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The Challenge of Integrated Care for Mental Health: Leaving the 50 minute hour and Other Sacred Things

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Abstract A growing body of research has demonstrated the effectiveness of integrating mental/behavioral healthcare with primary care in improving health outcomes. Despite this rich literature, such demonstration programs have proven difficult to maintain once research funding ends. Much of the discussion regarding maintenance of integrated care has been focused on lack of reimbursement. However, provider factors may be just as important, because integrated care systems require providers to adopt a very different role and operate very differently from traditional mental health practice. There is also great variability in definition and operationalization of integrated care. Provider concerns tend to focus on several factors, including a perceived loss of autonomy, discomfort with the hierarchical nature of medical care and primary care settings, and enduring beliefs about what constitutes "good" treatment. Providers may view integrated care models as delivering substandard care and passively or actively resist them. Dissemination of available data regarding effectiveness of these models is essential (e.g. timeliness of treatment, client satisfaction). Increasing exposure and training in these models, while maintaining the necessary training in traditional mental health care is a challenge for training at all levels, yet the challenge clearly opens new opportunities for psychology and psychiatry.

Keywords Integrated care · Integrated primary care · Psychology in primary care

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Integration with general healthcare is not a new phenomenon for psychologists and psychiatrists. Though reimbursement systems have traditionally lagged behind clinical practice, for decades health psychologists have made a significant contribution to patient care by addressing behavioral factors that impact on health (Stanton, Revenson, & Tennen, 2007). Adaptation to illness, stress management and smoking cessation, for instance, have long been viewed as key psychological interventions in the care of medical patients and have been shown to reduce morbidity due to chronic illness (Peyrot & Rubin, 2008). These efforts received substantial reinforcement and credibility by becoming an essential core feature of the chronic disease management protocols demonstrated to improve healthcare outcomes (Wagner, Austin, & VonKorff, 1996). Although best known for their contribution to management of diabetes, such programs have now been adapted to a number of other illnesses, including hypertension, chronic obstructive lung disease and congestive heart failure (Carels et al., 2004; Institute of Medicine, 2006; Ng et al., 2007).

Similarly, consultation/liaison (C/L) to inpatient medicine and surgery first developed as a subspecialty of psychiatry but quickly expanded to include psychology. This field of endeavor, born in the 1950s extended psychological services to medical and surgical inpatients and

expanded medical services to focus on treatment of psychiatric problems, such as depression or psychosis, complicating medical illness (Lipowski, 1967). The knowledge base and practice of C/L differed in many respects from the usual practice of psychology and psychiatry (Lipowski, 1974).

Decades later a study by Smith, Monson, and Ray (1986) demonstrated the effectiveness of adapting the C/L process to outpatient primary care. Soon afterward, a number of studies began to address mental health issues in primary care, eventually leading to the development of models of integrated or collaborative care. Such programs adapted the chronic disease management approach to care of depression (Dietrich et al., 2004; Grembowski et al., 2002; Hedrick et al., 2007; Katon et al., 2005; Simon et al., 2007). A number of studies have now replicated the early findings that demonstrated improved patient engagement and better depression treatment outcomes when mental health care is readily available in primary care settings (Kilbourne, 2006; Oxman, Dietrich, & Schulberg, 2003; Skultety & Zeiss, 2007). A number of variations on this theme have continued the evolution of integrated treatment models for mental disorders presenting in primary care. These models range from telephone triage/assessment/referral for targeted mental disorders (Oslin et al., 2007) to horizontal integration that maintains control of treatment in the hands of PC providers while providing care management and decision support (Strosahl, 1996). More recently, flexible co-located collaborative teams of mental health providers in primary care, treating a wide variety and severity of illness, have improved access to care, patient engagement and adherence to evidence based treatment models (Pomerantz, Cole, Watts, & Weeks, 2008; Watts, Shiner, Pomerantz, Stender, & Weeks, 2007). Despite this growing body of evidence, integrated care systems often fail to be sustained after funding for the pilot project comes to an end (Goldberg, 2002; Schulberg, 2001). Inadequate reimbursement systems are the most commonly cited reason for failure of sustainability (deGruy, 2006; Goldberg, 1999). Equally important, integration of mental health services in primary care and other areas of medicine requires a paradigm change (Kessler, 2008). In our experience, however, providers are often reluctant to embark on such a change.

