1998 to 1,400 patient encounters in 2002.

Symbolizing the complexity of integrating primary care—the influx of patients was clearly a sign of success, but treating the mass became overwhelming—this scenario helped urge the program’s providers to alter their methods of care to accommodate everyone.

According to Henry Chung, M.D., the founder and former medical director of the Bridge Program, after seeing the incredible pressure for productivity from his mental health providers to not only match patient need but to also remain financially viable considering the ubiquitous reimbursement issues, Chung decided to revise his providers’ pace to meet the almost overwhelming need of the community.

Figuring a shortened visit was better than none at all, Chung helped train his psychologists to perform an initial evaluation in about 30 minutes, with

Figuring a shortened visit was better than none at all, Chung helped train his psychologists to perform an initial evaluation in about 30 minutes, with follow-ups at a rate of four patients per hour.

follow-ups at a rate of four patients per hour. For social workers, that rate evolved to an initial evaluation at one hour, and follow-up visits at two patients per hour (factoring in no-shows, patients would still be seen for 35-45 minutes even with this expectation of productivity, according to Chung).

“We are working at a more rapid pace,

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SAMHSA Integration Study

Focuses on Older Persons with Mental Illness

*Compiled from the PRISM-E Project
Description Brochure*

Many older individuals experience serious mental health and substance abuse (MH/SA) problems that affect their quality of life as well as their ability to function independently in the community. Although prevalence rates vary in epidemiological studies among the elderly, it is clear that elderly individuals experience high rates of depression and anxiety disorders, as well as alcohol abuse and dependence. With the projected increase in the number of older Americans in the years to come, it is evident that both the clinical and policy communities need to be well informed as to the nature and effectiveness of different service delivery models for treating mental health and substance abuse (MH/SA) problems.

Since older adults seek and receive MH/SA services more often from their primary care providers than from specialty MH/SA providers, the Substance Abuse Mental Health and Services Administration (SAMHSA) has developed a multi-site study to compare the effectiveness of service delivery models that treat MH/SA problems in primary care as opposed to specialty MH/SA settings. The study, known as Primary Care Research in Substance Abuse & Mental Health for the Elderly (PRISM-E) aims to identify differences in clinical and cost outcomes between models referring consumers to specialty mental health/substance abuse services outside the primary care setting and those providing such services within the primary care setting itself.

This 6-year study has been conducted in three phases; the study is currently in its fifth year. Nearly 2,300 persons have been randomized to either integrated or referral models of MH/SA care. Clinical screenings were conducted on over 27,000 persons. Participants were assessed at baseline, 3 months, and 6

months to determine changes in clinical symptoms and functioning over the course of treatment. Persons were enrolled from 10 experimental sites, and from one additional quasi-experimental site, which represent roughly 50 clinical settings and include a variety of providers from managed care environments, community health clinics, VA facilities, and group practice settings. Harvard Medical School, Brigham & Women's Hospital, and John Snow, Inc. teamed up to serve as the Coordinating Center (CC) for this multi-site study. The CC's role is multi-faceted, providing leadership, administrative

The study aims to identify differences in outcomes between models referring consumers to mental health/substance abuse services outside the primary care setting and those providing services within the primary care setting itself.

support, centralized quality control, technical expertise in the development and implementation of the multi-site protocol and design, and analytic expertise and support. The CC has taken the lead in designing and implementing the cost study portion of the project, and is also responsible for collecting and analyzing clinical outcome and cost data, as well as descriptive data on the integrated and referral models of care.

The CC has assembled a multi-disciplinary and multi-cultural team of investigators and consultants with expertise in the major technical areas relevant to the program. These areas include geriatrics/gerontology, mental health, substance abuse, primary care, cost and health economics, and multi-site research methods. The CC staff has extensive experience in managing large

studies and in providing training and technical assistance to community-based health care organizations. Through these experiences, CC staff has developed the capabilities to work successfully in the collaborative processes.

This initiative was funded by the Substance Abuse and Mental Health Services Administration (SAMHSA), with the Center for Mental Health Services (CMHS) as the lead center, with additional support and collaboration from the Department of Veterans Affairs (VA), the Health Resource Services Administration (HRSA), and the Centers for Medicare and Medicaid Services (CMS).

To date, total funding from SAMHSA has been \$15.3 million to fund 6 study sites (including one VA site) and a study Coordinating Center. HRSA has contributed \$676,000 to enhance services so that they could better conform to the study model criteria. The VA has contributed \$3.5 million for the direct support of 5 additional VA study sites. Additional support was received from Center for Medicare and Medicaid Services (CMS) in the form of access to Medicare claims data for the cost studies.

The study's anticipated contributions to the fields of aging, mental health, and substance abuse include: the ability to test a number of primary and secondary hypotheses; largest study of depression and alcohol use in the elderly; the first study of integration vs. referral service models in the elderly; the first effectiveness study of integration in the elderly; and, since other major studies mostly focus on compliance to clinical guidelines, PRISM-E is focuses on "real world" integration and diverse clinical sites.

According to PRISM-E project staff, the anticipated findings on the study outcomes should be released in early 2004. For more information, contact Betsy McDonel Herr, Ph.D., federal project lead, at 301-594-2197.

Analysis

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quality of care. Managed care has significantly increased an emphasis on cost containment and productivity standards among health care providers. In addition to the increased productivity standards, primary care providers have the demand of having to provide comprehensive services, which include MH/SA services, when they may lack the training to provide them. Such demands may lead to frustration of the primary care provider and problems with recruitment and retention of PCPs within health centers.

