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Integrating Care: Improving Overall Health by Integrating Behavioral/Mental Health Care into Primary Care

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Policy Brief

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Dr. Baird is currently an active participant in the Minnesota Department of Human Services Children's Psychiatric Consultation Protocols Workgroup, which will become a phone-based clinical resource for physicians prescribing atypical antipsychotic and ADHD medications for children. Dr. Baird also led the multidisciplinary team developing the Minnesota Complexity Assessment Method© which is currently being tested in collaboration with a variety of practices in Minnesota. In addition to being a physician, Dr. Baird is also a family therapist.

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Introduction

Hippocrates noted that the patient must be attended in light of "his" diet, work, home, and community setting. Since that time, we have struggled with the dilemma of how to put the patient's presenting problems in the context of the patient's life circumstances. That goal has proven elusive. So how do we sort out where to put the emphasis with our healing arts?

What I hope to do is establish some concept of a repetitive cycle that we've been through for a long time, about either splitting people between mind and body or trying to unify us back together again. We've gone through cycles of splitting and re-unifying the concept of dealing with patients. I want to introduce a new concept that we're calling complexity. It's a social determinance of health by some standards of conversation, but its other factors than medical that often interfere with medical care and medical decision-making.

Sometimes the task seems straight forward. A broken bone needs mechanical attention. But what if it's a three-year old with a broken bone? How did a three-year old come to break that bone? Or if it's a 75- or 80-year-old, what were the circumstances that led to that injury? Under what circumstances did the patient break that bone? And is that important in relevance to healing that fracture? And if someone has a headache, a very common presenting

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complaint in primary care, they may have a symptom derived from a very long list of minor to deadly "medical" illnesses. Do we treat this person with diagnostic efforts or with radiation?

If we use enough scans, does that treat it? And we're tempted to do that. Sometimes there's actually a very solid medical treatment, and that's wonderful. And in fact, as our cultures have matured in healthcare since Hippocrates time, the splitting the bio-psychosocial model, splitting the mental health and medical sides have helped a great deal. We've been able to subcategorize illnesses and treatments. We've covered everything from aspirin to prevention to infectious disease theory. All those things helped us make progress and in the real world of medicine this has saved lives. And yet, if we treat everything as if we can reduce it to its common denominator biologically, what have we lost? That's the dilemma we're facing today.

So in the case of the patient presenting with a headache, what if it falls into the category of fatigue from family discord, loss of a job, not enough sleep, too many bills to pay, loss of a spouse? Is that relevant in the diagnostic pattern? How do clinicians sort this out? What symptoms have no direct biological root cause but are real, painful, threatening and a cause for a medical contact?

Once we're engaged, how far does the clinician go in seeking a "definitive" answer? And at what price do we pursue certainty in not just dollars, but risk, time, opportunity and cost for both the clinician and patient? If the root cause is related to psychophysiological distress, is that acceptable as "real?" So then what is the treatment? Individual or family psychotherapy? Medication? Both therapy and medication? Is it explanation and reassurance? Cultural healing rituals?

If someone does have psycho-physiological distress, that tension, or whatever the overworked body does, yields a symptom of some

kind related to that emotional or psychological stress. Is it okay to say that? Is that real? Or somehow, do we discount that as if it's not as good as 'I have an infection'. That's okay because it's a definitive medical symptom with a definitive medical solution.

When the presenting complaint is primarily a mental health issue, such as disrupted thinking as in schizophrenia, what is the best short-term and long-term treatment? What is the consequence of a very late diagnosis of schizophrenia? The same questions apply to a vast array of mental health issues, such as manic depression, Attention Deficit Hyperactivity Disorder (ADHD), dementia, obsessive-compulsive disorder, panic disorder, and addiction disorders. And for each of these there is a spectrum of the distress/disorder. So, at what level is the problem ok to offer "watchful waiting" versus active intervention? What are the indications for family education and support? When is community support essential and realistic? And, are these types of interventions or treatments mutually beneficial regardless of when we intervene?

These are not easy questions.

René Descartes, widely regarded as the father of modern philosophy, attempted to relieve the tension building from the overwhelming challenge of understanding the whole person in the full context of life by splitting the problem into two parts. This solved part of the dilemma for a while, and professionals learned a great deal by splitting the mind and body into separate discrete parts (Cartesian Mind-Body Split) (Kiapokas, 1999).

