SPECIAL ARTICLE

Developing a Strategy for Managing Behavioral Health Care Within the Context of Primary Care

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Although most patients with psychological disorders are diagnosed and treated within the primary care setting, there are few guidelines to help primary care physicians and managed care plan administrators construct programs of behavioral health care that are compatible with the primary care environment. We report the findings from a review of the literature from 1970 to 1996 on factors that predict the use of mental health and substance abuse services with specific reference to primary care. We use a heuristic framework of service use that includes the characteristics of patients, primary care physicians, practice settings, and managed care plans. Recognizing that the factors associated with the use of services center on the primary care practice, we argue that programs of behavioral health care will work best when they are decentralized to account for variations among primary care patients, physicians, and practices; when they are integrated clinically, financially, and administratively within the primary care setting; and when primary care physicians are active leaders in the design and implementation of these services, for clinical and financial reasons.

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Editor's Note: Mental health care is an integral part of family practice. In a push to cost-efficiency, managed care took the dollar amounts previously paid to psychiatrists and mental health workers and made that a "carve-out." Some family physicians have thought that this means they should not provide behavioral care and refer it instead into the mental health system. However, generally managed care companies have continued to pay family physicians for the mental health care they provided previously, albeit often hidden through family physicians coding a medical instead of a psychiatric diagnosis or implicitly through capitation. I have heard of companies refusing to pay family physicians when the diagnosis code for the visit was depression, but that reimbursement rule seems rare and doomed to fail, as noted by Fisher and Ransom. From the managed care perspective, the companies are most likely to change and respond if we could provide them a proved better model that was at least as or more cost-effective than their current efforts. Is having mental health providers in family physician offices as suggested by Fisher and Ransom the answer? Many family practice residencies and some practicing family physicians already incorporate mental health providers directly into their offices. I believe this model has potential and hear rumors that some plans may try it, but I hope family practice researchers will also consider finding and publishing evidence that can be used by all. The more appropriate care can be provided in the family physician office, the better off the patient will be.

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During the past 10 years the shift to managed care has introduced notable changes in the way mental health care is provided in the public and private sectors. In the private sector, these changes have largely been market driven, as the explosive growth of psychiatric hospitalization and spiraling outpatient services in the 1980s set a number of countervailing forces into motion. These changes started with initial peer review and expanded later to full-risk capitation by for-profit, "carved-out," managed behavioral health care companies that promised to control costs and improve quality.[1-4] Because mental health and substance abuse care (ie, behavioral health care) are so intertwined with patients' general health and well-being[5] and because the costs for behavioral health care services are linked with the costs for health care overall,[6] it is not surprising that serious concerns have been raised about the speed and direction of changes in behavioral health care services and the implications these changes hold for the primary care physician and patient.[5,7-11]

Four issues can be abstracted from the discussion concerning the relationship between primary care and behavioral health care. First, what role should primary care physicians play in the provision of behavioral health care services? Should they be-

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come active participants in triaging patients and developing and providing some kinds of behavioral health care services as part of their primary care practices? Or do the day-to-day demands of busy managed care practices preclude such involvement so that these responsibilities should be shifted to others? Second, how should behavioral health care services be organized and provided so that they meet the multiple needs of primary care patients and, at the same time, mesh with the various needs and styles of primary care practice? Third, how should the capitated financial resources for primary and behavioral health care be allocated and managed? Should funding streams be combined, kept separate, or linked in ways that lead to shared risk between primary care and behavioral health care providers? Fourth, how should the administrative requirements of clinical care, such as use review, quality improvement, and information management, be structured? Should primary care and behavioral health care administrative systems be combined, separated, or linked?

One way to address these questions is to take a step back from the current, and often heated, debate about managed care and examine the research literature for guidance. Are there any data on factors linked to the use of mental health services to inform primary care physicians, behavioral health care specialists, and managed care administrators how to design a clinically sensible and cost-efficient system of behavioral health care within the context of primary care that will meet subscriber, plan purchaser, and primary care physicians' needs? To address this question, we reviewed the literature on the use of mental health services from 1970 to 1995, using several computerized searches, tracking down the primary sources of recent review articles, and scanning the table of contents of several journals that have dealt with these issues (eg, ARCHIVES OF FAMILY MEDICINE, *General Hospital Psychiatry*, *Health Affairs*, *JAMA*, and *Medical Care*). What we found is that none of the 4 questions can be answered definitively from the available evidence. However, the literature that exists on the use of mental health services within the broad context of primary care provides a vehicle for understanding some of the essential dynamics of use, thus enabling us to adopt some new perspectives for designing systems of care. Several lines of investigation provide compelling evidence for primary care clinicians to take these issues seriously for the benefit of their patients and their practices (**Table 1**). We will summarize this literature and its implications, and then outline the directions we would like to see new planning efforts take.

Table 1. Evidence Supporting the Need for Primary Care Physician Involvement in Behavioral Health Care Services

Mental health diagnoses, such as depression, rank among the most frequent diagnoses in primary care.[12-14]
Patients with mental health diagnoses display functional deficits that are equal to or greater in severity than those of other major chronic diseases, such as diabetes and hypertension.[15-20]
A notable number of high medical care users are patients with emotional disorders, particularly depression[21] and somatization.[22]
Many routine visits to primary care physicians involve counseling for psychological stressors.[23]
Approximately 50% of office visits resulting in a mental health diagnosis are to physicians who are not psychiatrists.[24]
Many primary care patients have notable but subthreshold comorbid mental health conditions.[15-20]
Approximately two thirds of all perscriptions for psychotropic medications are written by general medical physicians.[25]
Mental illness diagnoses are associated with an increase in general as well as specialty health care costs.[6]

FACTORS ASSOCIATED WITH THE USE OF MENTAL HEALTH SERVICES

From our reading it is clear that there is no standard criterion against which the rates of use of behavioral health care services can be compared outside of the context in which the care takes place. The use of behavioral health care services is not necessarily linked with the prevalence or severity of patient symptoms, and where such an expectable relationship can be found, its strength is rarely impressive.[26,27] For example, one review article[28] reported that only 12% to 25% of the use of medical services can be attributed to objectively assessed disability or morbidity. Furthermore, reports studying one aspect of the system of care, such as how patient characteristics affect use, rarely consider other aspects of the system of care, such as how physician characteristics or the type of care plan also influence use. This has led to a segmentation of the literature and has omitted studies that address the kinds of interactions among patient, physician, clinical setting, and care plan influences that we see in actual clinical practice. It is helpful, therefore, not to focus on a single correlate of use but, instead, to consider an interdependent system of factors that influences use of services in specific clinical settings.

