Report of a Surgeon General's Working Meeting on

The Integration of Mental Health Services and Primary Health Care

Held on November 30 - December 1, 2000
At the Carter Center: Atlanta, Georgia

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INTRODUCTION

A groundbreaking meeting was held November 30 – December 1, 2000, to advance the integration of mental health services and primary health care. The meeting was an outgrowth of the U.S. Surgeon General's landmark report on mental health.[1]

That report's single recommendation was to encourage people to seek help for mental illness. It found that a startling majority of adults and children with mental illness do not receive any services. The report featured primary care as one of the prime portals of entry into treatment—especially for those reluctant to access, or unaware of their need for, mental health services. Primary care was also seen as an opportune site for emphasizing wellness and prevention of mental illness. Yet few programs nationwide are expressly organized to integrate mental health services and primary health care—and even fewer have been evaluated fully.

The meeting[2] was designed to set a blueprint for the future. Its specific objectives were to forge consensus among diverse participants on *core principles* and on a *national action strategy* for the integration of mental health services and primary health care.

Participants invited to the meeting represented a cross-section of consumers and families, insurers and health care systems, researchers and other experts, clinicians, and representatives from foundations and government (Appendix A). These groups are key to launching a new public/private approach.

This meeting report covers Surgeon General David Satcher's remarks, the format of the meeting, its highlights, and, finally, the core principles and national action strategy generated and voted upon by participants. The report does not include activities that have occurred since the Carter Center Meeting.

Brief Summary of Dr. Satcher's Remarks

The meeting opened with an eloquent speech from Dr. David Satcher. He began by noting, in particular, the diversity of the participants including business, health care systems, consumers, families, and foundations, as well as government agencies. He was particularly impressed with the balanced presence of primary care and mental health experts who were well established in their fields. These experts included "real world" and "front line" people who would be key to helping solve some of the unfortunate barriers within our current health care system. He then challenged the participants to think beyond each of their individual perspectives and consider ways to overcome barriers between primary care and mental health. He noted that many golden opportunities exist for integrating mental health services and primary care.

He presented his thoughts regarding the highlights of the Millis report on the role of primary providers (Millis, 1966). That report identified a number of roles for primary care providers. They included providing first contact of care, providing comprehensive care, providing the coordination and integration of care, and providing community leadership.

Dr. Satcher acknowledged, as a family physician, both the frustrations and opportunities presented to the primary care provider on a daily basis. As the Surgeon General he pronounced the evidence in 1999 in *Mental Health: A Report of the Surgeon General* and the need to create a system of care that not only treats illness but also promotes health. He named building a balanced community health system as one of his top three national priorities. A balanced community health system balances health promotion, disease prevention, early detection, and universal access. This system concept would require a partnership between primary care and mental health and between public health and medicine.

Primary care offers golden opportunities as a point of first contact with patients and their families, in which a meaningful relationship can be established to educate

[1] U.S. Department of Health and Human Services (DHHS). *Mental Health: A Report of the Surgeon General*. Rockville, MD: Author, Substance Abuse and Mental Health Services Administration, Center for Mental Health Services, National Institutes of Health, National Institute of Mental Health, 1999.

[2] Sponsored by the Assistant Secretary for Health/Surgeon General of DHHS.

and motivate patients, as well as to detect health conditions. A "balanced partnership" provides an opportunity for the coordination and integration of patient care. This is actualized by involving the health team and the family and targets continuity of care, which ensures comprehensive high-quality care.

Dr. Satcher addressed specifically the lack of time in primary care that providers have to adequately attend to the many responsibilities that our health care systems require of them. He urged primary care providers to remember that they are not alone. In fact, he challenged the primary care provider to be the quarterback of the health care team that collaboratively makes the system work for the patients and their families. He spoke of our negligence of the health care system for not engaging the potential resources available within families. Not only is family involvement therapeutic for the patient, but it is the key to sustaining continuity of care and providing high-quality care.

He then encouraged providers to act as responsible community leaders who educate, motivate, and mobilize the public regarding the definition of mental health as stated in *Mental Health: A Report of the Surgeon General*. He went on to define mental health as a person's ability to function and to be productive in life; to adapt to changes in his/her environment; to cope with adversity; and to develop positive relationships with others. He emphasized that without good mental health one cannot have good health and well being. Therefore the primary care and mental health partnership is crucial for overall balanced health.