Our understanding of medical problems accelerated with the identification of the germ theory, while physiology and anatomy improved our understanding of the human body. Therapeutic options improved significantly with the invention of antibiotics, aspirin and a host of new products that "fixed" many acute medical problems. Since then, there's been a continuing effort to either

define the boundary between mind and body or bring them back together. Over the centuries, many efforts to split the problem have failed (it's all genetics, all biochemical or all environmental). Many illnesses have both mind and body components.

The field of medicine improved the treatment of acute problems and clinician scientists made possible a series of dramatic successes with the prevention of communicable diseases. Mortality decreased from acute illnesses, while Western cultures evolved to face a new struggle with chronic illnesses that can last a lifetime. In the 70s and 80s, when I began writing about engaging families in healthcare, we were then talking about systems theory, which is now called "Complex Adaptive Systems", but it's the same concept. When you intervene in a complex interactive system with people that interact with each other continuously and which evolve, you can't always predict the consequences. This is one of the fundamentals of complex adaptive theory. When we intervene with psychotherapy or medication or surgery, sometimes there are these unintended consequences that last far beyond that intervention.

A movement toward re-integrating mind and body, along with environment, was picked up again by George Engel in 1967 when he coined the "bio-psychosocial model. (Engel, 1977) We have to consider everybody in the full context of their lives," echoing Hippocrates from quite a few years earlier. And we've been struggling to bring the bio-psychosocial model into practical reality ever since Engle created it. So this ebb and flow of unification and splitting has continued. From the 1970s to 2000, many books have been published on the general topic of integrated mental and behavioral health and that list continues to grow each month.

We still struggle with our early language conflicts regarding this task of integration. For example, what is meant by integration, collaboration, shared-care and other terms intended to bring mind-

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body-environment into the thinking of how to both understand a patient, as well as how to help the patient. We have to start with a language that everyone can agree upon.

Psychologist C.J. Peek, has written a lexicon of related terms for the Agency for Healthcare Research and Quality (AHRQ) (Peek, 2011). He notes the problem as parallel to what early pioneers in electrical engineering faced. They had to get together and agree upon terms such as watts, ohms, and volts to be able to move ahead with research. Only when they had agreed upon the meaning of a common set of terms, or lexicon, did they make headway. We still benefit from the result. We are in the early stages of a parallel effort for integrated care.

For integrated mental health, we haven't quite created that agreed upon language. What is collaboration? If you're from some parts of the world that term has a World War II connotation — you collaborated with the enemy, never mind your own culture. That's not what we're intending. That ringing sort of tone comes to some people when you say collaborator. Integrate doesn't have that tone to it, but sometimes it doesn't mean something concrete. So we created a paradigm for this year ago. We created, as we did for lots of things, several levels of collaborational integration. And at the far end, the mental health people and the medical people don't talk to each other, except if they really have to, like at a conference. So we try to move to the middle, somewhere we could call a basic collaboration, so we have regular ways of getting together.

The focus of our efforts needs to be to keep moving forward with the integration of mental/behavioral health and primary medical care. Parallel efforts are underway to move behavioral health services into specialty medical care, such as intensive care units, cancer centers, and occupational health programs. (Patterson et al., 2002) Primary care is the primary role for family medicine. This includes general internal medicine and general pediatrics, as

well as general health care for women as a subpart of the field of obstetrics and gynecology. Therefore, many other physicians and health professionals are involved in primary care in the US. In 1996, the Institute of Medicine defined primary care as:

> "the provision of integrated, accessible health care services by clinicians who are accountable for addressing a large majority of personal health care needs, developing a sustaining partnership with patients, and practicing in the context of family and community." (Institute of Medicine, 1996)

Barbara Starfield, a pioneer in the research to define the impact and value of primary care, noted that there are four pillars on which primary care rests:

1. first contact care
2. continuity over time
3. comprehensiveness
4. coordination with other parts of the health care system

(Starfield, 1998)