To reduce the volume and complexity of the literature we reviewed, we grouped the studies into shared content domains. We then arranged these domains into a functional framework, similar to that of Mechanic,[27] that provides a realistic representation of the main contributors to the use of mental health services (**Figure**). The domain on the left of the Figure reflects how the characteristics of care plans and the ways services are provided and reimbursed affect the use of services. The large rectangles at the top and bottom refer to characteristics of patients and physicians, respectively, that account for variation in use. The domain in the center addresses aspects of the actual clinical encounter that mediate detection, referral, and, ultimately, use. The arrows reflect potential paths of influence. We describe these domains, present representative studies, and summarize the essential findings.

Patient Characteristics and Service Use

Before summarizing how the type and severity of behavioral disorder,

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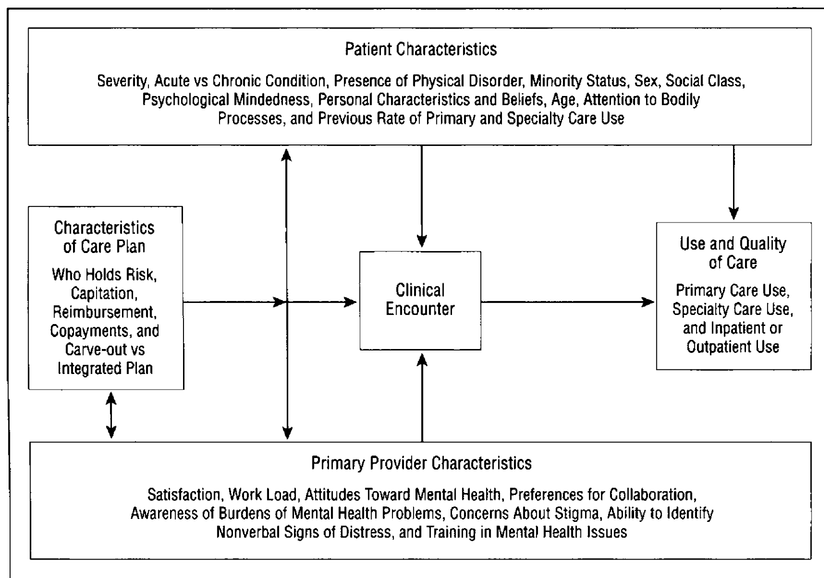

Factors associated with the use of mental health and substance abuse services.

patient sex, age, social class, and ethnicity, urban vs rural clinical setting, and patient characteristics affect the use of behavioral health care services, it is useful to draw distinctions among 4 types of studies prominent in the literature:

1. Epidemiological studies documenting the number of patients in a community or catchment area whose mental health problems are diagnosable.[29] These patients are not identified through a specific health care facility and may not receive care for their problems.
2. Studies assessing the number of patients in primary care settings who display mental health problems but who may or may not receive mental health care.[13,19,30]
3. Studies assessing the ability of the primary care physician to recognize the presence of diagnosable mental health problems during a clinical encounter. These studies often record the accuracy of physician detection in patients whose mental health problems are documented separately by specialists.[31]
4. Studies assessing the number of patients enrolled in insurance plans that actually use mental health services.[32]

Each of the 4 study types yields different statistical rates. For example, the prevalence of diagnosable psychological, behavioral, and substance abuse problems in community samples has been reported to be approximately 28%, with considerable variation from study to study (incidence per year, 6.6%; and relapses, 5.7%).[29,33] Prevalence rates among patients in primary care settings are reported to be as high as 50% to 75%.[12,24,34-37] Rates of detection of mental health problems within a clinical encounter by physicians are between 20% and 45%.[38-44] These values vary considerably by clinical setting, patient disorder, and previous mental health diagnosis.[43] Rates of actual use of mental health services per year are much lower, between 4% and 6%.[45]

Crow et al[45] summarized most of the large-scale mental health use studies to date. The values reported are for insured patients with at least 1 outpatient mental health visit per year, regardless of referral source. Across all patient groups, use rates varied from a high of 5.5%[46] to a low of 4.3%.[47-49] The average number of visits for insured patients who saw a mental health specialist at least once a year were between 8.2 and 5.5.[47-49] These rates vary by type of plan, type of treatment, provider of treatment, and year of assessment. They also aggregate data across several important patient, physician, and plan characteristics that affect use.

Type and Severity of Disorder. There are relatively few studies of the use of mental health services based on diagnosis or type of behavioral problem. Excluding the severely and chronically mentally ill, patients with depression and somatization disorders tend to use more outpatient mental health services than patients with other mental health conditions.[50] Low rates of mental health specialty care are found most often with patients with situational, developmental, or life stress problems. The more severe the mental health disorder, the greater the probability that the patient will be referred for specialist care.[51]

Sex. In general, more women than men use mental health services and use them more often,[52] but the differences in use based on sex are usually not statistically significant (5.3%-9.1% vs 3.5%-8.7%).[45,46] However, Verbrugge documented that although men and women reported mental distress to their physician as their main problem with equal frequency, physicians referred distressed men more frequently to specialty care than distressed women, thus treating women more often than men in the primary care practice.[53,54]

Age. Children and adolescents use mental health services at approximately one third the rate of adults (2.2% vs 6.6%) across all sources of referral.[45] Most studies suggest a general increase in use of behavioral health care services from early adulthood until age 30 to 35 years 5.4%). Rates peak between the ages of 35 and 49 years (6.6%), followed by a gradual decline.[47,48] Although the prevalence of mental health problems in the elderly is thought to be relatively high, the elderly do not use specialty mental health services at a high rate (2.8%).[49]

Social Class and Ethnicity. Culture and ethnicity are notably correlated with the probability of service use but not with the amount of service use.[45] White persons who are not Hispanic display the highest frequency of outpatient mental health service use (4.6%)[49]; use by African Americans is somewhat lower (4.2%).[47,48] No data for Hispanics, Asians, or other ethnic groups were available in these studies, but Taube et al[49] included a category for all ethnic minorities combined (frequency of use, 2.3%). This consid-