There are effective ways to recruit MH/SA staff to primary care settings. A significant barrier to establishing

integrated mental health services is attracting credentialed mental health providers to health centers, particularly in rural areas. One successful strategy health centers use to overcome this barrier is to develop academic partnerships in which mental health/substance abuse students can gain clinical experience in health centers. Another strategy is to contract for on-site mental health service delivery with an established provider. Many health centers have contracts with their local community mental health center to provide on-site MH/SA service delivery to health center patients, and this trend is increasing.

In the absence of on-site MH/SA providers, primary care providers can still improve their patient care with appropriate mental health training. An

appropriately trained primary care provider can conduct a mental health assessment and determine whether the patient can be adequately served at the health center level or whether he/she needs to be referred to an off-site mental health specialty provider. Primary care providers can be taught to employ mental health interventions that are just 2 to 3 minutes in length, and to use education and “watchful waiting” for at-risk patients. The primary care provider may be trained to use a variety of concrete treatment options to assist patients to focus on positive health outcomes and behavioral changes. The PCP may also use flexible patient contact strategies (e.g., the

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Analysis

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telephone) to follow their patients with identified mental health issues. Finally, primary care providers can be taught to emphasize functional goals over symptom elimination and “cure.”

CONCLUSION

With a unified strategy from the health center’s board of directors and executive director, to the medical director and the MH/SA director, integrating mental health/substance abuse services into primary care can improve patient access to MH/SA service delivery, increase MH/SA skills that PCPs need to improve health outcomes, and improve overall health outcomes. This unifying strategy should include the mental health program mission, scope, tactics, and core philosophy. It also needs to be embraced by senior level management and must involve key internal stakeholders (department heads and office managers). Senior administrative and clinical management will also need the clinical staff to embrace the integration of mental health services and to address philosophical resistance. Preparatory workshops can also help health center clinical and administrative staff learn how to integrate MH/SA service delivery into their health center.

There are many challenges associated with integrating MH/SA services into primary health care. Both primary care providers and MH/SA providers must learn new skills and adapt to a new clinical partnership. Health centers must have referral relationships that will enable them to consult with and refer patients with more complicated mental health issues to the public specialty MH/SA providers in the community. These relationships can certainly benefit health centers and their patients, but can also benefit the public mental health system by improving the quality of referrals that are sent from the health center and by improving the continuum of mental health care available to underserved and vulnerable Americans. ♦

Help from HRSA/BPHC

TRAINING

The Bureau of Primary Health Care (BPHC) within the Health Resources and Services Administration (HRSA) administers the Consolidated Health Center Program that funds community health centers. HRSA/BPHC is committed to reducing health disparities and improving the quality of the health care delivered through the health centers they fund. Health centers can apply to participate in a Health Disparities Collaborative focusing on the identification and management of depression among health center users. A team of senior-level health center staff, including the medical director and the executive director, can participate in this 12-month quality improvement experience.

The training involves a population-based care approach in which the mental health provider is made a member of the primary care team, and is readily available to primary care providers as they see patients in the clinic. In the training exercise, subgroups within the clinic, e.g., adults with chronic diseases, are initially targeted for depression screening and management. A Depression Registry is developed and is used by the primary care providers, the mental health provider, and the case managers to document and track patient care and response to therapies. All therapies are evidence-based and may include anti-depressant medications, cognitive-behavioral therapy, problem-solving therapy, etc. Medication management is provided by trained primary care providers with ready access to a psychiatrist for consultation, and self-management support is provided by the mental health provider, the nurse, or the case manager.

HRSA/BPHC also offers extensive mental health training and technical assistance through contracted mental health providers. This training is useful to health center administrators and clinicians as they consider whether or not to integrate services. The technical assistance offers them more in-depth assistance in designing their program and in developing their administrative support. Visit www.bphc.hrsa.gov for more info.

FUNDING

The BPHC has made access to mental health services for underserved populations a priority and has initiated a Mental Health/Substance Abuse Service Expansion Grant to provide funding to federally supported health centers to establish or enhance mental health services.

The purpose of this grant program is to improve access to mental health services for underserved and vulnerable populations that use health centers. The grant funds on-site integration of mental health or substance abuse service delivery in federally funded health centers. Currently, over 240 grantees, or over 25% of health center grantees, have successfully competed for these funds. HRSA/BPHC is providing over \$24 million annually for mental health/substance abuse service expansion. Contact the HRSA Grants Application Center at 1-877-477-2123.

TOOLS

A description of the PRIME MD Patient Health Questionnaire (PHQ-9) is available on the Web. For more information, type PRIME MD into any search engine. To download resources for managing depression on the primary care level, visit www.healthdisparities.net ♦

A Tale of Two Coasts:

Oregon and Massachusetts Undertake Integration Measures

By Robert Hennessy, Editor

Ken Duckworth, M.D., interviewed while serving as the interim commissioner for the Massachusetts Department of Mental Health, is pondering an interesting question: Why are there junk food machines in mental health clinics? To some, this question may not be relevant in the face of the mounting challenges in today's mental health care environment. To others, the question is not only valid, but the lack of an easy answer is indicative of a system without an appropriate connection to physical health.

Across the country, states are striving to integrate the fields of mental health and health for the universal goal of providing better care for their consumer populations. Oregon and Massachusetts are two states that subscribe to the belief that an integrated system is a more effective system, so *networks* interviewed a top official from each state to get a literal coast-to-coast look at current efforts in state-level integration.