Recent legislation and market changes have defined a more comprehensive clinical and economic enterprise for primary care - the Medical Home. This concept was pioneered more than 15 years ago by pediatric clinicians who needed to have more comprehensive services for children with severe and multi-system illnesses. With improved care coordination, added nursing staff to call or reach out to families with seriously ill children, and improved connections to nearby community resources, the children did better and some costs were reduced due to fewer hospitalizations and emergency room visits. This has evolved now to become a model of almost all sources of primary care and the model has been adopted by all major primary care organizations. (NCQA, 2011)

Key components include:

    • Meeting the majority of the needs of patients' medical and mental health needs

    • Providing easy access via visits, phone or electronic communication

    • Registries that track patients with common conditions

    • Patient advisory panels to help guide the practice

    • Documented involvement of patients and families in medical decision-making

    • Coordination of care provided by specialists beyond the medical home

    • Accountability for overall quality, cost, and improved patient experiences

New definitions of the Medical Home or Health Care Home include a requirement that behavioral/mental health services must be part of the overall set of services offered. (NCQA, 2011)

However, during recent decades mental health services have usually been "carved out" of primary medical care and supported with a separate budget and management system. Most commonly, these services are offered from a separate facility away from primary care and have separate charts, a separate culture, different definitions of time for visits, who is included (individuals, families, groups), while rarely including direct involvement from the "medical" clinicians in the care process, care planning or care coordination. Several authors have outlined various degrees or "levels" of integration or collaboration across the mental health/medical divide. (Doherty, McDaniel, and Baird 1996)

FIVE LEVELS OF COLLABORATION

	Model				
	1	**2**	**3**	**4**	**5**
	Minimal Collaboration	**Basic Collaboration from a Distance**	**Basic Collaboration On-site**	**Close Collaboration in a Partly Integrated System**	**Close Collaboration in a Fully Integrated System**
Characteristics	* Separate systems * Separate facilities * Communication is rare * Little appreciation of each other's culture; little influence sharing	* Separate systems * Separate facilities * Periodic focused communication, mostly letter; occasionally phone * View each other as outside resources * Little understanding of each other's culture or sharing of influence	* Separate systems * Same facilities * Regular communication, occasionally face-to-face * Some appreciation of each other's roles and general sense of larger picture, but not in depth * Medical side usually has more influence	* Some share systems * Same facilities * Face-to-face consultation, coordinated treatment plans * Basic appreciation of each other's roles and cultures * Share same biopsychosocial model	* Shared systems and facilities in seamless biopsychosocial web * Patients and providers have some expectation of a team * Everyone committed to biopsychosocial, in-depth appreciation of roles and culture * Collaborative routines are regular and smooth * Conscious influence sharing based on situation and expertise
Handles Adequately	Routine, with little biopsychosocial interplay and management challenges	Moderate biopsychosocial interplay, e.g., diabetes and depression with management of each going reasonably well	Moderate biopsychosocial interplay, requiring some face-to-face interaction and coordination of treatment plans	Cases with significant biopsychosocial interplay and management complications	Most difficult and complex biopsychosocial cases with challenging management problems
Handles Inadequately	Cases refractory to treatment or with significant biopsychosocial interplay	Significant biopsychosocial interplay, especially when management is not satisfactory to either mental health or medical providers	Significant biopsychosocial interplay, especially those with ongoing and challenging management problems	Complex with multiple providers and systems, especially with tension, competing agendas or triangulation	Team resources insufficient or breakdowns occur in the collaboration with larger service systems

Adapted from Doherty, WJ, McDaniel, SH, Baird, MA. Five levels of primary care/behavioral healthcare collaboration. *Behavioral Healthcare Tomorrow* 1996; October 25–28.

Where Are We Now?