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erably lower value suggests that ethnic minorities use mental health services far less often than majority groups. Rates of use tend to increase with education and as newly emigrated ethnic minorities become acculturated.[45,49]

Urban vs Rural Setting. The use of mental health services is higher per capita in urban compared with rural settings. There is considerable variation in use among urban settings, suggesting other operating factors, but such factors have not been studied systematically.[50] It is known that rural physicians refer fewer patients than urban physicians for specialty mental health care services[55] and that rural patients are less inclined to use specialty mental health services after referral by their primary care physician than urban patients.[5]

Personal Characteristics of Patients. Several personal traits of patients have been linked to the use of mental health services. These include personal beliefs about the cause of symptoms, style of stress management, and mood. In general, these studies indicate that a personal focus on internal physiological and psychological states,[27,56-58] patient beliefs about the cause of their symptoms (somatic vs other),[59] and patient negative mood[60] are positively linked with use of mental health services. Furthermore, between 33% and 50% of primary care patients who are given a referral for specialty mental health care do not complete the referral, suggesting the operation of additional patient psychological and situational factors.[61,62]

Physician Characteristics and Service Use

A major source of variation in patient use of behavioral health care services is the ability of the physician to detect, diagnose, and respond to an emotional or behavioral problem during a clinical encounter. Although there has been considerable recent interest in documenting the problems associated with detection in primary care among all physicians,[38,41,43,44] there has also been a growing recognition of the variability among physicians to detect and diagnose these problems.[63,64] We review several aspects of the primary care setting and physician style that are associated with use of behavioral health care services.

Physician Demographics. The rates of patient referrals to mental health specialists by postresidency primary care physicians increase with physician age and number of years in practice.[65] Furthermore, primary care physicians with large workloads refer more patients for mental health care services than primary care physicians with small workloads.[66] If the frequency of "unnecessary medical visits" is viewed as a surrogate measure for lack of detection of psychosocial problems, Sihvonen and Kekki[67] showed that the physician-rated frequency of these visits was inversely related to physician duration of time at that practice site, physician report of work satisfaction, and what the authors called physician "task identity." We found no study that specifically addressed differences in detection or referral for mental health services based on physician sex.

Primary Care Specialty. Two studies found few differences in the accuracy of detection between family physicians and general internists, although both documented considerable variability in accuracy within both groups.[68,69] Kessler et al[43] showed that family physicians had lower rates of detection and referral for emotional and behavioral problems than general internists. The differences were explained in part by the fact that the family physicians in the study had a larger number of patients to see per half day and had less time to see each patient than did the general internists. It may be that there are few differences in rates of detection between these 2 primary care specialties when both have the same length of time with the patient to make the diagnosis or that family physicians make the diagnosis over time rather than at a specific visit.

Physician Beliefs and Practice Styles. Several personal characteristics of physicians and physician practice style preferences have been positively linked with the detection of patient mental health problems, referral, and use of mental health services: beliefs about the "psychogenesis" of symptoms,[70] trust in clinical ability to make an accurate diagnosis of depression,[64] personal sensitivity to patient psychological issues and nonverbal indicators of distress,[71] and an affective style of interviewing.[38] Negative linkages include physician concerns about stigmatizing patients,[70,72,73] perceptions of burden and discomfort experienced by patients with depression, and beliefs that the patient will refuse a mental health referral.[65]

Furthermore, deGruy[5] noted that physician practice preferences vary along several dimensions that are linked to use of behavioral health care services: some physicians include children and adolescents in their caseload, and some include only adults; some clinical practices are large with considerable in-house resources, and some are single physician offices with or without a family nurse practitioner; some physicians practice in generalist settings, and others practice with a specific focus (eg, obstetrics, geriatrics, or adolescent medicine); some practices are procedure oriented, whereas others refer patients needing procedures; some practices are organized around unique cultural or community needs, and others are more diverse in their orientation and patient variety; and some practices include major teaching programs, and others do not.

These studies suggest that physicians cannot be considered a uniform group of practitioners. Beliefs about psychosocial issues, comfort in dealing clinically with depression and related conditions, style of interviewing, and practice preferences have substantial effects on physician accuracy in detecting, referring, and treating psychological and behavioral problems. Despite these differences, clinicians rarely miss or neglect psychosocial problems when they are presented directly.[74]

Care Plan Characteristics and Service Use

Despite the obvious relevance, there have been few empirical studies that address the variation in the rates of use of mental health services based on characteristics of health care plans. Two areas in which more di-

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Table 2. Summary of Factors Affecting Use of Services

Variable	Effect
Patients	
Type of disorder	Rates high for affective, somatization disorder
Sex	No differences in rates; men referred to specialty care more often than women
Age*	Children and adolescents, 2.2%; adults <35 y, 5.4%; adults 36-49 y, 6.6%; and adults >49 y, 2.8%
Ethnicity (varies by degree of acculturation)	Whites who are not Hispanic, 4.6%; African Americans, 4.2%; and others, 2.3%
Education	Without high school, 4.3%; and with high school, 5.8%
Clinical setting	Higher rates in urban compared with rural settings
Personal characteristics	Higher rates mean inward-focused, not psychologically minded, negative mood, somatic beliefs
Primary care physicians	
Demographics	Detection decreases with job stress and work load; rate of referral increases with job stress, work load, age, and years in practice
Primary care specialty	No apparent differences
Beliefs and practice style	Concern about stigmatization, beliefs about how symptoms are caused, beliefs about patient burdens from symptoms, expectations about patient refusal of referral, comfort in making a mental illness diagnosis, personal sensitivity to psychological issues, and affective style of interviewing
Practice structure	Procedure focused; size and resources of practice, comfort with collaboration, specialty interests (eg, geriatrics and pediatrics), and focus on specific cultural or community needs
Managed care plan	
Type of benefit	A carve-out vs an integrated plan
Copayment	High copayments lead to reduced use (less effect for high-income patients, costs may occur later or patients may return with somatic problems)

Rates are approximate and vary from study to study. These figures are included to demonstrate variability based on different age groups.

rected research has been done are in the structural aspects of care, such as whether the behavioral health care benefit has been carved out, and the effect of the size of the patient's copayment.