"Why do so many medications that help treat mental illness cause weight gain—especially when rapid weight gain can lead to diabetes and high blood pressure, among other physical ailments?" asked Duckworth.

"When I was a trainee in 1986, cigarettes were actually distributed to patients by our system. Even today, the culture has not been aggressive enough about prevention, about moving toward the health model," said Duckworth. "Massachusetts has

taken this issue on and is working to shape a new culture, but the system is stressed [financially] and it is getting harder," he said.

Massachusetts is using their current infrastructure and data to find out why mental health patients are dying more frequently of heart disease and other physical illnesses than other segments of the population. A recent Department of Mental Health (DMH) study showed that the death rate for DMH clients between the ages of 15 and 64 was substantially higher than the rate for the

"Our job at the state level is to make our services friendly to people who want to make lifestyle changes."

same age groups across the state of Massachusetts in 1998, 1999 and 2000. The report states that many of these premature deaths could be attributed to some consumers' poor lifestyle choices, such as smoking and overeating.

"When a patient says he wants to quit smoking, [medical providers] have a gameplan; when he asks about mental health, he can get a 'That's not my job' answer," Duckworth said. "There is a disconnect and this has to change. Our job at the state level is to make our services friendly to people who want to make lifestyle changes," he said.

To help encourage more positive lifestyle choices among its consumers, Duckworth, working with the National Alliance for the Mentally Ill, is producing a video and curriculum using first-person accounts of people with serious

mental illnesses who have made lifestyle choices that are positively impacting their physical health.

Other techniques in the state include informing patients about the interrelated nature of mental health treatment options. "We are re-writing our pharmaceutical info sheets to say that weight gain is a common side effect for these meds and that diabetes is also a possible result for people who gain a lot of weight. This keeps the patient informed," said Duckworth. While further emphasizing side effects may seem risky to some providers who want their patients to utilize medications, not doing so can facilitate deception. "I have had nurses who wouldn't weigh their patients for fear that the patients would stop taking their meds if they got too heavy. It's all inter-related," he said.

With an eye on a more holistic system, the Massachusetts DMH is also looking at its state hospitals. The system is reviewing everything from the nutritional value of what their cafeterias are serving to medical data charts to review the pharmacology, family history, and current diagnoses for use in creating an electronic database that could aid in a patient's mental health treatment plan.

In addition, the state is running a pilot project where medical nurses are working part-time in mental health settings and billing their work to Medicaid. "The mental health teams are keeping the nurses busy—preventive health care, physical exams, following up people's medical problems, all under the supervision of the mental health staff," said

Duckworth. “This project places the nurses at locations where the [mental health] patients feel comfortable. This is not a big, expensive program, and there is no new money behind this.”

Officials in Oregon have also been busy on a variety of integration-oriented projects, according to David Pollack, M.D., medical director for the state’s Office of Mental Health and Addiction Services. “In terms of systems change, the state can facilitate things to happen in an evolutionary way or a systematic way. We have chosen the path of evolution,” said Pollack.

The state is currently running depression-related projects in various counties, including some rural areas. The focus is on developing better communication between primary care and mental health providers—a quid pro quo effort (supported by a grant for coordination of services) between the two fields. One project encourages primary care clinics to identify complex and high-utilizing patients and to refer them into the mental health system. In return, patients with less severe forms of depression would be referred back to primary care for treatment and monitoring. A key element of this project is providing ongoing consultation to the primary care providers.

Through these projects, primary care providers were given intense training on recognition and treatment of depression, including psychopharmacology issues as well as methods for communicating with mental health patients in a primary care environment. This training was provided by the Portland-based Foundation for Medical Excellence, creating a public-private relationship that could serve as an example to states as a means for improving

systems with outside help. In fact, Oregon officials are utilizing a number of non-state entities to improve the integration of its health care system.

For instance, state officials have participated with the Foundation for Medical Excellence to form a “healthcare integration think tank” that offers continuing education programs on medical topics, and has recently chosen to focus on improving depression treatment in primary care. The group has met to discuss grant solicitation, project research, and systems change, which, according to Pollack has, “created an infrastructure of support.”

On-site mental health triage is a positive first step to a more integrated

“We created a telephone triage system through Oregon Health & Science University where any prescribing provider in the state can obtain a curbside telephone consultation from a psychiatric faculty member.”

system according to Pollack, who not only supports co-location of mental health staff in health centers, but, in an age of dwindling resources, has taken the process a step further. “We created a consult service—a telephone triage system—through Oregon Health & Science University where any prescribing provider in the state can obtain a relatively prompt curbside telephone consultation from a psychiatric faculty member,” said Pollack.

Oregon’s mental health and addiction services office has also put on a conference on improving collaboration between psychiatric and primary care providers. “The conference generated widespread interest, provided a list of

projects going on around the state, and stimulated spin-off programs,” said Pollack.

Coincidentally, the health, mental health, and substance abuse departments within the Oregon Department of Human Services have recently been realigned to fall under one umbrella, a move that is paying off for Pollack and the effort to integrate services.

“In addition to the critical merger of the formerly separate offices of mental health and addictions, all the health-related offices and Medicaid are now under the same administrator. Now we have regular meetings of the state medical directors, and we are recognizing the overlapping concerns and opportunities to work together,” said Pollack.