The good news in the mental health report, he indicated, is that we have the ability, perhaps 80 to 90 percent of the time, to treat mental disorders with a range of different treatments. However, the bad news is that less than half who suffer each year seek treatment. And many who make contact with the health system don't necessarily make contact with the mental health system because they are experiencing mental illness, because they are unaware, or because of the stigma surrounding mental illness. Others have trouble because of barriers associated with the health care system itself.

Dr. Satcher moved on to ask what is the vision for the future and what is the task ahead. He then pointed out that *Mental Health: A Report of the Surgeon General* devoted an entire chapter to laying a vision for the future. He went on to identify the eight courses of action in that chapter to include the following:

- Our work should be based on the best available science so that we may prevent disease and promote good mental and physical health. Thus, we must continue and enhance mental health research, especially prevention and promotion.
- We must acknowledge and find ways to overcome the barriers of stigma.
- We need to build public awareness regarding mental health and effective treatments.
- We must address the serious shortage of mental health providers and the lack of training available for many community helpers who could potentially impact a person's health.
- We need to ensure the delivery of state-of-the-art treatment which means moving front-line knowledge to front-line care so that primary care providers have access to knowledge, technology and teams of experts to support their work with their patients and families.
- We need to tailor treatment to age, gender, race, and culture.
- We need to facilitate entry into treatment.
- We need to remove the financial barriers that create complexity and restrictions within our health care system.

Dr. Satcher ended with a quote from John Gardner, Secretary of Health, Education, and Welfare in the 1960s, "Life is full of golden opportunities carefully disguised as irresolvable problems."

Meeting Format

The conference agenda was structured around formal presentations, question-and-answer sessions, and small breakout groups for detailed deliberation. Panel presentations and question-and-answer sessions furnished a common understanding of the nature of the problem, some "real world" programs, the hurdles and opportunities programs face, and findings from research.

Dr. Satcher's speech was followed by a state-of-the-art review of practice and research findings gathered from structured interviews. The structured interviews had been conducted before the meeting by consultant and meeting organizer Brenda Reiss-Brennan, President of Primary Care Family Clinics, Inc. Over 90 interviews were completed of attendees and nonattendees from a diverse group of experts representing business, foundations, federal agencies, consumers and families, research, employers, economists, epidemiologists, providers, health care consultants, and payors. Ms.

Reiss-Brennan gave an overview of her findings about participants' level of interest in the process of integration[3] and their rationale for developing systemic approaches to promoting healthy families and communities.

The interviews indicated that clinical research knowledge appears to be directing the field toward integration and economic knowledge appears to be directing the field away from integration. In the middle of this quality gap, being squeezed to maximum capacity, are providers of care and their patients and families, who attempt to negotiate major health disabilities in stressed environments. This current nonintegrated process of care creates costly burdens for the health care system, the family, and the community.

Interviews revealed consensus among participants to build collaboration and commitment among stakeholders that result in strong leadership, mobilization of successful implementation strategies, and demonstration of affordable, evidence-based integrated care.

After plenary and panel presentations, participants were divided into five breakout groups, covering seminal issues of design, training, economics, research, and quality. The breakout groups were charged with developing ideas for core principles and action steps, and then bringing those ideas forward for general discussion by all participants.

A reporter from each breakout group presented their group's priorities when participants reconvened in a general session. With the aid of a professional facilitator to guide the discussion and build consensus, participants separately voted on their top core principles and action steps.

Meeting Highlights

Nature of the Problem

Every year, about 20 percent of U.S. adults and children have a mental disorder. Despite an array of effective known treatments, the majority of those with mental disorders do not receive treatment and thus needlessly suffer from distress and disability. Mental disorders are highly disabling, ranking second only to cardiovascular conditions as a leading cause of worldwide disability by the World Health Organization (Murray & Lopez, 1996). Moreover, these disorders impose substantial cost burden to patients, their families, and communities at large. That burden is reflected in lost productivity and premature death and in the amount of medical and community resources expended.