Carve-outs vs Integrated Service Plans. The term *carve-out* refers to a managed care plan that pays for and provides behavioral health care services separately from the general health plan that covers medical services. Several authors[75-79] have argued against carve-outs on practical and clinical grounds. Some of the arguments against carve-outs are that they lead to fragmentation, reduce comprehensive evaluation of the patient's condition, prevent efficient use of resources, increase cross-professional conflicts, and increase duplication of care.[80-83] Few empirical studies of the effects of behavioral health care carve-outs and use of general health and behavioral health care services have been done, but our overview of the field suggests general support for integrated care when quality of care and costs for total health care are considered.[80,83-85] For example, Carr and Donovan[86] developed and implemented several kinds of collaborative arrangements between physicians and mental health practitioners within primary care settings. They reported that 88% of physicians recorded a reduction of referrals to mental health specialty care over time, and a similar number reported an increase in personal confidence when handling mental health issues in their practices. These findings suggest that collaborative, integrated care may lead to a reduction of referrals for some kinds of behavioral health care services. This parallels other research that indicates that emergency, hospital, and specialty care decreases as the availability of service within primary care settings increases.[87]

Patient Copayment. Copayments are fixed patient fees established by the health care plan to contain the cost of service. Several studies have found a negative correlation between the size of a copayment and the use of a service, a so-called barrier to care.[45,88] For example, Cherkin et al[89] showed that an increase in copayments of $5 led to a 10.9% reduction in primary care visits and a 3.3% reduction in specialty visits in a federal employee health maintenance organization (HMO) plan. Increases in patient copayment tended to affect low-income patients more than high-income patients.[90] Furthermore, an increase in copayment charges was associated with an increase in the use of services outside the plan for patients with a high socioeconomic status but not for those with a low socioeconomic status.[91] In contrast, the review of results by Wells[88] from several different care plans suggested few or no effects of copayments on service use in noncapitated or fee-for-service plans.

There is some evidence that overall health care service use may not decrease with an increase in patient behavioral health copayments in all cases; it may only become distributed in other forms, either to primary care physicians within the plan or to specialists outside the plan.[92] This observation led Wells[88] to conclude that "individuals with the greatest psychological distress or poor people may achieve worse outcomes under greater cost containment."

How the structure of mental health services within medical care plans influences the delivery of services, or at least its reporting, is well illustrated by a recent study by Rost et al.[73] These investigators found that 50% of 444 primary care physicians surveyed reported that they had substituted a general medical diagnosis for a psychiatric diagnosis of depression during the 2 weeks of practice before the interview because of their uncertainty about diagnosis, their concerns about reimbursement, and their reluctance to stigmatize their patients and jeopardize their employment and insurance options. This practice, which we believe is common, reduces the validity of detection data and increases the probability of underreporting mental illnesses.

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OVERVIEW

A summary of factors affecting the use of mental health services is provided in **Table 2**. The use of services varies by at least 7 patient characteristics, 4 physician and practice characteristics, and 2 plan characteristics. This means that the number and type of mental health services used varies among patients and from primary care practice to primary care practice, based on variations among the main and interactive effects of these defined characteristics. It is helpful to view these factors not as independent contributors to use but as an interrelated system of influences centered within the primary care context. For example, the findings summarized in Table 2 identify relatively high behavioral health care use rates for patients who in various studies have somatization and affective disorders, are between 36 and 49 years old, are well educated, live in urban areas, are not from ethnic minorities, are somatically focused, and have low copayments. The data also suggest an association with relatively high rates in practices that have been variously described as having physicians who have high workloads, are experienced and older, are relatively less concerned about stigmatization, believe that psychological issues play a role in many physical symptoms, believe that it is important for patients to follow through on referrals, are comfortable making psychological and behavioral diagnoses, are comfortable discussing patients' psychological concerns, and use an affective style of interviewing. Furthermore, rates of use vary as a function of practice structure, with relatively low rates in procedure-focused practices and practices that emphasize services to children and the elderly.

In addition, the review suggests that there is considerable variability in the role physicians play as detectors, providers, and intermediaries when behavioral health care services for their patients are concerned. How behavioral health care problems are handled depends in part on the physician's preferences for managing common mental health problems personally, for obtaining and using consultation from behavioral health care specialists, and for arranging for specialist-provider mental health services within the primary care practice rather than in the community.

IMPLICATIONS

These findings lead us to a general observation concerning the 4 questions we posed at the outset. Data linking use with a single patient, practice, or physician characteristic, and compiled across all patients, physicians, clinical settings, and geographic areas, should be used with considerable caution. There is no single, generic patient, physician, practice setting, locale, and health plan from which to build an optimal behavioral health care system that is compatible with all of the clinical practices and patients in the system. This suggests that types of behavioral health care services and systems of service provision should be tailored to meet the needs of local practices and patient case mixes and not developed on a systemwide or regional basis that does not consider this kind of patient, practice, and community variability. To meet these ends, we argue that the behavioral health care service system must be integrated within the primary care environment.[7,10,76,92] As in politics, all clinical care is local.

Such integration is surprisingly rare. A 1996 poll[93] indicated that of an estimated 181 million Americans with health insurance, approximately 68% were enrolled in some type of specialty managed behavioral health program. Approximately 21% were covered by risk-based, managed behavioral health care plans that were independently serviced by carve-out companies, and this value is expected to increase in 1997. Should this trend continue, primary care physicians' ability to provide care that is relevant and compatible with the patients and practice setting will be increasingly limited.

How did this disintegration of health care come about in the first place? In brief, HMOs and medical groups, which were allocated the mental health portion of the health care premium, failed to control costs and provide quality in mental health services at a crucial period of managed care development. Between 1986 and 1990, spending by employers for mental health coverage increased by 50%.[9] This increase was largely due to a dramatic surge in unnecessary and uncontrolled hospitalization, especially for adolescents.[2] Fee-for-service plans were especially vulnerable to these increasing costs and were ripe for utilization review and selective contracting, 2 early managed care technologies. Full-scale managed behavioral health care companies were not far behind. Mental health and substance abuse care were seen as costs to be reduced rather than as basic resources that could strengthen comprehensive patient care. Carve-out companies entered the field, promising results that could be reflected on the balance sheet. The ensuing cost reduction was notable, primarily due to the reduced use of psychiatric hospitalization.[94]

Large HMOs that offered mental health and substance abuse care contained costs largely by controlling access to care, but they paid insufficient attention to the quality of care and to the development of creative new services that fit the needs of a rapidly changing health care environment. In northern California, for example, where it has 2.4 million members, Kaiser Permanente saw many of its largest customers (eg, Bank of America, Chevron, Pacific Bell, Wells Fargo, and the Teamsters Union) sign contracts with managed behavioral health care companies to provide mental health care under separately funded and administered programs.[9] Other network model HMOs and medical service provision groups under contract with HMOs also saw mental health benefits carved out, or they willingly carved them out themselves.