“It’s so important for state mental health leaders to know what’s going on in the healthcare world and vice versa,” said Pollack. “There are resources that we should avail ourselves of from HRSA [Health Resources and Services Administration], SAMHSA, and private foundations. Rather than competing with each other or duplicating our efforts, we should seek out opportunities for collaboration.”

To contact Dr. David Pollack, e-mail him at david.pollack@state.or.us For a copy of the “Suggested Model for Integration of Behavioral Health into Primary Care,” an integration tool created by Pollack, visit www.nasmhpd.org/ntac To contact Dr. Ken Duckworth, e-mail him at ken.duckworth@dmh.state.ma.us ♦

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For information on a variety of public mental health issues, please visit NTAC's Web site at www.nasmhpd.org/ntac

Case Study

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but to understand the rhythm of primary care, we had to work at the medical pace. Of course, you have to consider the effect of working more productively," said Chung. "So, we monitored two things: 1) what was the minimum acceptable productivity that we needed to sustain service, factoring in [reimbursement issues]?, and 2) what was the carryover effect, the spiritual effect, on our patients? The patients did not mind, because they were used to a quick pace with the medical providers. The clinicians did not mind, because we did a much better job of accounting for (and decreasing) our no-shows due to improved case management," said Chung.

As with any major initiative, measuring the success and/or applicability of integration is essential. According to Kirk Strosahl, Ph.D., a clinical psychologist and a national consultant on integration, there are many ways to gauge the success of an integrated effort at the primary care level. One important factor to measure is access. "Out of the number of patients served in the community, what percentage will see a mental health provider? Even if you get your hands on the person for 20 minutes at least, there is a chance [he or she] will learn at least one thing about behavioral health." Strosahl said that he would like to see access figures rise from the current level of 3% to the 15-20% range. "Most of the 3% are the same people—the chronic population that never leaves the system. We should use this more productive integration model to churn through the behavioral health demand in the community."

Another aspect to measure is the productivity of the medical providers (the daily output of patients). Having a mental health provider on-site normally increases the productivity of medical providers by 15 percent, according to Strosahl. "This is where the income is—medical

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Case Study

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reimbursement will counter mental health losses, if there are any,” he said.

Of course, consumer satisfaction and medical provider satisfaction are two important factors to monitor. “We have seen huge increases in both,” said Strosahl. “In fact, I have worked on this type of program with the U.S. Air Force, and the satisfaction ratings were so high with their medical providers that the Air Force Surgeon General moved [integration of mental health providers] from a temporary project to standard program.”

Mission-specific outcomes, for example where patients are initially screened for depression and then surveyed again after a series of treatments, and other percentages, such as the number of patients that are actually placed in a community mental health or addiction treatment program after referral, are examples of other statistics to record, according to Strosahl.

Even though productivity, efficiency, consumer and provider satisfaction, and the numbers screened or referred are all valuable measures, the most salient measure for the patient and for their provider is the patient’s health outcome (i.e. did the patient’s depression improve?). Many federally funded community health centers that have begun identifying and managing depression are tracking their patient’s health outcome, and many patients being treated for depression are regularly re-screened for depression to track their response to therapy. If their depression is not lifting, their therapy can be modified to suit their needs.

Despite successes—at any level—the list of challenges remains longer than the list of achievements. To successfully insert mental health care into existing health systems, the aforementioned integration veterans suggest the following:

1) Develop a strategic vision that includes the mental health mission and philosophy. This strategic mental health

vision needs “buy-in” by senior management and should involve all stakeholders.

2) Look at integration/adding mental health professionals as an investment. While it may seem financially risky at first, by increasing medical provider productivity as well as the number of patients served, the move should pay off. Also, the medical providers should realize that integration is intended to decrease their overwhelming workload—a very powerful incentive when looking for allies during the process.

3) In addition to incorporating mental health providers, be sure to educate the primary care providers (PCPs). According to Donna Torrisi, M.S.N., director of the Abbotsford Family Practice and Counseling Network in Philadelphia, PA, “Be sure to educate your PCPs with the clinical practice guidelines for depression, etc. and train them, making sure they have the tools to do this, that they can refer patients. Once they are trained, they will find this to be a very compelling experience,” she said.

4) Cater your care to the community that is served. Look to your populations, and your data, before implementing changes to be sure they are appropriate for the needs of your consumers and family members.

5) Be patient and stay focused. “It takes time for PCPs, nursing, front desk staff to observe what you are trying

to do—they need training, and you need patience, but it will work if management stays committed,” said Chen.

6) Climb the reimbursement mountain. “Make sure your patients are getting whatever kind of reimbursement they are entitled to,” said one veteran. Hiring or appointing a person to navigate this paperwork process is a move that can pay for itself. Much like working toward a bigger tax return, it is essential to educate yourself on all the reimbursement guidelines and licensing requirements that can help the effort remain viable.

7) Just do it. “It’s not something that you need to contemplate an awful lot—the most important part is having the willingness on behalf of medical and behavioral staff, as well as support of the administration,” said Hayes. “If you have those things, jump in. The things that you need to work out are not the things that should hold you back,” he said. ♦

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www.integration

To learn more about topics presented in this issue, visit the following organizations on the World Wide Web.