Experience with Collocated Collaborative Care in VA Healthcare

Since 2005, the White River Junction (Vermont) VA Mental Health and Behavioral Sciences Service has provided collocated collaborative care in the primary care clinic (American Psychiatric Association, 2005). The "White River Model" is now a recognized standard of care in the VA system and is spreading in VA medical centers and community based outpatient clinics nationwide. This model places both a psychologist and a psychiatrist in a primary care practice covering 14,000 primary care patients. The principles of advanced clinical access helped to guide design of the clinic (Murray & Berwick, 2003). Advanced Clinical Access systems offer same day or walk in appointments for all patients. In the White River Junction primary mental health care clinic patients have open access to care at all times (i.e. no appointments required), thus reducing the attrition associated with common referral models of mental health care (Grembowski et al., 2002; Van Vorhees, Wang, & Ford, 2001, 2003). The clinic has been remarkably effective in increasing the number of primary care patients in need of mental health care who receive such care. The majority of patients receive all of their mental health care in this clinic, obviating the need for referral into traditional mental health care. Both health psychology and care management have been added to the functions of the clinic, spurring enhancement of chronic disease management in primary care.

Despite the demonstrated success of the model, there has been variable acceptance and commitment from psychologists and psychiatrists in other institutions, both within and outside VA. Some have embraced this model of care and others have resisted it. Careful exploration of clinician resistance has identified several important factors.

Differences in Competencies

The practice of psychology and psychiatry in integrated primary care is quite different from that practiced in traditional mental health care, and requires a different skill set or adaptation of existing skills (Bray, 2006). Among other differences, the need for enormous flexibility of approach, based on individual patient needs is paramount (Haas & DeGruy, 2005). Traditional mental health practitioners often have a carefully selected patient load and provide their preferred types of treatment to all. In integrated care systems, mental health providers must be trained to move quickly from one conceptual scheme to another, based on patient needs of the moment. Treatment is generally brief, problem focused and addresses the concerns expressed by the patient. Exploratory therapy has little place in such a system. Even traditional manualized cognitive behavioral treatments are often too long and involved for use in primary care. As one skilled dynamically oriented psychologist (who also excelled in hypnosis and cognitive approaches), when declining to make the move to integrated care in the White River Junction clinic eloquently stated; "I would not be very good at that." As treatments become briefer, such statements become more common.

Theories of Treatment

Psychologists and psychiatrists, like other clinicians, have beliefs about treatment that are generally based on a theory. A clinician who favors long term dynamic or exploratory therapy sees the transference relationship or the power of interpretation of unconscious conflict as essential for lasting change. Cognitive-behavioral therapists may rely on manualized problem-focused interventions that typically require a great deal more time than would be available in a primary care setting. These providers may view the high intensity, rapid pace treatment setting of primary care as not suitable for self exploration or proper application of most manualized treatments. In addition, these mental health practitioners may have the underlying belief that brief, focused mental health treatment in primary care is substandard and/or just another way to deny necessary care to patients. Also, the frequent use of standardized assessment instruments in integrated care to take the place of a longer, skilled clinical interview stands in sharp contrast to the long held principle that open ended questions give the most reliable information.

Despite these concerns, outcome studies to date demonstrate that integrated care approaches are sufficient treatment for the majority of patients in primary care clinics. With few exceptions, results obtained in integrated care have equaled or exceeded those in specialized mental health care in terms of symptomatic, functional and patient satisfaction measures. Clinician resistance to such brief, focused treatments are reminiscent of the resistance to cognitive/behavioral therapies when first introduced in the latter part of the twentieth century.

Health Psychology and Specialty Mental Health

Many mental health clinicians see health psychology and specialty mental health as very different entities and make their conscious choices to practice in one or the other. Health psychology traditionally focuses on helping individuals improve their physical health behavior and/or adjust to chronic physical illness. It relies heavily on theories of stress and coping, self regulation, personality and social processes (Stanton et al., 2007). Some clinical health psychologists may see their role as "only" focusing on health promotion and helping patients manage chronic physical illnesses while referring those with mental illness (but no health related or chronic illness issues) to specialty mental health care. Yet, epidemiologic studies have demonstrated that close to half of the general primary care population will experience a mental disorder at some time in their lives, many of whom will remain untreated (Kessler et al., 2003; Regier et al., 1993; Wang et al., 2006). Coexisting mental disorders in primary care have been shown to decrease the effectiveness of psychological interventions (Hegel et al., 2005). Many patients most in need of behavioral medicine approaches also have mental illnesses that impact on their ability to benefit from such treatments. A good example of this is smoking in patients with schizophrenia or obesity in many patients whose health behaviors are impacted by direct symptoms of their illness or side effects of its treatment. These are populations especially in need of assistance from psychologists and/or psychiatrists.