We believe that mental health benefits were carved away from general medical plans during the expansion years of the late 1980s and early 1990s because key decision makers (who were not primary care physicians) did not see the value of investing in these services and were driven by the marketplace to reduce spiraling mental health costs. As a result, these decision makers turned to emerging behavioral health care carve-out companies that prom-

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ised and provided substantial cost control. Unfortunately, this short-term solution was accompanied by a fragmentation of care that did not consider the kinds of factors that influence the use of services that we summarized in this article.

The Role of the Physician and the Structure of Services

Let us return to the first 2 questions posed at the outset: (1) What role should primary care physicians play in the provision of behavioral health care services? (2) How should behavioral health care services be organized and provided?

The ability to coordinate care across a spectrum of specialists, along with the potential for effective integration and collaboration, is compromised by programs that remove behavioral health care from the primary care physician's purview. This observation is not an argument against the use of carve-outs per se, because at its best a carve-out is simply a way of paying for services. In their practical application, carve-out plans, or other arrangements that create separate and parallel clinical and administrative structures, tend to fragment care and duplicate costs.

deGruy[5] explains the heart of the clinical problem in a recently published report on managed care commissioned by the Institute of Medicine. According to deGruy, the relationship between physical and mental problems is one in which emotional distress and behavioral symptoms are usually embedded in a matrix of reported physical symptoms. This relationship is documented by considerable research.[95] Primary care clinicians deal with mental symptoms as part of something—part of a larger, more general health problem. Conversely, psychologically distressed patients experience increased physical symptomatology.[96] deGruy observes:

> systems of care which force the separation of "mental" from "physical" problems consign the clinicians in each arm of this dichotomy to a misconceived and incomplete clinical reality which produces duplication of effort, undermines comprehensiveness of care, hamstrings clinicians with incomplete data, and ensures that the patient cannot be completely understood.[5]

deGruy[5] also notes that primary care patients do not view their mental diagnoses as something apart from their general health, and they will not tolerate physicians doing so. One third to half of primary care patients refuse referral to a mental health professional,[61,62] and these patients cut across all demographic and diagnostic groups.[97] It makes sense, therefore, to integrate selective mental health resources within the primary care environment, either by supporting the primary care physician through consultation or direct and familiar linkages to community resources or by bringing mental health providers directly into the primary care context. As deGruy observes,

> Mental health care cannot be divorced from primary medical care, and all attempts to do so are doomed to failure. Primary care cannot be practiced without addressing mental health concerns, and all attempts to do so result in inferior care.[5]

Thus, we argue that to assure the provision of relevant and effective behavioral health care to their patients, primary care physicians must acknowledge the important role they play in the system of care and contribute actively to the development and implementation of programs of care that make sense for their patients and practices. How that care is organized and structured is among the responsibilities of a provider of comprehensive primary care. No one else has more experience with the patient or family, the community, and the coordination of available resources than the primary care physician. This does not assume that a single strategy has to be adopted by all primary care physicians in a single medical group, no matter how large or small. A menu that includes in-house mental health care, consultation with a mental health specialist, or community referral could be developed. What is essential is that physician-led plans consider the factors known to influence the use of behavioral health care services so that plans are decentralized to meet patient, physician, and community needs.

Financial and Administrative Arrangements

Questions 3 and 4 addressed how capitated finances for primary care and behavioral health care should be managed and how administrative requirements, such as utilization review, for primary and behavioral health care should be structured. We argue that financial and administrative arrangements should follow clinical arrangements and suggest that the financial and administrative portions of behavioral health care services be integrated with the general health plan structure. This kind of integration avoids at least 5 often unrecognized problems that separate, parallel systems create.

First, primary care physicians have unwittingly subsidized the success of carve-out companies by doing a substantial share of mental health–related work without compensation.[25] This work includes providing basic counseling and support, prescribing psychotropic medications, fielding calls about psychosocial issues from patients and family members who are encouraged by health plans to turn to their primary care physician first for all their health needs, and dealing with increased office visits because of incomplete or unsatisfying care from a carve-out provider. An integrated financial system can direct these cost savings back into the system that is managed by the medical group.

A second financial problem is that separate administrative systems introduce financial disincentives that work against maximizing efficiencies and savings. Because 2 independent pots of money are created, any savings on the health care side are achieved independently from their effect on the medical side and on the primary care physician's expenses. The carve-out company decides what is medically necessary and sufficient care. Patients can get "turfed" back to their primary care physician for less than optimal reasons.

These independent pots of money create a third financial problem, namely that neither plan can

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"flex" the benefit to do what is best for the patient and the primary care clinician's management strategy while also doing what is wise for total patient care and cost. When primary care clinicians and behavioral health care specialists work together, and when there is only one pool of resources, the potential for such flexibility is built in for the benefit of patient and physician.

A fourth financial problem is that separate administrative systems create 2 independent proprietary databases. These dual databases make it difficult to target high-risk patients for special intervention, to monitor integrated quality of care, to assess the reciprocal medical-behavioral cost-offset effects, and to monitor possible risk-sharing arrangements between behavioral health care providers and primary care physicians.

Finally, several administrative functions and costs are duplicated when parallel systems are introduced. Health plan purchasers end up paying twice for functions designed to select and credential facilities and providers, authorize treatment, manage and review use, improve quality, measure and report outcomes and other processes of interest, and pay providers. Less obvious is the cost of dividing these functions from one another, locating the providers required in different places with different management information systems, and introducing parallel worlds that do not communicate with one another or understand each other's needs and concerns. As managed care matures, these functions need to be integrated, clinically and administratively, to eliminate the lingering mind-body split and to create a persuasive, cost-efficient alternative.