We have many more mental health/behavioral health services available for a wider range of behavioral and mental health disorders than we had 30 years ago. We created more and more elaborate ways to categorize mental health disorders and behavioral distress. A new version of the Diagnostic and Statistical Manual or DSM is now emerging. (DSM-5 Overview, 2012) But the concern about understanding the patient in context is still a challenge. Naming a diagnosis may or may not really lead to understanding the patient. The diagnostic manuals help for billing purposes. It creates a pattern for subsequent treatment that should match what is thought to be therapeutic for a specific diagnosis in the medical model. But does a descriptive diagnosis or label really help the clinician and patient reach an improved understanding and plan to move forward with a more productive and less painful, less disabling life with fewer disabling symptoms? Does that diagnosis provide a better understanding of how this patient/person can proceed with fewer impediments toward health? Does it help the clinician and patient/client understand the source of his or her distress by naming the official diagnosis in our "medical" language, coded for billing reasons, or does it help the clinician understand the patient's most promising pathway toward improved health? It's possible that a medically-oriented diagnosis does not do these things. (Doherty and Baird, 1983, 1987; Bearhs, 1986; Seaburn et al., 1996; Kathol and Gatteau, 2007; Prosky and Keith, 2003; Callahan and Berios, 2005)

First case example:

A 57-year old single female presented to my clinic "to get a mental health referral", which was the presenting complaint to the front desk. She was dressed professionally, was smiling and very articulate. She did not appear to be upset at this moment.

Primary Care Physician (Physician):

> "Hello, I'm happy to meet you. I did read the note from the nurse and talked with her but I want to get to know you. May I just listen and not turn on the computer for bit? Can you tell me about your distress, and I'll learn about that first."

Ms. X began to tell me her story.

> "I had an upsetting experience at work three days ago during which time I became so enraged at my supervisor that I threw a plastic garbage can across the room!" (Pause, but no tears.)

Physician:

> "I've just met you but that doesn't fit the calm, professional, articulate person I see. Can you tell me more?"

Ms. X:

> "Yes, well there is a story behind this. You see, I've been working at this college bookstore for 23 years. I've developed expertise over the years about the topics for which our college is well known. Students, graduates and others both near and around the world contact me and our store to order special books, reprints, theses, and papers. The institution raised a lot of money recently and built a brand new, expansive space for us. We've been moving into this space for the past three months. But, during this shift, a new "business manager" was hired to lead us to a more profitable model for the store. We have dropped much of the academic material for which people have been contacting us and ordering from us for many years. Now we're supposed to sell toiletry items and cough drops to make more money! This young person who is supposed to know so much demands that I discourage our long-standing clients and focus on

the younger students who spend more on disposable items. After three months, I still don't have a desk nor functional computer. But that is not what finally got to me. One too many times he declared that our mission was no longer to serve the academic needs of the students and prior clients but to make money via rapid sales of disposable items. That is when I lost it! He reported that I need some help. So here I am!"

Background:

Ms. X has a master's degree, divorced many years ago, has good friends and a solid social network. When she was in her 20s she became depressed and entered Jungian therapy which lasted off and on for almost 20 years. She came to our clinic because her prior therapist had retired long ago.

Physician:

"Good for you! That therapy is an asset. We can draw from that like withdrawing money from the bank."

Ms. X:

"You seem to approve of that therapy. I was not expecting that. I thought you or someone would 'poo-poo; that and send me to a psychiatrist and start medication. But I don't feel depressed. I'm angry!"

Physician:

"You look angry. But you are articulate, have no psychiatric symptoms now, are thinking clearly, and report a complex but understandably upsetting outburst. I wonder if you are angry but also grieving over the loss of meaning in your work."

Ms. X:

> "That's it! I am very angry about just that! I'm not a sales clerk, I'm a librarian! This young kid who is in charge of our bookstore has turned it into a drugstore! That is not how I plan to spend my remaining working years! And, I am grieving – I have, indeed, lost the pleasure and motivation to do what I'm supposed to do at my job."

Physician:

> "If you are grieving, do you have some ritual or ceremony for your grief? Could you plan something to do with your friends at church or at work?"

Summary:

The patient left the office very pleased, did not want a mental health referral and is considering a plan to do something with food, music or clothing to create a ritual regarding her loss. She wants to grieve and not be so angry. But she is not depressed.

Diagnosis for billing purposes: Grief reaction

Plan:

Create a ritual; no "further" psychotherapy, no medications, return to socially supportive network, thinking but not acting too quickly on alternative work options.

Second case example

A few years ago, a new clinic was established in Minnesota to provide for the medical and mental health needs of patients with Serious and Persistent Mental Illness (SPMI) that were covered by Medicaid. The clinic was established in an effort to cuts to Medicaid costs, the biggest value change coming out of the

Medicaid for single adults without children. Most of whom were men, single men without children, with serious mental illness and addiction problems, as well as complicated medical problems.