American Association of Community Psychiatrists: The only national organization that solely represents community psychiatrists, the group has produced a position paper on “Interface and Integration with Primary Care Providers.” www.wpic.pitt.edu/aacp/

Bureau of Primary Health Care, Human Resources and Services Administration, U.S. Department of Health and Human Services: Your online A-Z source of information on community health centers from the federal point of view, including a “Models That Work” section and a search engine for locating a community health center close to home. <http://bphc.hrsa.gov/>

Charles B. Wang Community Health Center: A closer look at the center, which is profiled in the article beginning on Page 5 of this issue. www.cbwchc.org

Health Disparities Collaboratives: “A national effort to improve health outcomes for all medically underserved people with chronic diseases,” with a goal of eliminating health disparities and improving functional and clinical outcomes by helping health care organizations change the way they deliver care. The “Depression Collaborative” is a key program area. www.healthdisparities.net

The Institute for Healthcare Improvement: A partner with the Bureau of Primary Health Care in the creation of training manuals to help patients with chronic illness. The resulting Depression Training Manual, “Changing Practice, Changing Lives,” is available in PDF file format. www.ihl.org/

The National Association of Community Health Centers: A one-stop source of information about America’s “health center safety net,” the site features

up-to-date legislative action and regulations that impact health center operation, technical assistance resources for navigating the complex health care environment, and new funding and education opportunities. www.nachc.com/

National Council for Community Behavioral Healthcare: A tremendous resource on primary care behavioral health, the National Council site offers visitors a tour of the history of integration, a look at current research efforts, and a preview of the future of integrated efforts, as well as an opportunity to download their newly released Background Paper on the subject. www.nccbh.org

The National Nursing Centers Consortium: Includes information on the group’s Depression Training Program, a two-year program designed to increase nurses’ ability to recognize, diagnose, and refer or treat depression. The training is being offered to registered nurses, public health nurses, and nurse practitioners at NNCC member centers. www.nncc.org

The Lynn Community Health Center: A closer look at the center, which is profiled in the article beginning on Page 5 of this issue. www.lchcnet.org/

The World Health Organization: The WHO addresses the need for a more integrated system of care in its *World Health Report 2001* as an important aspect of “solving mental health problems.” www.who.int/whr2001/2001/main/en/chapter3/index.htm

Give us a call!

If you have ideas for a future issue of networks, or if you would like to be a contributing writer for networks, contact Rob Hennessy, editor, at 703-739-9333, x131, or via e-mail at robert.hennessy@nasmhpd.org

A Consumer View: Navigating Un-integrated Waters

By Joseph Swinford

Mr. Swinford is the director of the Tennessee Department of Mental Health and Developmental Disabilities Office of Consumer Affairs and a member of the board of directors of the National Association of Consumer/Survivor Mental Health Administrators.

The health care system is often frustrating for all consumers. It seems that no matter what causes someone to seek health care (mental health issue, physical disability, or the common cold) the outcome is more like a trip down an assembly line than a healing experience. It's not that the system is all bad, or that consumers don't get the care they need; the symptoms are usually relieved and conditions often improve as a result of the care. However, the trip through the system often requires a road map and a Global Positioning Satellite system to find one's way to wellness.

It has been said that people are made of three parts: mind, body, and spirit. While there may be three parts, the person is still a single entity. I find this to be true in my experience. As a consumer dealing with depression and anxiety, as well as respiratory and other physical issues, the combined impact on my life is substantial. The symptoms tend to feed on each other and the result is that my ability to function in my work and family life becomes impacted.

Worrying about the physical problems, which leads to a more depressed mood, compounds the anxiety. This causes me to worry even more and starts the cycle again.

Although I struggled with emotional problems most of my life, I never sought treatment for anything but physical symptoms until I was an adult. My first efforts were typical—I was given some medication for the gastrointestinal symptoms and was told to “reduce my stress level.” There was no direction on

how to reduce the stress, just a destination—life with less stress. That advice was given to a 22-year-old who was left to figure out how to get there.

Years later, the anxieties increased to the point of severe panic and I sought care fearing a heart attack. Again, the physical symptoms were treated but underlying problems were missed. Fortunately, I soon found a good primary care doctor who was skilled at identifying the underlying cause—*anxiety*. This doctor helped me

While some may look at integration and see challenges, consumers look at the potential and see hope.

with some ways to address the root cause *and* the physical symptoms.

The journey to wellness improved during my third time of crisis. No longer being under the care of the previous doctor, I was suffering from physical and emotional symptoms. The Emergency Room doctor ruled out underlying physical conditions and a clinical social worker directed me to inpatient psychiatric care. She also connected me with a psychiatrist who excelled in looking at the whole person. Although the primary care doctor was a missing piece, this psychiatrist helped to guide me on the road to wellness.

After another relocation, I found a new

primary care doctor who would also look at me as a whole person. I also found a new psychiatrist, who impressed me at the first visit by asking for permission to contact my primary care doctor. Not only did he ask for permission, he established contact, so the two could work together. Working with these two professionals as a team, I now have the integrated support I need to assist me in managing my illnesses as I progress on the road of recovery and wellness. Interestingly, after finding this combination of doctors I began to experience more major physical problems. This time, my shortness of breath and chest pains seemed to resemble a panic attack. Having learned from previous experiences, I thought these symptoms were a result of anxiety. After some tests, the doctors found that this time it was actually a physical condition—*asthma*.

While some may look at integration and see challenges, consumers look at the potential and see hope. We hope that one day we will be able to experience a more integrated health care system since our illnesses and symptoms overlap into a single, integrated experience that we call *our lives*. Our hope as consumers is that our health care experience will be a total experience, and our ultimate goal is for a health care system that serves as a tool to promote recovery and wellness. Recovery, after all, is building a rewarding life despite the challenges (in this case co-occurring mental and physical illnesses) that one faces, and a more integrated health care system is key to this effort. ♦

Coming Soon from NTAC...