Extrapolating from the review of service use data, we conclude that funding for primary and behavioral health care services should be pooled, and decisions for allocating resources should be placed in the hands of the clinicians and managers who have responsibility for the comprehensive care of the patient. This may require that behavioral health care specialists and primary care physicians share financial risks as part of a single or linked group of health care specialists. Collaboration and responsibility among providers of care at the clinical level need to be linked with collaboration and responsibility at the financial level so that primary care physicians and behavioral health care specialists have the same incentives to provide the highest quality of care and the most cost-effective care possible.

We are not suggesting that primary care physicians themselves should provide more mental health and substance abuse care within the managed care setting; we seek only to acknowledge and strengthen what they are already doing. Recognizing that primary care is best conceived as a single system of care, our position is the same as that taken in the "AAFP White Paper on the Provision of Mental Health Care Services by Family Physicians,"[7] namely, that mental health and substance abuse services should remain within a uniform benefits package and should not be split off and that the necessary, desirable, and cost-effective role of family physicians in providing primary mental health services should be recognized and supported.

To reach these goals, primary care physicians need to assume greater leadership in managed care systems. Concerning behavioral health care, such leadership might include increasing control of plan design and plan resources, selecting and contracting with local behavioral health care facilities and professionals, collaborating with behavioral health care specialists to support the primary clinical management plan, initiating flexible ways to provide services that support patient and plan needs as a whole, and integrating the management services operations of the medical and behavioral health care functions of the plan within a single information system.

In conclusion, we suggest that basic behavioral health care services ideally should be integrated within and become an extension of a program of comprehensive primary care. Many managed care plans do not provide the range of needed services, the philosophy of service, and the flexibility for physicians to contribute to programs of care that address the specific patient, practice, and physician needs suggested by this review. Primary care physicians, medical groups, behavioral health care specialists, managed care companies, and purchasers of managed care plans must play active roles in designing systems of behavioral health care that address these crucial treatment issues. Our hope is that the physician leaders of the future will be wiser managers of behavioral health care resources than were their forebearers.

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REFERENCES

1. Bennett MJ. The greening of the HMO: implications for prepaid psychiatry. *Am J Psychiatry.* 1988;145:1544-1549.
2. England MJ, Goff VV. Health reform and organized systems of care. In: Goldman W, Feldman S, eds. *New Directions for Mental Health Services: Managed Mental Health Care.* San Francisco, Calif: Jossey-Bass Publishers Inc; 1993:5-12.
3. Feldman S, Goldman W. Editor's notes. In: Feldman S, Goldman W, eds. *New Directions for Mental Health Services: Managed Mental Health Care.* San Francisco, Calif: Jossey-Bass Publishers Inc; 1993:1-3.
4. Shueman SA, Troy WG, Mayhugh SL. Principles and issues in managed behavioral health care. In: Shueman SA, Troy WG, Mayhugh SL, eds. *Managed Behavioral Health Care: An Industry Perspective.* Springfield, Ill: Charles C. Thomas Publisher; 1994:7-28.
5. deGruy FV. Mental health care in the primary care setting. In: Donaldson MS, Yordy DD, Lohr KL, Vanselow NA, eds. *Primary Care: America's Health in a New Era.* Washington, DC: National Academy Press; 1996.
6. Simon GE, von Korff M, Barlow W. Health care costs of primary care patients with recognized depression. *Arch Gen Psychiatry.* 1995;52:850-856.
7. American Academy of Family Practice, Commission on Health Care Services. AAFP white paper on the provision of mental health care services by family physicians. *Am Fam Physician.* 1995;51:1405-1412.
8. Boyle PJ, Callahan D. What price mental health? the ethics and politics of setting priorities. Washington, DC: Georgetown University Press; 1995.
9. Iglehart JK. Managed care and mental health. *N Engl J Med.* 1995;334:131-135.