There are roughly 60,000 people in that category, and they cost a lot of money, and the budget for them was cut by 60 percent, not 6, 60. This particular clinic supported approximately 4,000 patients, and these people got a complete bundle of services for whatever they needed. It was like an intensive care unit for primary care. Just like intensive care units, there are several staff members, not just physicians. In this case, they have social work, nursing, pharmacy, always mental health of some type, psychiatry when needed, and a physician.

For the first several visits, the patient always meets the whole team. They talk awhile and create a care plan. Over time, some of the visits go to nursing. Some go to social work. Some go to physicians, but they evolve over time to what's needed. It's capitated 100 percent. The clinic doesn't get more money for having more visits by doctors and less money for nurse visits. It's all one bundle. The goals for a very high cost group of patients with both serious mental illness and medical conditions were to reduce the cost and improve their care. It worked.

Summary of patient response:

The patient is a rather bold, outspoken, stable patient with schizophrenia, hypertension, and diabetes. He used to be in the hospital ER or the hospital itself about every other week.

Patient (in the clinic system 10 months):

> "You know what, I like these guys. And they're paying attention, so I don't have to go the ER anymore and teach them a lesson."

These were his words. From his standpoint, he used to go to the ER to teach the man a lesson about not paying attention. Now when he was disgruntled and didn't take his medication, he'd end up in the ER on purpose, he'd get there somehow on his own, and teach the system a lesson. In this new setting, he observes that these people actually care. They don't say you've got the wrong kind of problem when he comes in the clinic. They say 'how may I help?' And when he's upset about something or disconnected from some social service or needs rent support or something else, they connect him. They don't say 'go someplace else and find the answer.'

So for the 4,000 patients in the clinic, their costs have gone down. Although this one clinic can't take care of the entire population that needs similar care, in this instance, capitated models worked for the combined bundle of services and facilitated help needed. And furthermore, once the patient caught on that he was part of the solution, not the opposite, he was quite helpful and very outspoken, and while he still has schizophrenia, diabetes, and hypertension, they're much better managed when he's not fighting us and we him.

Measurable outcomes:

Diabetes, hypertension and asthma improved; ER visits decreased and hospital days decreased significantly. For some visits, the social worker is prominent or the only professional involved; for others the physician, psychologist or psychiatrist is the primary, but rarely the only professional.

Diagnosis:

Schizophrenia, diabetes, asthma, hypertension, social isolation, and despair, but payment is capitated or per patient per month based upon a total combined budget for 4,000 people.

Plan:

Rarely see just one provider; establish trust; encourage self-development, self-care for minor ailments, connected with community resources to gain job skills, stay physically active, and reconnect with family.

These two vignettes reflect very different people as patients and very different types of combined bio-psychosocial dilemmas for the patient and approaches for provision of care and methods of payment for care. But both reflect a unifying approach to the patient.

What are the big lessons we're learning about integrated care that relate to health care policy?

1. Budgets must be unified for behavioral/mental health and medical care. Separate budgets lead to separate cultures, values, tasks that split vs. unite and "either-or" thinking rather than "both-and" approaches to patients, budgets and care plans.

2. Finding the cost-offset for integrated behavioral and medical care is not simple and is elusive - especially if one cannot track overall medical/mental health costs. Evaluation of work productivity and rates of returning to normal function studies are expensive and rare, but are the most appropriate methods of assessing the cost-benefits of integrated care. By not funding such studies, we waste time and money doing less adaptive evaluations. Most commonly, we only track separate mental health costs not connected to preventable medical costs. In that pathway we reinforce the mind/body split and undermine integration efforts.

3. Care teams are best integrated as close to the primary care health care home as possible. Joint visits, brief informal

consultations, shared values and resources are more feasible when care is integrated physically. But, "co-location does not always equal collaboration." We have many examples of medical and behavioral clinicians working near each other but not sharing ideas, charts, values, care plans and approaches to care for patients.