Meeting the Mental Health Needs of American Indians and Alaska Natives

The most recent installment in our Cultural Diversity Series, this special report takes an in-depth look at the cultural and historical factors that influence the needs of Native American persons who have mental illness. The report is in final editorial review.

Big Picture

Continued from front cover

reasons, but we don't have a lot of evidence to support integration. There are models at contained sites, for example, a health center that has all services in one building. They work O.K., but the research data are not as strong as they would like them to be. Part of the difficulty has been that there has been a lot of discussion about what integration is, from conceptual integration to co-location of services. Some of the data look very positive, but they tend to be for specific locations only.

Ray: Unequivocally, yes. If you look at the amount of behavioral health issues—by primary care's own data—it's between 60-75% of all people they see have substance abuse and/or mental health issues. Primary care writes 65% of all psychotropic meds, and 60% stop taking those medications within three or four weeks, by their own data. Primary care workers have 12 minutes to see someone. How can they pick up affect, mood, and personal history in that time? If the data of the surgeon general and other sources are correct, there is an enormous amount of [mental health] problems not being diagnosed and treated. This is injurious to consumers, injurious to the physicians, injurious to the medical economics.

Benjamin: Absolutely. These are two disciplines that, historically, haven't crossed paths as much as they need to. Public health doesn't provide a lot of mental health services right now. We are striving everyday to try to get behavior change. There is an expertise of why people do what they do, and we haven't integrated this expertise into [public health] practice enough. We have a group of people who are experts, and we should be taking advantage of it.

Hardy: The answer is yes, but the real question is what is meant by "integrated." From the perspective of the individual or the community, the issues of mental health and physical health are certainly intertwined,

and any good clinician is concerned about the mental health aspects of any illness that he or she may be treating. The same would apply to community programs. In theory, integration makes great sense. If you are talking on the other hand about merging organizational structures within state government, that's another issue. However, within government—particularly at the state

"Primary care workers have 12 minutes to see someone. How can they pick up affect, mood, and personal history in that time?"

level—anything that can be done to foster collaboration in making services available should be done. Also, anything that is going to be done is going to take time because the cultures as I see them are slightly different in how they approach management of conditions.

Walker: Yes. I feel that basically the public health approach could add a lot to aiding the core mission of mental health. It's a win-win for the populations we serve. I believe we get to better outcomes and well-being for everyone in our communities by being more integrated in approach and vision at both the individual client level as well as the broader systems' levels. Integration fosters a more holistic approach to the healing process. But, in order to accomplish this at all levels, both systems must use a population-based approach to a continuum of services that include prevention, early identification, treatment and recovery supports. I think mental health agencies would be doing this more today if they had the resources. Also, in over half of the states substance abuse is already within a public health entity, which should help integration and adopting a population-based approach. Mental health could use health's data and research expertise, as health has vital stats and health surveys. It is not clear if your question assumes substance abuse is in the mental health or the public health entity. That being said, having public health and substance abuse together makes it easier for substance

"At a global level, the concept is appealing for both practical and financial reasons, but we don't have a lot of evidence to support integration."

abuse to focus on problem behaviors in addition to addictions and diagnoses. This relationship is an advantage to be exploited because of [health's] full range of expertise in primary prevention, expertise in data, and a population-based approach.

2 From a dollars and cents perspective, is integration cost-effective, or cost-prohibitive?

Gonzales: At the most simplistic level, theoretically it should be cost-effective. There are data of treating mental disorders and the impact of cost from health care, but the results are really mixed. I can't say which way, but another option for this question is 'cost-neutral.' A solution for getting an answer to this question is to convince researchers to study the topic in depth, but in partnership with administrators, clients, and providers on front lines. At NIMH we are developing mechanisms to bring these groups together for study. Most centers can't invest time and money into research. This could provide a venue to test the cost issue. Also, we could come into a definition of integration so we can study and then test different models.

Ray: It depends on where you decide to measure it – integration could be defined a number of ways. At what level do we integrate? How do we? What is true integration? At Cherokee Health Services in Tennessee, community health and

behavioral health are totally integrated. You go in the same entrance for both services; you have the same records. Services are provided so that anyone can get a "hallway handoff" - no waiting for a visit with a therapist. True integration eliminates stigma, and therefore reduces cost.

Benjamin: Cost-effective. The more efficient we are at achieving behavioral change, the less money we have to spend on things that don't work in health. The

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Big Picture

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issues of the mental health side of things, like stress and its role in hypertension and cardiovascular disease, violence, and using a mental health knowledge base to reduce violence, abuse, rape, use of weapons, and violent behavior clearly translates into lower expenditures. Public health is trying to figure how to reduce that kind of behavior—and mental health prevention techniques have a very important role in this effort.

Hardy: So much depends on the good will of people to make something work. There could be real cost savings if people in the private and public sectors and even corporations and foundations agreed to address an issue and pool resources among agencies and make a difference, but it will have to be done incrementally. It will have to be organized around issues that are important to people, and it will have to be done by people of good will. There is a nice example with NASMHPD, the National Governors' Association, the state departments of education, and others working together on the issue of youth suicide by bringing together multiple agencies within a state and pooling resources. The more we can do with a demonstration project where a difference can be made, the more people will want to work together to make things cost effective and to make a real difference in communities.