The prevalence of mental disorders in primary care is somewhat higher than that in the population. About 25 percent of people receiving primary care have a diagnosable mental disorder (Olfson et al., 1997), most commonly anxiety and depression. Depression occurs in about 6 to 10 percent of primary care patients (Katon & Schulberg, 1992). Older adults are particularly vulnerable in an unintegrated system because many of them are treated in primary care for a variety of health conditions, and depression may go undiagnosed and untreated. Low-income minority populations face similar identification barriers because primary care services are often cost prohibitive and difficult for them to access.

Major depression is one of the more prevalent conditions observed in the primary care setting afflicting an estimated 5 to 9 percent of presenting patients. Such prevalence coupled with evidence that most depressed patients receive mental health care from primary care physicians (Coyne et al., 1994; Reiger et al., 1993; Rost et al., 1998) has prompted much attention in the field.

Mental disorders frequently co-occur with other mental or somatic (physical) disorders. Estimates of this "comorbidity" range from about 20 to 80 percent of primary care patients (Sherbourne et al., 1996; Olfson et al., 1997). Comorbidity adds to disability and contributes to morbidity and mortality.

There are a number of barriers to effective diagnosis and treatment of mental illness in primary care. Overwhelming societal stigma is partly to blame for patients resisting diagnosis, resisting treatment altogether, or not adhering to treatment recommendations (DHHS, 1999). Primary care providers vary in their capacity to recognize and diagnose disorders, and, if they do so correctly, they may not adequately treat or monitor patients. Some estimates are that about half of those with mental disorders go undiagnosed in primary care (Higgins, 1994). Finally, mental health services—in either primary care or through referral to specialty care—are often difficult to access, fragmented, or poorly financed. Thus, the integration of mental health services and primary health care faces broad-sweeping attitudinal, educational, organizational and financing problems. These problems stem in part from the historical separation of mental health from the mainstream of medicine (DHHS, 1999).

Opportunities

Primary care holds a myriad of opportunities to engage patients in need of mental health care. These opportuni-

[3] Participants spent a significant amount of time discussing integration but were unable to reach a consensus on a definition for integration.

ties range from health promotion to disease prevention and treatment.

As a first point of patient contact with the health care system, primary care is often closer to home or work and more affordable than specialty care. It offers the possibility of cost-effective treatment, particularly with less severe mental disorders. Primary care also has the potential for early identification of symptoms and for coordination and continuity of care for both mental and somatic disorders. This is highly important given the frequency of comorbidity and the long-term nature of many mental disorders. Further, a focus on mental health within primary care underscores a message of the Surgeon General's report: Mental health is fundamental to overall health.

Primary care is not only where individuals receive care; it is where family members do too. By establishing relationships with the family, primary care providers have the advantage of tapping the family as a source of support. These relationships with the family are key for children and older people with mental disorders.

Perhaps most importantly, primary care is where many consumers prefer to receive mental health services (Annexure et al., 1997). Primary care is often perceived by consumers as less stigmatizing than the specialty mental health sector.

Most of these opportunities for integrating mental health care have yet to be realized, with the exception of one mental disorder: depression. Research and practice on prevention, diagnosis, and treatment of depression in primary care have been proceeding for more than a decade (Schulberg et al., 1999). A special subgroup of meeting participants met to explore depression as a model for service integration.

There are many possible ways to organize and staff mental health services in primary care, for integration does not exclusively rely on a single setting or type of professional. Some programs described at the meeting use a psychiatric social worker to deliver mental health services and to "bridge" primary care and specialty mental health care, with patients seen in either setting. Other programs use multidisciplinary teams, including mental health care, to furnish care in the context of routine health visits and follow-up within the primary care setting. Regardless of the variation, a central feature of many programs is enhanced training of primary care providers in the detection of mental health problems.

Obstacles and Challenges

As is true for any new approach to health care, an array of obstacles stand in the way of attaining the promise of integrated and collaborative care. The nature of the problem is compelling, and the opportunities plentiful. Our Nation's health care system is a highly complex and diverse system serving the interests of consumers, professionals and providers, hospitals, insurers, employers, and government. The rationale for integration of care, according to meeting participants, needs to be made for each of these stakeholder groups and bolstered by empirical research on cost, efficacy, quality, and consumer satisfaction.

And beyond these traditional stakeholders are many vulnerable populations who are uninsured and thus left out of public or privately funded systems of care. The obstacles and challenges described by meeting participants are highlighted below.