4. Lack of medical care for patients with serious and persistent mental illness (SPMI), such as schizophrenia, results in premature death, high costs for medical treatment, recurrent and avoidable hospitalizations and over-use of emergency rooms. SPMI patients die up to 25 years earlier than matched for age cohorts. (World Federation for Mental Health, 2010; Druss and Bornemann, 2010; Fernández et al., 2010)

5. In the US, we over-treat or "medicalize" all forms of distress. Most fee-for-service reimbursement models for mental health and medical providers promote over-diagnosis, over-treatment, and over-medicalization of behavioral/mental health distress. More care visits or admissions yield more income for care systems and providers. Thomas Szasz, MD may have been right when he wrote The Myth of Mental Illness. (Szasz, 1961) "With ever more refined definitions of mental illnesses, we diagnose more and more people with these illnesses and find more and more need for our services. The trend is moving to other parts of the world with our "help."

This "Americanization of Mental Illness" has been noted (Watters, 2010) and reflects our cultural propensity to treat as a medical or clinical psychiatric problem behaviors and upsetting symptoms with medication rather than with other therapeutic options, such as psychotherapy, social support, education, and social adaptation. Ironically, some have observed that in parts of the world with no

access to psychiatry or psychoactive medications, people with observed and clear-cut schizophrenia have fewer days lost from productive life tasks than in the US.
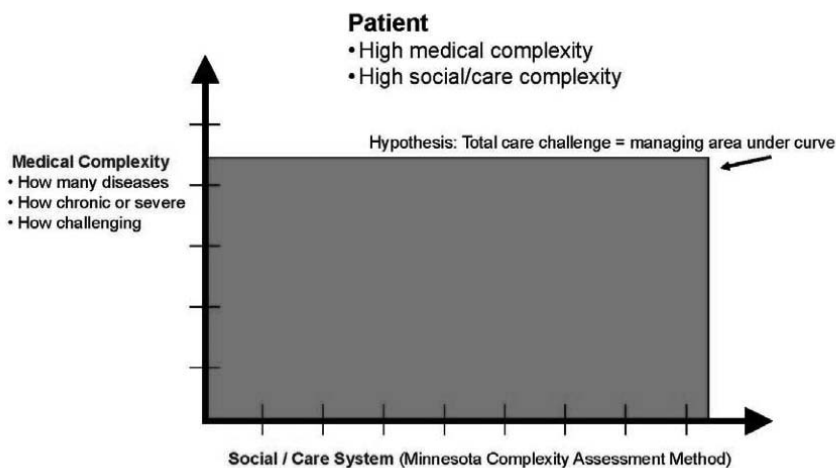
> 6. We have come to rely too heavily on medications to treat behavioral and mental health conditions. The evidence is mounting that for especially depression, medications are no more effective than placebo. (Fournier et al., 2010, Hagen et al., 2010) However, systematic screening, outreach, and team-based care that are systematic improve the outcomes for people with a diagnosis of depression and treated in primary care settings. (Katon and Seelig, 2008)

Introducing a new concept: Complexity

While we have evolved to overuse of medications, we have not created a systematic way to identify and address the barriers some patients face that impair care planning and medical decision-making that would be expected to yield positive outcomes. This is especially relevant for patients with significant chronic illnesses and overlapping depression or other mental health conditions. A team of clinicians and researchers in the Netherlands (Huyse and Stiefel, 2006) and later in Minnesota, (Peek et al., 2009) call these factors "patient and care system complexity". These are factors that inhibit normal care and decision-making in health care.

The Minnesota team adapted the European complexity scale to fit a fast-paced outpatient US system of care and modified the model. They have developed a method for assessing complexity, the Minnesota Complexity Assessment Method (MCAM) that I will briefly outline. By creating a language for complexity, developing a tool to assess it, and moving toward care process steps to focus more helpfully with the patient on some of their relevant

"complexity" that inhibits their care or positive outcomes, we believe we can be of more concrete value to the patient.