Perceived Loss of Autonomy

In traditional mental health treatment, the independent psychologist or psychiatrist views himself or herself as the sole proprietor of the therapeutic encounter. He or she does not rely on a nurse to assess psychological vital signs, depend on a laboratory to provide monitoring of treatment need or effectiveness or require a number of other clinicians to attend to related issues. By contrast, the integrated care provider is part of a care team, often led by a non-mental health provider. The preferences of the provider become secondary to those of the care team organized around the patient. Full autonomy is unattainable in such systems. For those who prefer the more isolated and controlled solo practice environment, this is an untenable prospect. In fairness, this is not unique to psychologists or psychiatrists. Many primary care and other physicians resist the team approach to care as well and prefer a solo or group practice in which each provider cares for a panel of patients with a nurse and receptionist as the only other people in the office.

The growing emphasis on the "medical home" model of primary care is leveling the structure of many systems of care (American Academy of Family Physicians, 2008). Such team-based care is increasingly being presented as the next revolution in healthcare. This modern improvement over the "primary care provider as gatekeeper" notion of the early 1990s continues to gather steam as a successful way to improve outcomes.

Stranger in a Strange Land

The typical mental health/psychotherapy environment is unique in health care. Patient turnover is slow and waiting rooms are rarely filled with physically sick people or restless children. At most, one child with ADHD is waiting at any given time. Physically ill adults generally cancel their therapy appointments. In private mental health settings, patients come in one at a time and, other than perhaps a receptionist, no other individuals are present. The therapy office may be dimly lit, quiet and personable—the antithesis of a typical primary care clinic or office.

Additionally, in many mental health clinics that are part of a larger medical center or system, psychological care may be seen as something "soft," "unscientific" or otherwise devalued when it is not an embedded part of primary care. In such environments, psychologists and psychiatrists may feel unsupported or even disrespected. Such perceptions can be intimidating and demoralizing.

Unfortunately, the longer mental health clinicians avoid such places, the more likely these myths will be perpetuated. In addition the hierarchal model of care often places the physician at the top of the treatment pyramid and many psychologists and other providers have great discomfort in such systems. Those mental health providers who have, however, established themselves in primary care often quickly find that their usefulness to the healthcare mission inevitably overcomes these initial misperceptions about the role a mental health provider can play.

Lack of Model Definition

Integrated care is often viewed as a fuzzy concept. It may embrace a combination of many models, including co-location, care management, collaboration, health psychology, consultation/liaison, enhanced referral and communication. It can also include very specific and highly specialized psychological interventions that are commonly delivered in more specialized settings (Kessler, 2005). Without a coherent definition, many come to see it as less viable than clearly defined or manualized systems of care. Some authors have suggested it is best understood as a continuum along several dimensions (Blount, 2003; Doherty, McDaniel, & Baird, 1996). Techniques and approaches vary widely from setting to setting and proficiency in one system may have little relevance to the next. A recent comprehensive technical review by the Agency for Healthcare Research and Quality (Butler et al., 2008) emphasized the many models it embraces and suggested simply that integrated care is a system that "unifies care for physical and mental concerns."

Concerns About "The Medical Model" in Mental Health Care

The "medical model" is often unfairly derided in mental health settings as "treating the symptom, not the problem." The medical model provides more than just pharmacologic treatment. The medical model prioritizes patient needs into primary, secondary and tertiary levels of assessment and treatment. Interestingly, three decades ago, the same criticism was leveled by more traditionally trained psychologists toward problem-focused cognitive/behavioral treatments. Traditional mental health care tends to see one, or at most two, levels of need—i.e. severe persistent mental illness and "everyone else." Nevertheless, most individuals referred to mental health systems receive the same comprehensive evaluation, often based on the premise that the patient's problem is really just a manifestation of other processes, often hidden from the individual. It is not uncommon for clinicians to approach evaluations as the first step in uncovering these hidden conflicts or realities, which, while present, may well be irrelevant to the problem that brought the person to treatment. Pathology does not necessarily lead to dysfunction. No wonder, then, that the majority of patients entering psychological treatment drop out long before completion and most commonly after only one or two sessions, particularly when length of treatment is not clearly defined at the outset (Sledge, Moras, Hartley, & Levine, 1990).

