Outlining the Scope of Behavioral Health Practice in Integrated Primary Care: Dispelling the Myth of the One-Trick Mental Health Pony
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CITATION
Patient presentation in primary care ranges from psychosocial considerations to physical and mental health concerns including serious mental illness. To best prepare for addressing all aspects of health, integrated primary care practices should be equipped with the expertise and resources to appropriately treat the range of presentations. We conducted a literature review of research articles to determine the span of service types provided by behavioral health providers in primary care settings. Among 675 articles retrieved, only 17 addressed health behaviors, 64 examined both health behaviors and mental health, and 160 included only mental health topics. Within these groups, depression was the dominant screening, assessment, and treatment target, and only 42% of all studies included Method and Results sections. Literature supports that integrating behavioral health providers and services into primary care settings benefits patients, primary care providers, and the practice at large, resulting in improved care experiences. However, primary care practices appear to not use the full range of services behavioral health providers can offer. Increased health policy efforts and payment reform are needed to enable a more expansive view of what behavioral health providers could do in a primary care context.

Keywords: behavioral health primary care, integrated care, health policy, mental health
health behavior change? In this paper we de-
scribe services provided by BHPs based on
the available peer-reviewed literature. We
then describe the full range of services that
can be provided in PC by BHPs and provide
policy recommendations to better support this
range of services.

Method

A research librarian conducted a literature
search of Ovid Medline (1946 to present) and
PsycINFO 1806 to June, week 1, 2013 using the
search terms in Table 1. We limited the search
to English language articles published between
2000 and 2013 with adult samples in the U.S. In
Medline, the search terms were exploded as
MeSH terms and combined. We included ex-
planatory and pragmatic studies and excluded
articles specifically addressing medication,
prescribing psychologists, other medical profes-
sionals only, telemedicine, editorials, and
reviews of articles, books, or books chapters.

We categorized the references into three top-
ics: (a) mental health only, (b) health behavior
only, or (c) mental health AND health behavior.
We define “mental health only” as the delivery
of mental health services, and “health behavior
only” is service delivery related to chronic con-
ditions like obesity, insomnia, COPD, and dia-
betes. The third category includes the delivery
of both mental health and behavioral health
services (e.g., depression and HIV+). For all
three groups, a BHP must have provided these
services to PC patients. Lastly, we identified
references that included Methodology and Re-
sults sections. To assess interrater agreement of
these categories, two raters reviewed 20% of the
241 total citations.

Results

Search terms produced 675 references. The
following were excluded because of the prede-
termined criteria: editorials (n = 29); medica-
tion-focused (n = 31); telemedicine (n = 17);
pediatrics (n = 50); other medical professionals
only (n = 19); and international PC settings
(n = 233). An additional 17 were excluded,
because their focus was not in PC or integrated
PC settings; 22 were reviews or introductions to
special journal topics; and 16 were not relevant
to the search terms. This resulted in 160 mental
health only, 17 health behavior only, and 64
mental health AND health behavior references
(see Figure 1). Interrater agreement was .79
among all three groups. According to estab-
lished guidelines on interrater reliability, num-
bers above .70 are considered acceptable (Stem-
ler, 2004).

Across all groups, 42% of the references in-
cluded methods and results sections. Of the 160
mental health-only publications, 84 included
these sections. None were found in the 17 health
behavior–only group and 18 of the 64 health
behavior AND mental health references in-
cluded them. The majority of references without
methods/results were either explanatory, policy-
based, commentaries, or provided recommenda-
tions. Among the 84 in the mental health–only
group, depression was most widely covered
(n = 45), followed by anxiety (n = 14), comor-

<table>
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<tr>
<th>General search terms</th>
<th>Mental health terms</th>
<th>Health behavior terms</th>
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<tbody>
<tr>
<td>Psychiatrist</td>
<td>Mental disorders</td>
<td>Pain management</td>
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<td>Mental health profes</td>
<td>Depression</td>
<td>Insomnia</td>
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<td>Psychologist</td>
<td>Anxiety</td>
<td>Tobacco dependence</td>
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<td>Primary care clinic/</td>
<td>PTSD/posttraumatic stress disorder</td>
<td>Medication treatment/adherence/compliance</td>
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<td>setting/office</td>
<td>Bipolar</td>
<td>Smoking</td>
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<td>Schizophrenia</td>
<td>Illness behavior</td>
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<td>ADHD/attention deficit hyperactivity disorder</td>
<td>Adjustment to illness</td>
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<td>Eating disorder</td>
<td>Coping/coping behavior</td>
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<td>Dementia or Alzheimer</td>
<td>Hypertension</td>
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bid depression and anxiety, bipolar, and general mental health (each $n = 4$), and PTSD, borderline personality, schizophrenia, eating disorders, and ADHD (each $n = 2$). There was one reference each for severe mental illness, substance abuse, and depression with PTSD. Of the 18 health behavior AND mental health references, 11 pertained to depression within chronic illness samples (i.e., chronic pain, cancer, COPD, diabetes or HIV), and the remaining addressed specific medical illnesses and either anxiety ($n = 3$) or general psychiatric comorbidity.

**Discussion**

Based on our review, it is clear that BHPs are most often utilized and known for delivering mental health services in integrated settings (160 mental health-only vs. 80 behavioral-health-inclusive references). Depression is the dominant screening, assessment, and treatment focus. Although addressing depression is important, it is also clear that a range of other mental and behavioral health concerns are prevalent and eligible for BHP’s varied expertise.