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10. Patterson JE, Scherger J. University family therapy training and a family medicine residency in a managed-care setting. *Fam Syst Health.* 1996;13:5-16.
11. Wells KB, Sturm R. Care for depression in a changing environment. *Health Aff (Millwood).* 1995;14: 78-89.
12. Barrett JE, Barrett BA, Oxman TE, Gerber PD. The prevalence of psychiatric disorders in a primary care practice. *Arch Gen Psychiatry.* 1988;45:1100-1106.
13. Ormel J, Von Korff M, Ustun B, Pini S, Korten A, Oldehinkel T. Common mental disorders and disabilities across cultures: results from the WHO collaborative study on psychological problems in general health care. *JAMA.* 1994;272:1741-1748.
14. Spitzer RL, Williams BW, Kroenke K. Utility of a new procedure for diagnosing mental disorders in primary care. *JAMA.* 1994;272:1749-1756.
15. Broadhead WE, Blazer DG, George LK, Tse CK. Depression, disability days, and days lost from work in a prospective epidemiological survey. *JAMA.* 1990;264:2524-2528.
16. Hays RD, Wells KB, Sherbourne CD, Rogers W, Spritzer K. Functioning and well-being outcomes of patients with depression compared with chronic general medical illnesses. *Arch Gen Psychiatry.* 1995;52:11-19.
17. Jaffe A, Froom J, Galambos N. Minor depression and functional impairment. *Arch Fam Med.* 1994; 3:1081-1086.
18. Mintz J, Mintz LI, Arruda MJ, Hwang SS. Treatments of depression and the functional capacity to work. *Arch Gen Psychiatry.* 1992;49:761-768.
19. Spitzer RL, Kroenke K, Linzer M, et al. Health-related quality of life in primary care patients with mental disorders: results from the PRIME-MD 1000 study. *JAMA.* 1995;274:1511-1517.
20. Wells KB, Burnam MA, Rogers W, Hays R, Camp P. The course of depression in adult outpatients: results from the Medical Outcomes Study. *Arch Gen Psychiatry.* 1992;49:788-794.
21. Katon W, Von Korff M, Lin E, et al. A randomized trial of psychiatric consultation with distressed high utilizers. *Gen Hosp Psychiatry.* 1992;14:86-98.
22. Smith GRJ, Monson RA, Ray DC. Patients with multiple unexplained symptoms: their characteristics, functional health, and health care utilization. *Arch Intern Med.* 1986;146:69-72.
23. Stewart MA, McWhinney IR, Buck CW. How illness presents: a study of patient behavior. *J Fam Pract.* 1975;2:411-414.
24. Schurman RA, Kramer PD, Mitchell JB. The hidden mental health network: treatment of mental illness by nonpsychiatrist physicians. *Arch Gen Psychiatry.* 1985;42:89-94.
25. Beardsley RS, Gardocki GJ, Larson DB, Hidalgo J. Prescribing of psychotropic medication by primary care physicians and psychiatrists. *Arch Gen Psychiatry.* 1988;45:1117-1119.
26. Mechanic D. Correlates of physician utilization: why do major multivariate studies of physician utilization find trivial psychosocial and organizational effects? *J Health Soc Behav.* 1979;20:387-396.
27. Mechanic D. Health and illness behavior and patient-practitioner relationships. *Soc Sci Med.* 1992; 34:1345-1350.
28. Berkanovic E, Telesky C, Reeder S. Structural and social psychological factors in the decision to seek medical care for symptoms. *Med Care.* 1981;21: 693-709.
29. Shapiro S, Skinner EA, Kessler LG. Utilization of health and mental health services. *Arch Gen Psychiatry.* 1984;41:971-978.
30. Coyne JC, Fechner-Bates S, Schwenk TL. Nondetection of depression by primary care physicians reconsidered. *Gen Hosp Psychiatry.* 1995; 17:3-12.
31. Katon WJ. Implications for care delivery of mental illness in primary care. In: Marks IM, Scott RA, eds. *Mental Health Care Delivery: Innovations, Impediments and Implementation.* New York, NY: Cambridge University Press; 1990:61-68.
32. Wells KB, Manning WG, Duan N. Sociodemographic factors and the use of outpatient mental health service. *Med Care.* 1986;24:75-85.
33. Regier DA, Narrow WE, Rae DS, Manderscheid RW, Locke BZ, Goodwin FK. The de facto US mental and addictive disorders service system: epidemiological catchment area prospective 1-year prevalence rates of disorders and services. *Arch Gen Psychiatry.* 1993;50:85-94.
34. Blacker CV, Clare AW. The prevalence and treatment of depression in general practice. *Psychopharmacology.* 1988;95:514-517.
35. Bowers PJ. Selections from current literature: psychiatric disorders in primary care. *Fam Pract.* 1993; 10:231-237.
36. Hoeper EW, Nycz GR, Cleary PD, Regier DA, Goldberg ID. Estimated prevalence of RDC mental disorder in primary care. *Int J Ment Health.* 1979;8:6-15.
37. Leon AC, Olfson M, Broadhead WE, et al. Prevalence of mental disorders in primary care: implications for screening. *Arch Fam Med.* 1995;4:857-861.
38. Badger LW, deGruy FV, Hartman J, et al. Psychosocial interest, medical interviews, and the recognition of depression. *Arch Fam Med.* 1994;3: 899-907.
39. Badger LW, deGruy FV, Hartman J, et al. Patient presentation, interview content, and the detection of depression by primary care physicians. *Psychosom Med.* 1994;56:128-135.
40. Block M, Schulberg HC, Coulehan JC, McClelland M, Gooding W. Diagnosing depression among new patients in ambulatory training settings. *J Am Board Fam Pract.* 1988;1:91-97.
41. Borus JF, Howes MJ, Devins NP, et al. Primary health care providers' recognition and diagnosis of mental disorders in their patients. *Gen Hosp Psychiatry.* 1988;10:317-321.
42. Jones LR, Badger LW, Ficken RP, Leeper JD, Anderson RL. Mental health training of primary care physicians: an outcome study. *Int J Psychiatry Med.* 1988;18:107-121.
43. Kessler LG, Amick III BC, Thompson J. Factors influencing the diagnosis of mental disorder among primary care patients. *Med Care.* 1985; 23:50-62.
44. Ormel J, Koeter MW, Van den Brink W, Van de Willige G. Recognition, management, and course of anxiety and depression in general practice. *Arch Gen Psychiatry.* 1991;48:700-706.
45. Crow MR, Smith HL, McNamee AH, Piland NF. Considerations in predicting mental health care use: implications for managed care plans. *J Ment Health Administrations.* 1994;21:5-23.
46. Diehr P, Price K, Williams SJ, Martin DP. Factors related to the use of ambulatory mental health services in three provider plans. *Soc Sci Med.* 1986; 23:773-780.
47. Horgan CM. Specialty and general ambulatory mental health services: comparisons of utilization and expenditures. *Arch Gen Psychiatry.* 1985; 42:565-572.
48. Horgan CM. The demand for ambulatory mental health services from specialty providers. *Health Serv Res.* 1986;21:291-319.
49. Taube CA, Kessler LG, Bums BJ. Estimating the probability and level of ambulatory mental health service use. *Health Serv Res.* 1986;21: 321-339.
50. Verhaak PF. Analysis of referrals of mental health problems by general practitioners. *Br J Gen Pract.* 1993;43:203-208.
51. Williamson PS, Yates WR. The initial presentation of depression in family practice and psychiatric outpatients. *Gen Hosp Psychiatry.* 1989;11: 188-193.
52. Kessler RC, Brown RL, Broman CL. Sex differences in psychiatric help-seeking from four large surveys. *J Health Soc Behav.* 1981;22:49-55.
53. Feinson MC. Are psychological disorders most prevalent among older adults? examining the evidence. *Soc Sci Med.* 1989;29:1175-1181.
54. Verbrugge LM. How physicians treat mentally distressed men and women. *Soc Sci Med.* 1984;18: 1-9.
55. Standfeld SA, Leek CA, Travers W, Turner T. Attitudes to community psychiatry among urban and rural general practitioners. *Br J Gen Pract.* 1992; 42:322-325.
56. Hansell S, Mechanic D, Brondolo E. Introspectiveness and adolescent development. *J Youth Adolescence.* 1986;15:115-132.
57. Hansell S, Mechanic D. Body awareness and self-assessed health among older adults. *J Aging Health.* 1991;4:473-492.
58. Mechanic D. Adolescent health and illness behavior: review of the literature on a new hypothesis for the study of stress. *J Hum Stress.* 1983;9:4-13.
59. Ingham JG, Miller PM. Self-referral to primary care: symptoms and social factors. *J Psychosom Res.* 1986;30:49-56.
60. Pennebaker JW. *The Psychology of Physical Symptoms.* New York, NY: Springer Publishing Co Inc; 1982.
61. Orleans CT, George LK, Houpt JL, Brodie HK. How primary care physicians treat psychiatric disorders: a national survey of family practitioners. *Am J Psychiatry.* 1985;142:52-57.
62. von Korff M, Myers L. The primary care physician and psychiatric services. *Gen Hosp Psychiatry.* 1987;9:235-240.
63. Kirmayer LJ, Robins JM, Dworkind M, Yaffe MJ. Somatization and the recognition of depression and anxiety in primary care. *Am J Psychiatry.* 1991; 150:734-741.
64. Main DS, Lutz LJ, Barrett JE, Matthew J, Miller RS. The role of primary care clinician attitudes, beliefs, and training in the diagnosis and treatment of depression: a report from the Ambulatory Sentinel Practice Network Inc. *Arch Fam Med.* 1993;2:1061-1066.
65. Gottlieb JF, Olfson M. Current referral practices of mental health care providers. *Hosp Community Psychiatry.* 1987;38:1171-1181.
66. Finlay W, Mutran EJ, Zeitler RR, Randall CS. Patient age, visit purpose, and the ordering of consultations in a primary care clinic. *J Aging Health.* 1990;2:261-281.
67. Sihvonen M, Kekki P. Unnecessary visits to health centres as perceived by the staff. *Scand J Prim Health Care.* 1990;8:233-239.
68. Goldberg HI, Dietrich AJ. The continuity of care provided to primary care patients: a comparison of family physicians, general internists, and medical subspecialists. *Med Care.* 1985;23:63-73.
69. Kebbon L, Swartlin PG, Smedby B. Psychiatric symptoms and psychosocial problems in primary health care as seen by doctors. *Scand J Prim Health Care.* 1985;3:23-30.