Patient
- High medical complexity
- High social/care complexity

Hypothesis: Total care challenge = managing area under curve

Medical Complexity
- How many diseases
- How chronic or severe
- How challenging

Social / Care System (Minnesota Complexity Assessment Method)

(Peek, 2010)

This hypothesis asserts that by systematically assessing for complexity, clinical teams will be able to reduce the overuse of the diagnosis of depression, shift part of the clinical team's effort to the relevant issues for the patient and may often connect the patient to non-medical community resources as needed. This is intended to be of more realistic benefit to the patient facing complexity than adding another mental health diagnosis to their list of problems. A recent study in Scotland has tested a new adaptation of MCAM, the Minnesota Edinburgh Complexity Assessment Method (MECAM) and found that, indeed, this tool is useful in gaining a more complete bio-psycho-social understanding of the patient. It was found to be time efficient, useful in a busy ambulatory setting and did yield increased referral to and connection with community social resources thought to be useful for the patient. Further testing

is being done to understand more thoroughly the clinical benefits and limitations of this tool and concept (Maxwell et al., 2012).

Five Domains of Care Complexity

1. **Illness impact**
   - Functional impairment; diagnostic uncertainty
2. **Readiness**
   - Distress and distraction
   - Behavioral unreadiness to engage in care
3. **Social**
   - Lack of social safety, support, and participation
4. **Health system**
   - High intensity or disorganization of care
   - Difficult patient-clinician relationships
5. **Resources for care**
   - Lack of common language/culture with providers
   - Lack of sufficient insurance for care

Peek, Baird, & Coleman (2009)

The following policy recommendations address the "lessons learned" noted earlier in this brief. Overall, we need to continue to work closely with patients, families and communities to understand not only the combined medical and mental health diagnoses but also their social issues that interfere with normal care and medical decision making.

Recommendations for policymakers

1. Unify "health budgets" i.e., eliminate separate mental health and medical budgets in care systems and insurance systems.

2. Define medical/health care homes as including behavioral/mental health and medical care.

3. Integrate primary medical care into some specialty mental health centers who provide the bulk of care for patients with serious and persistent mental illness.

4. Support the development of understanding the patient's social and care system complexity. The language or lexicon is being built now. Metrics and assessment for more detailed understanding are needed as we move forward.

5. Unify training programs for mental health, medical, social workers and care managers. By growing into their professional roles together early as trainees, these future professionals will be better at unifying our care systems.

Finally, I think to some degree, we professionals are the drugs sometimes and there's a positive placebo effect of that. We want to make sure it's positive and rewarding for the patient. And medications do reduce symptoms and help patients sometimes because people become less symptomatic enough that they can focus on their adaptive responses to whatever the strain and stresses are. What I'm advocating is that for lots of things within the primary care domain of distress, if we help the patient adapt in some way, then the next time this adaptive response is needed, they trust they have it inside and not out there in a bottle. And yet, that's a hard impulse to counteract, once they trust that medication. This creates a paradox. A paradox is two competing agendas that have to be balanced. You can't have just one or the other. We can't have just medication or just psychotherapy, talk therapy or support networks. We probably need them both. But our social hand is atrophied and our medical hand is hypertrophied. What we need is for them to be balanced when it comes to integrating mental health care and primary care to improve the overall health of our patients.

For more information

Beahrs, J.O. 1986. *Limits of Scientific Psychiatry: The Role of Uncertainty in Mental Health*. New York: Brunner/Mazel.

Callahan, C.M., and G.E. Berrios. 2005. *Reinventing Depression: A History of the Treatment of Depression in Primary Care 1940-2004*. New York: Oxford University Press.

Doherty, W.J., and M.A. Baird. 1983. *Family Therapy and Family Medicine*. New York: Guilford Press.

Doherty, W.J., and M.A. Baird, (Eds.). 1987. *Family-Centered Medical Care: A Clinical Casebook*. New York: Guilford Press.

Doherty, W.J., S.H. McDaniel, and M.A. Baird. 1996. "Five Levels of Primary Care/Behavioral Healthcare Collaboration." *Behavioral Healthcare Tomorrow* 5(5): 25-27.

Druss, B.G., and T.H. Bornemann. 2010. "Improving Health and Health Care for Persons with Serious Mental Illness: The Window for U.S. Federal Policy Change." [Commentary] *Journal of the American Medical Association* (JAMA). 303(19): 1972-1973.

DSM-5 Overview: The Future Manual. 2012. Retrieved June 25, 2012, from: http://www.dsm5.org/about/pages/dsmvoverview.aspx.

Engel, G.L. 1977 "The Need for a New Medical Model: A Challenge for Biomedicine." *Science* 196: 129-136.