Walker: I believe that integration at all levels is cost effective, especially in the longer term. To achieve the best outcomes, there should be resources for screening and assessment as well as early intervention programs and services. Since typical public and private insurance mechanisms will not pay for all the early intervention services needed to change behaviors (especially those related to alcohol and other drugs), it may be more costly in the short term since investments need to be made up front to save the dollars on the back end. In addition, there needs to be support for

healthy communities in which stigma about mental health and substance abuse are significantly reduced. Dollars are needed for public education and awareness as well as family and community supports for individuals to enhance integration into the community. Finally, I believe there are savings and cost efficiencies in providing integrated individual services in community settings.

3 Are there any arguments for making the two fields more distinct?

Gonzales: This is a hard question to answer. From a research perspective, I don't know that there are any, except that there may be certain special topics or special theories that may test better in a different arena. First you test in one, then test in an integrated arena. Hard to quantify without a common definition of integration.

Ray: In a perfectly resourced world, we could let specialists do what they do best, and keep the less severe cases in primary care

if the patients are responding, but I wouldn't buy the argument.

Benjamin: I think they have very clear scientific boundaries and areas where they are different already. But, their strengths are in their differences. There are people who are trying to understand the different strengths for use in the other field. The question is, when you take those mental health pieces, and apply them in health, can we achieve the same kind of results, or even better?

Hardy: No. There is already a cultural difference, and if anything, I would like to see both ends of the continuum benefit from the strengths of the other. Public health people tend to believe that they approach things from a population perspective with an eye on prevention. The perception of many in the public health community is that the mental health system is much more focused on the provision of care to individuals who already have an illness. I don't think that

anybody feels that there is a lack of interest or willingness to do it. I just think that it gets into the area of cost: What it costs to provide care to people who are already receiving services, versus what can be done from a preventive perspective. We could both learn a lot from one another, so I certainly wouldn't want to see us driven further apart.

Walker: They do overlap, and I applaud the work by mental health professionals in the face of great challenges in the past, but we need to come to more agreement on definitions and terms. Mental health needs more integration within a public health systems framework. We need more [mental health] linkages with systems that deal with physical health. Although I'm sure this will be debated, I believe it is fundamentally better to bring behavioral health to primary care and other health care settings in the community than bringing health to mental health entities. I realize this has major implications for the training and education of all health care providers.

4 What are the largest obstacles to integration?

Gonzales: History, tradition, political investment, the way things are already financed and organized. One other obstacle is that people underestimate how hard it is to conceptualize the depth of the problem, hone in on operationally defining it, and then applying theory and good measurement to definition. There are also cultural obstacles within the areas. People estimate only one or two levels of obstacles ahead of them. There are issues that need to be addressed from a state policy maker level, client level, administrator level, provider level. Think of a matrix with some issues spread across all levels – financial issues, attitudinal issues, manpower issues, etc. We need to know from a research perspective which kinds of combinations of those levels are best suited by which models.

Ray: Insurance issues. Certain things can't be billed to certain codes for the other field. Systemic issues. The two systems

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don't talk to each other. There is primary care and then the tertiary mental health system. Different language, different approaches, different work styles. The public health system allows 12-14 minutes for patient visits – it's very reaction-oriented. We [in mental health] tend to think in 50-minute hours, they [in health] think in 15-minute billables. Financial questions are an issue. Community health center programs are all federally run; they are not bound by local and state governments. This is good and bad, in that a decision can be implemented quickly at the federal level.

Another issue is training. For example, clinical research shows that cognitive behavioral therapy and medication together as treatment is better than medication alone, but just

using cognitive behavioral therapy is better than medication alone. If you use both, recovery rate percentages are in the 80s-90s. But, how many people are trained in cognitive behavioral therapy and are in the public system? We need to see techniques that are applicable in the general population. To be successful in primary care, we can't use the 50-minute hour - we have got to learn new skills and learn from the medical model to be more successful.

Benjamin: Lack of exposure. Historically, mental health has viewed itself as an acute care practice or a chronic system. The area of prevention has not been a strong component of that, and that serves as a barrier. Health has historically said that mental health folks have distanced themselves, and we have not brought the two fields together often enough to see the commonalities.

Hardy: The biggest obstacle to any change anywhere is that people are already overwhelmed with what they are doing, particularly since September 11, the anthrax crises, and smallpox. The attentions are so focused and the hours are so tight—it is not the best of times to be reflective. The

[mental health and health professionals] are exhausted. So, the biggest obstacle is time. Right now, there's very little ability to try to pick some new ideas that can make a difference and focus on them.

Walker: The cultures and approaches of public health and mental health are historically different. Both need to realign around a vision and mission that is population-based and that advocates for a continuum of care from prevention, to treatment and recovery. Regardless of organizational structure, there should be an integrated approach at the state and local policy level as well as service system levels. For example, more maternal and child health programs funded by public health

should be given a leadership role for issues on mental health. In addition, health expertise should be made available to mental health services for the severely impaired. Developing a joint mission and

roles between public health and mental health should be supported by modeling of federal agencies. Currently, federal direction of these two systems supports different national surveys, different estimates on need and issues, and different views of prevention and treatment. If there was more cooperation at the federal level, we would have more resources to work with at the state and local level.