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70. Link B, Levav I, Cohen A. The primary medical care practitioner's attitudes toward psychiatry: an Israeli study. *Soc Sci Med.* 1982;16:1413-1420.
71. Robbins JM, Kirmayer LJ, Cathebras P, Yaffe MJ, Dworkind M. Physician characteristics and the recognition of depression and anxiety in primary care. *Med Care.* 1994;32:795-812.
72. Jencks SF. Recognition of mental distress and diagnosis of mental disorder in primary care. *JAMA.* 1985;253:1903-1907.
73. Rost K, Smith GR, Matthews DB, Guise B. The deliberate misdiagnosis of major depression in primary care. *Arch Fam Med.* 1994;3:333-337.
74. Verhaak PF, Wennink HJ. What does a doctor do with psychosocial problems in primary care? *Int J Psychiatry Med.* 1990;20:151-162.
75. Cronin C, Milgate K. Organized systems of care: a vision of a future healthcare delivery system. *Health Prog.* 1992;73:22-28.
76. Katon W, Von Korff M, Lin E. Collaborative management to achieve treatment guidelines: impact on depression in primary care. *JAMA.* 1995;273:1026-1031.
77. Mechanic D. *Inescapable Decisions: The Imperatives of Health Reform.* New Brunswick, NJ: Transaction Books; 1994.
78. Reidy Jr WJ. Staff model HMO's and managed mental health care: one plan's experience. *Psychiatr Q.* 1993;64:33-44.
79. Schulberg HC, Madonia MJ, Block MR. Major depression in primary care practice: clinical characteristics and treatment implications. *Psychosomatics.* 1995;36:129-137.
80. Baldwin LM, Inui TS, Stenkamp S. The effect of coordinated, multidisciplinary ambulatory care on service use, charges, quality of care and patient satisfaction in the elderly. *J Community Health.* 1993;18:95-108.
81. Borus JF, Casserly MK. Psychiatrists and primary physicians: collaborative learning experiences in delivering primary care. *Hosp Community Psychiatry.* 1979;30:686-689.
82. Groenewegen PP. Substitution of primary care and specialist care: a regional analysis in Denmark. *Soc Sci Med.* 1991;33:471-476.
83. Morrill RG. The future for mental health in primary health care programs. *Am J Psychiatry.* 1978; 135:1351-1355.
84. Daniels ML, Linn LS. Psychiatric consultation in a medical clinic: what do medical providers want? *Gen Hosp Psychiatry.* 1984;6:196-202.
85. Hansen V. Psychiatric service within primary care: mode of organization and influence on admission-rates to a mental hospital. *Acta Psychiatr Scand.* 1987;76:121-128.
86. Carr VJ, Donovan P. Psychiatry in general practice: a pilot scheme using the liaison-attachment model. *Med J Aust.* 1992;156:379-382.
87. Sjonell G. Effect of establishing a primary health care centre on the utilization of primary health care and other out-patient care in a Swedish urban area. *Fam Pract.* 1986;3:148-154.
88. Wells KB. Cost containment and mental health outcomes: experiences from US studies. *Br J Psychiatry.* 1995;166:43-51.
89. Cherkin DC, Grothaus L, Wagner EH. The effect of office visit copayments on utilization in a health maintenance organization. *Med Care.* 1989;27:1036-1045.
90. Birch S. Health care charges: lessons from the UK. *Health Policy.* 1988;13:145-157.
91. Simon GE, Von Korff M, Durham ML. Predictors of outpatient mental health utilization by primary care patients in a health maintenance organization. *Am J Psychiatry.* 1994;151:908-913.
92. Sturm R, Wells KB. How can care for depression become more cost-effective? *JAMA.* 1995;273:51-58.
93. Oss M, Stair T. Sixty-eight percent of insured in managed behavioral health: annual market share survey reports an increase in managed behavioral health enrollees in 1996. *Open Minds.* May 1996:12.
94. England MJ, Vaccaro VA. New systems to manage mental health care. 1991;10:129-137.
95. Kroenke K, Spitzer RL, Williams JB, et al. Physical symptoms in primary care: predictors of psychiatric disorders and functional impairment. *Arch Fam Med.* 1994;3:774-779.
96. Katon W, Von Korff M, Lin E, et al. Distressed high utilizers of medical care: *DSM-III-R* diagnoses and treatment needs. *Gen Hosp Psychiatry.* 1990;12:355-362.
97. Olfson M. Primary care patients who refuse specialized mental health services. *Arch Intern Med.* 1991;151:129-132.

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The use of special protective cushioned footwear led to a lower recurrence rate of diabetic foot ulcers. (*Diabet Med.* 1994;11:114-116.)

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