Fernández, A., J.Á. Bellón Saameño, A. Pinto-Meza, J.V. Luciano, J. Autonell, D. Palao, L. Salvador-Carulla, J.G. Campayo, J.M. Haro, A. Serrano, and the DASMAP investigators. 2010.

"Burden of Chronic Physical Conditions and Mental Disorder in Primary Care." *British Journal of Psychiatry* 196(4): 302-309.

Fournier, J.C., R.J. DeRubeis, and S.D. Hollon. 2010. "Antidepressant Drug Effects and Depression Severity: A Patient-Level Meta-Analysis." *Journal of the American Medical Association* 303(1): 47-53.

Hagen, B., G. Wong-Wylie, and E. Pijt-Zieber. 2010. "Tablets or Talk? A Critical Review of the Literature Comparing Antidepressants and Counseling for Treatment of Depression." *Journal of Mental Health Counseling* 32(2): 102-124.

Huyse, F.J., and F.C. Stiefel, (Eds.). 2006. *Medical Clinics of North America: Integrated Care for the Complex Medically Ill.* 90(4). Elsevier.

Institute of Medicine. 1996. *Primary Care: America's Health in a New Era*. Washington DC: National Academy Press.

Kathol, R., and S. Gatteau. 2007. *Healing Body and Mind: A Critical Issue for Health Care Reform*. Westport, CT: Praeger.

Katon, W., and M. Seelig. 2008. Population-based Care of Depression: Team Care Approaches to Improving Outcomes." *Journal of Occupational & Environmental Health* 50(4): 459-467.

Kiapokas, M.S,. and A.S. Hatzinikolaou, 1999. (Trans.) *Hippocrates of Cos and the Hippocratic Oath*. Athens: The Cultural Centre of the Municipality of Cos.

Maxwell, M., C. Hibberd, R. Pratt, I. Cameron, and S. Mercer. 2012. *Development and Initial Validation of the Minnesota Edinburgh Complexity Assessment Method (MECAM)*

for Use within the Keep Well Health Check. NHS Health Scotland. Retrieved June 27, 2012, from http://www.healthscotland.com/uploads/documents/18446-DevelopmentOfMinnesotaEdinburghComplexityMethod.pdf.

National Committee for Quality Assurance (NCQA), 2011. *NCQA Patient-Centered Medical Home: Health Care That Revolves Around You*. Washington, DC: NCQA.

Patterson, J., C.J. Peek, R.L. Heinrich, R.J. Bischoff, and J. Scherger. 2002. *Mental Health Professionals in Medical Settings: A Primer.* New York: W. W. Norton.

Peek, C.J. 2010. "Building a Medical Home Around the Patient: What it Means for Behavior." *Families, Systems, and Health* 28(4): 322-333.

Peek, C.J. 2011. "A Collaborative Care Lexicon for Asking Practice and Research Development Questions." In C. Mullican (ed.), *A National Agenda for Research in Collaborative Care, Papers from the Collaborative Care Research Development Conference*. Rockville, MD: Agency for Healthcare Research and Quality.

Peek, C.J., M. Baird, and E. Coleman. 2009. "Primary Care for Patient Complexity, Not Only Disease." *Families, Systems, & Health* 27(4): 287-302.

Prosky, P.S., and D.V. Keith, (Eds.). 2003. *Family Therapy as an Alternative to Medication: An Appraisal of Pharmland*. New York: Brunner-Routledge.

Seaburn, D.B., A.D. Lorenz, W.B. Gunn, B.A. Gawinski, and L.B. Mauksch. 1996. *Models of Collaboration: A Guide for Mental Health Professionals Working with Health Care Practitioners*. New York: BasicBooks.

Starfield, B. 1998. *Primary Care: Balancing Health Needs, Services, and Technology*. New York: Oxford University Press.

Szasz, T. 1961. *The Myth of Mental Illness: Foundations of a Theory of Personal Conduct*. New York: Harper and Row.

Watters, E. 2010. "The Americanization of Mental Illness." *The New York Times*. January 8, 2010.

World Federation for Mental Health. 2010. *Mental Health and Chronic Physical Illnesses: The Need for Continued and Integrated Care*. Woodbridge, VA.