5 In your opinion, what are the largest benefits to a more integrated system?

Gonzales: Given the fiscal crisis facing states on mental health and public health sides, one potential benefit is economics and cost-efficiency, but this has to be tested out. Second, there could potentially be a more holistic approach to the client and there are opportunities to designate mental health conditions and settings. Last, the hope would be that theoretically we could improve outcomes for clients. It's worth pursuing only if it is much more focused. Right now, the discussion is too global, there are some sites that work, but you

hear nothing about integrating medical care into the public mental health system, we need more research on these topics. There are some investigators who are starting to look at integrating primary care into mental health. It's theory-driven with focused models and set outcomes. Bottom line, from a research perspective, if the efforts are focused, and the intent is specific, then it is worth pursuing.

Ray: Most people with chronic illness have serious health issues—they are not always taken seriously by medical doctors, and they also don't report symptoms as well. Mental health could help primary care physicians separate somatic complaints from serious illness such as cancer and cardiovascular problems. I think it's a win-win for both sides of the aisle.

Benjamin: Ultimately, a healthier community. When we sit down and look at what each other does, there is a huge opportunity to improve public mental health—more than we had previously identified.

Hardy: The benefits could be huge. Our staff has talked about the top ten lessons learned by state health officials since September 11 and anthrax. Three of the top ten dealt with the importance of mental health support and the issues that not only victims had, but issues that responders had. And that's not to mention how woefully lacking we were from the public health perspective to try to meet those needs. In almost everything we [health professionals] deal with, there is a critical mental health component, such as with HIV infection. Obviously, access to mental health counseling is huge in our HIV program, as well as in terrorism response. And the astonishing thing to me is that the #1 chronic disease in America is depression. We deal with chronic illness, we talk about obesity, cardiovascular disease, diabetes, and cancer and these are all real problems, but from a public health perspective, there is not enough we are doing at the community level about depression. There are all kinds of opportunities out there.

Walker: Improved health outcomes, more efficient service systems, and

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healthier communities that support mental health needs. There could be better relationships between health colleagues so that substance abuse, mental health, and health share knowledge on issues such as substance abuse and HIV.

6 What can public mental health learn from public health?

Gonzales: There is a lot they can learn from one another, in terms of existing clinical models that may work. Both need to learn more about their own cultures, to explore how they are different and similar so they can explore a more integrated model. They need to explore their weakness and failures to find commonalities. They could see which weaknesses to face. Then the weaknesses should be built into research mechanisms, rather than a restart by plopping a study down into a situation without enough research beforehand. There has been an increasing awareness on the research side that they have to have a full sense of what a real-world setting's intricacies are. They must work ahead of time to learn what obstacles are ahead.

Ray: In the 1960s, JFK said that it was time to put mental health care into the mainstream, into healthcare. The original philosophy was for the prevention and treatment arm for mental health and addiction to be in the community – it was intended to be a barometer for public health in that community. The federally qualified programs have retained this. The President's New Freedom Commission, in clear language, said that the system is in terrible shape and it is broken and fragmented. Also, their mid-term report says that treatment works, and it says we did find model programs – so it's not an issue of lacking science or evidence – it's a "will and a wallet" issue, we don't have either of these to make it happen.

Benjamin: There are three things: 1) a focus on prevention; 2) public health has a good core of community-based, population-based health centers—this is not available

enough in mental health; and 3) public health has a disease and science base, and as we learn more and more about mental health, we will be integrating this into the system. When we learn more about the science base of mental health, we will find a link between some somatic and science-based diseases.

Hardy: I'd like to re-phrase the question as, "What can public health bring to the table?" I think what public health brings is the approach to an issue: First, we have the assessment of where we are in the community, the definition of the problem; then the planning of intervention strategies; and then the selection of one, two, or three most appropriate interventions; and finally the evaluation effect of the interventions. It's a thought process that may exist in mental health, but the perception is that we can increase its usage in the field. Also, there is a whole cadre of support people who do a lot in the mental health area, even though they weren't trained in that way, e.g., the public health nurses, the public health educators, the nutrition counselors—

all sorts of people who work in public health that have an impact on mental health through their interrelations with people.

Walker: A population-based and systems development approach to improving health of communities. Public health is concerned with assuring the health of everybody, including those who are covered by private insurance as well as public programs such as Medicaid. This kind of broad approach is needed in mental health agencies, which tend to focus on the publicly insured and the most severe diagnoses. I feel many state mental health directors share this approach but have not had the resources to do it.

7 What can public health learn from public mental health?

Gonzales: *Editor's note: See answer to Question #6.*

Ray: How to diagnose these mental health disorders, how to be more effective in management—for instance, psychopharmacology is currently wasteful in dosage—and we could educate the health field more, get better care.

Benjamin: Mental health has a very strong holistic component to it that is a real lesson for health. The other thing is that strong communication is the strength of the mental health provider, especially the concept of risk communication. We could really learn a lot about that.

Hardy: As for what mental health can bring to the table, mental health professionals have a whole different knowledge base than we have, so there is a unique kind of staff expertise that we don't tap into—the whole knowledge of what the

current state of mental health issues, policies, and funding systems are. These are things that are totally foreign to us on the public health side. If we are going to make progress in integration, there are great opportunities out

there. We need some really targeted success stories of what happens when the professions work together. The more [anecdotal and evidence-based] success stories we have, the more people will be energized.

Walker: Public health can learn better ways of serving the most vulnerable and at-risk populations. Public health would benefit from the clinical expertise and knowledge about mental health treatment, as well as understanding the role of stigma and discrimination in accessing care and delivery of care for individuals with mental illness. ♦

Editor's note: The opinions expressed in this column are those of the panel participants only, and do not necessarily represent the views of the participants' employers.

"When we learn more about the science base of mental health, we will find a link between some somatic and science-based diseases."

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