Design

A major design challenge to the integration of mental health services and primary health care is the *lack of motivation*—on the part of consumers, providers, and payors.

- Consumers are hesitant to accept and follow through on mental health services.
- Primary care providers are overwhelmed by limited time to attend to each patient's needs. Visits last on average 13 to 16 minutes, and patients have an average of six problems to address with their provider (Williams et al., 1999).
- Partnerships between primary care providers and mental health professionals have been stymied by different cultures of care, including styles of communication and duration of office visits.
- Payors have limited motivation to offer integrated programs owing to what they see as high start-up costs, lack of consumer demand, and limited evidence for cost neutrality or cost offsets (in terms of lower overall health care costs, lower disability costs, or improved worker productivity) (Malek, 1999).
- Other major design challenges include delegation of roles and responsibilities of primary care physicians and other professionals (e.g., mental health specialists, nurses, health educators) and the need for common integrated information technologies for medical records, scheduling, billing, and reporting.

Training and Practice Guidelines

There are few training programs and practice guidelines that emphasize the integration of mental health services and primary care.

- Primary care providers generally have little formal training in the diagnosis and treatment of mental disorders and even less in promoting mental health wellness and disease prevention.
- Primary care providers have sparse guidance about decision support, i.e., what disorders (alone or in combination) and at what level of severity can be treated effectively in primary care versus being referred to mental health specialty care.
- There are few incentives for educational institutions and professional organizations to step beyond existing training and practice programs to embrace integrated and collaborative approaches.
- If demand for services expands, integrated programs may be unable to keep apace because of an insufficient supply of well-trained mental health professionals in rural areas and many other parts of the country (Peterson et al., 1998).

Economics

There are many economic barriers to the creation and implementation of integrated care.

- The funding of mental health services is generally separate from the funding of general medical services.
- There is lack of parity, i.e., the level of funding of mental health services is more restrictive than and not on an equal footing with that for general health services. Further, over the past decade, spending for mental health services has decreased as a percentage of overall spending for health care (DHHS, 1999).
- An increasing number of health plans are moving to "carved-out" mental health services, i.e., separate systems of financing, delivering, and managing specialty mental health services. Carved-out mental health plans have little economic incentive to offer, or to participate in, integrated treatment because these plans cannot recoup cost offsets (reductions in overall health care utilization/costs as a result of treatment of mental disorders).
- There is little, if any, economic incentive for mental health and primary care providers to collaborate across disciplinary lines and develop a team approach to care.

Quality

There are few explicit programs for measuring quality of services that integrate mental health care and primary health care. One step forward has been the development of quality improvement programs for treating a single mental disorder—depression—in primary care (Wells et al., 2000).

- The development and continued monitoring of quality-improvement programs rests on a foundation of skills and knowledge concerning staffing and treatment of mental disorders in primary care, yet such knowledge has yet to be developed beyond that for depression.
- Greater attention to quality improvement is likely needed for vulnerable populations. For example, research has found that patients at greatest risk of having their mental health problems go undetected in primary care include African Americans, men, and younger patients (Borowsky et al., 2000).

Research

With the exception of depression, research is sparse on the development or evaluation of programs for the integration of mental health services and primary care.

- Research funds are generally limited to the conduct of research and thus cannot be used to sustain research programs found successful.
- Programs with strong efficacy based on research are difficult to translate into the "real world" of practice owing to heterogeneity and diversity of patient populations, comorbidity, and less monitoring of outcomes by providers (DHHS, 1999).
- Little research has been directed to integrating primary care and mental health services for people with severe mental illness.
- There has been a paucity of investigator-initiated research applications in this area.

Recommendations Toward Core Principles

Meeting participants agreed to the following principles—or fundamental elements required to facilitate the development and implementation of programs that integrate mental health services and primary health care. They provide a framework, not only for local programs, but also for a National initiative.