It is important to note that integrated care models and research to date have clearly demonstrated that most patients are much less complicated than many mental health providers assume. Thus, application of the medical model of primary, secondary and tertiary care has great utility and offers an opportunity to conserve specialty resources so that they can be more appropriately provided to those who truly need and can benefit from them. Referral of such patients who have already begun in primary care helps to assure patient readiness and willingness to accept treatment and thus promises to reduce the dropout rate and enhance both patient and provider satisfaction. Those patients with severe and persistent mental illness or acute decompensations can be referred into the necessary tertiary care of assertive community treatment, recovery focused or, when indicated, inpatient levels of care. In the VA clinic cited earlier, more than 75% of patients had all of their mental health care in primary care, even though all new patients were seen there, regardless of diagnosis, severity or acuity of illness.

Like the rest of healthcare, mental health needs primary and secondary providers. Those with particular affinities for one type of patient care/setting or another are needed and providers need not feel the need to be trained and able to do all levels/types of care.

Balancing the Needs

Healthcare serves many purposes, including health maintenance and disease prevention, episodic acute care, chronic disease management and rehabilitation and recovery. It must meet the broad range of needs of every member of the population and the specific needs of the individual. At one time or another, the majority of individuals in the population will need specialized interventions by a psychologist or psychiatrist, be it for depression, stress management, smoking, obesity or other behavioral problem, or more

severe mental illness including schizophrenia. For most of these individuals, the problems and needed interventions are fairly straightforward and do not require the extensive assessment and interventions that characterize traditional mental health care.

Access to care is a critical component of quality. In a given year, 60% of those in need of mental health services do not or are not able to access them. Without access there can be no care and thus no quality. Moving mental health services into primary care has repeatedly been demonstrated to improve access and increase the number of people who will actually receive such care. Thus it is essential to overall healthcare of any population to have some form of integrated primary mental health care.

At the same time, some patients will require the more extensive care typically delivered in traditional mental health systems, though recent studies are already beginning to demonstrate that many of those illnesses can also be managed with a collaborative care approach which may be generalizable to the primary care setting (Bauer et al., 2006a, b). In short, there is a need for both primary and specialty mental healthcare providers in this evolving field. As more and more psychological care shifts into primary care systems, the more specialized providers can be freed up to enhance their own treatments as needed.

The majority of current practicing psychologists and psychiatrists are trained in the traditional "50 minute hour" paradigm of mental health care. As noted above, some are unable to make the shift to these newer models of care because of their training in and commitment to a particular theory and approach to illness and treatment. There exists a significant need to create opportunities during training programs to bridge this gap. There will always be room for primary and specialty approaches to mental illness and treatment. There needs to be a common understanding to assure acceptance by those who practice in both primary care and specialty mental health care settings. Since psychologists and psychiatrists, like other clinicians, acquire many of their beliefs and biases from those professionals who train them, this acceptance and understanding can only develop through experience and the modeling of senior clinicians in clinical settings and training programs.

Despite their reservations, existing senior clinicians must be encouraged to expose themselves and their trainees to these new integrated models of care as they develop. Training programs must add experiences in integrated primary care and health care, in addition to increasing the number of training tracks in those subspecialties. Since health psychologists are already fluent in the language and culture of general healthcare, such fellowships must expand their offerings to include experiences in integrated care.

Health psychology and integrated care are close cousins, both in need of developing coherent and consistent theories that are accepted as valid. Research, particularly outcome research in these fields needs to continue, in order to assure credibility, respect and, hopefully reimbursability as well. The development and beginning use of Health and Behavior Codes is a move toward solving the reimbursement issues. Yet, as discussed above, the issue is larger than reimbursement alone.

Summary and Conclusions

Like cognitive therapy in the 1970s and 1980s, integrated mental health care programs face the challenge of gaining respect and acceptance by the larger mental health community. Also like cognitive therapy, education and positive research outcomes will help bring about this respect and acceptance.

At our medical center it is becoming apparent that a well developed integrated care program can enrich other therapies by providing a well screened, primed and prepared patient for the latter, thus enhancing the likelihood that therapists will see a higher percentage of their patients completing and benefiting from their treatment. Developing common understandings and exposure to differing approaches to mental health assessment and treatment models will go a long way toward ensuring the continued viability of both primary and specialty mental health care. The challenge for psychology and psychiatry is substantial, as is the opportunity (Freeman, 2007; Garcia-Shelton, 2002).

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