1. *Emphasis on Consumers and Their Families.* The needs of mental health consumers and their families should drive service delivery and systems of care. Cultural and ethnic diversity should be respected. The integration of mental health and primary care is meant to expand access to care and is not intended to preclude availability of mental health specialty care for those who need it.
2. *Promoting Health and Overcoming Disparities.* Promote health for all Americans and overcome disparities in the burden of illness and death experienced by African Americans, Hispanics, Native Americans, Alaska Natives, and Asians and Pacific Islanders.
3. *Basic Characteristics.* Research, training, and practice should incorporate consumer, family, and professional partnerships; cross-disciplinary professional collaborations; population-based health care; a holistic approach to health care; and respect for, and understanding the role of, spirituality and alternative medicine/traditional healing practices.
4. *Financial Incentives for Team Approach.* New types of financial incentives should be offered to encourage team approaches to care. The team includes consumers and families, primary care providers, mental health professionals, and nursing case managers. The team may also include care management, consultation, and specialty services.
5. *Reimbursement.* Reimbursement should be designed to support evidence-based care.
6. *Collaboration/Colocation.* Integrated service delivery should be guided by a commitment to collaboration or colocation of services.
7. *Chronic Illness, Continuity of Care.* Integrated service delivery should feature the treatment of chronic illness and continuity of care.
8. *Standardized Quality and Outcome Measures.* Quality and outcome measures should be standardized across systems and levels of care and include consumer/family participation. The collection of information should respect consumer and family privacy. The information should be transportable and longitudinal.
9. *Building on Existing Models.* The development of integrated programs should build on existing knowledge and/or models of care.
10. *Research and Demonstrations.* Research findings must be salient to key stakeholders, including diverse ethnic and cultural communities. Successful research and demonstration programs should be sustainable through multifaceted partnerships brokered by funding agencies.
11. *Investment in Training.* Training should build collaborative partnerships that are grounded in clinical and systemic decision making of the highest quality. Quality should reflect evidence-based knowledge that is disseminated in culturally sensitive ways to promote health and reduce stigma.
12. *Information Technology.* Information technology should be marshaled as a tool for communication, patient education, data collection, and access to care. This technology should support the infrastructure needed to deliver high-quality care while protecting patient and family confidentiality.

Recommendations Toward a National Action Strategy

The core principles provided the foundation on which participants were able to build consensus in developing actual strategies that would promote the bridging of primary care and mental health. These strategies were prioritized into the following action strategy recommendations. The recommendations reflect the merging of multistakeholder expert opinions from the fields of practice and research and were put forth as a guide to spawning a national action strategy to promote implementation of evidence-based quality care. Since the Carter Center meeting, this National Action Strategy has undergone further evolution.

1. Convene a group under the auspices of the DHHS to develop a framework for the integration of mental health care and primary care, including a focus on comorbidities, diverse modalities, and diverse populations.
2. Incorporate a list of skills, knowledge, attitudes, and simple tools that reflects evidence-based "best practices" and treatment management, leading to improved outcomes.
3. Design education and training standards for the integration of mental health care and primary health care—with all stakeholders, including accreditation bodies—and promote implementation of those standards by schools of health and behavioral health.
4. Evaluate whether program and policy initiatives on integration lead to the elimination of racial and ethnic health disparities and promote equal access to high-quality health care.
5. Develop a plan for research and demonstration projects on integration that meet basic methodological requirements for generalizability with respect to service delivery models and health outcomes.

   5.1 Articulate a vision for success for a consumer-driven integrated service delivery system that includes the following: awareness of the culture of primary care, patient education, professional training, follow-up care, and care management.

   5.2 Bring together multiple private and public funding sources for projects and develop a plan for projects—sustainability, if the projects are found successful.

   5.3 Convene accreditation and licensure and regulatory agencies to reduce barriers to implementation of research and demonstration projects (e.g., funding and/or regulatory waivers).

   5.4 Lead to development of initiatives that foster the development of service and economic models with these basic features: (a) collaborative/integrated care among consumers, primary care providers, and mental health specialists to meet local needs; (b) evidence-based approach to care delivery based on scientific methods (e.g., randomized controlled trial, quasi-experimental design, case-control study, survey designs); and (c) measurement of outcomes, such as access, costs, functional status, quality of life, patient/family/provider satisfaction, health beliefs/stigma, relapse reduction, sentinel events, recovery, and the effects of consumer and provider incentives on health outcomes and process measures.

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APPENDIX

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A Surgeon General's Working Meeting on The Integration of Mental Health Services and Primary Health Care, Held on November 30 — December 1, 2000

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