Research on the integration of behavioral health in primary care would also benefit from (a) increasing scientific rigor as only 42% of all retrieved references included Method and Results sections, and (b) further study on the impact of BHP interventions in PC so that efforts can be provided accordingly.

Although we do not summarize this literature through a more formal systematic review or meta-analysis, we identified key topics that have been published in integrated PC, and synthesize the literature to describe a range of needs and services that could be provided by behavioral health in PC. The goal of our review is to identify the role of BHPs in the literature and list role functions, thus extending the practice, policy, and research discourse for the field. This review suggests there is an opportunity for BHPs to provide services for a range of need in PC (Brown Levey et al., 2012). However, the literature supporting integration tends to segment services, and fragmented care underestimates the potential impact of integrated care on a broad range of health conditions.

**The Range**

Based on the reviewed literature, clinical practice, and integrated care practice facilitation/coaching, we propose that integrated BHPs are well suited to address a range of behavioral health needs of PC patients (Kessler, 2012). The potential functions of integrated BHPs are described in Figure 2 and below.

**Addressing psychosocial barriers to care.** As the literature suggests, a significant proportion of PC visits include psychosocial components, which directly and indirectly affect health outcomes. Barriers include social, cognitive, and behavioral factors that influence patient engagement and health status (Martikainen et al., 2002). Therefore, addressing these barriers and social determinants of health is critical.

**Evidence-based interventions for lifestyle changes to improve physical health.** Our review and clinical experience also indicate that
medical problems requiring behavioral or psychological intervention often result from challenging behavioral changes patients are asked to make to improve their health (i.e., diet, exercise, stress reduction, medication adherence). A robust literature for redesigning PC to better address health behavior change exists as people die prematurely secondary to lifestyle choices (40%) more than anything else (Petterson et al., 2008). First-line interventions include cognitive–behavioral treatments for insomnia (Morin, 2006) and irritable bowel syndrome (Toner, 2005), and motivational interviewing for weight management, exercise, smoking cessation, medication adherence, and safer sex practices (Hunter, Goodie, Oordt, & Dobmeyer, 2009; Rollnick et al., 2007).

Addressing mental health and substance use problems. Our findings also suggest that mental health and substance use concerns, from identification to active treatment, represent the primary domain of need addressed by integrated BHPs. PC providers often underrecognize (Hirschfeld et al., 1997), misdiagnose (Mitchell, Vaze, & Rao, 2009), or neither diagnose nor treat (Baik, Bowers, Oakley, & Susman, 2005) mental health and substance abuse issues. When BHPs work within fully integrated systems, patients have a higher probability of receiving behavioral health care than with external referrals (Agency for Healthcare Research & Quality, 2013; Edlund, Unützer, & Wells, 2004; Unützer et al., 2002).

Addressing the needs of patients with multiple chronic conditions (i.e., mental health and physical health concerns). Multiple chronic conditions contribute to poor health behaviors (Fortin et al., 2006; LeRoy et al., 2014). Multidimensional treatment plans often involve several collaborating providers and interventions involving multiple health behavior change and/or psychotherapy with pharmacotherapy (Koike, Unutzer, & Wells, 2002). Treatment plans must address the whole person complexity of multiple chronic conditions. Although single behavioral interventions (e.g., exercise, stress reduction) or pharmacological treatments (e.g., buproprion for depression and tobacco dependence) have known efficacy, treatment coordination can further reduce patient and provider burden. The range of application for integrated care includes interacting conditions such as physical symptoms without medical cause and psychosomatic symptoms, which often result from a complex constellation of conditions, social situations, and the inability of care systems to orient well to such presentations. This contributes to overutilization, misutilization, and failed services, which are often the result of a care system that is poorly prepared for complex presentations. Attention to behavioral and social factors is required and BHPs can play a larger role in this aspect of care.

Addressing the needs of persons with severe mental illness. Patients with severe mental illness (SMI; e.g., schizophrenia, bipolar disorder) have higher rates of mortality and greater prevalence of chronic disease when compared with the general population (Parks, Svendsen, Singer, Foti, & Mauer, 2006). Our review suggests that identifying mental health conditions, treating comorbid physical health diagnoses, monitoring medications and side effects, and communicating with other providers is critical and should occur within PC. The SMI population has lower no-show rates for behavioral health services provided in PC compared with community mental health settings (Reynolds et al., 2006). Integrated PC services are essential to improve health outcomes in the SMI population.

Policy Implications

If integration is to advance, be population-based, and impact aspirational goals like the
Triple Aim, integrated PC efforts must address the range of health services possible with BHPs, and not be limited to mental health interventions. For policymakers, conceptualizing integration on a range illuminates the full complement of interventions that could be available within true integration. Policies should include all facets of the integration team, not just one function. This new approach increases the likelihood that whole person care can be thoroughly addressed and improve whole person outcomes. This review suggests that the use of BHPs for mental health conditions is the most visible and studied dimension; however, health behavior change, multimorbidity, and interactions commonly considered complex are an important and relatively newer, less empirically studied aspect. Likewise, researchers and program evaluators have a responsibility to examine the full spectrum of behavioral health services in PC, beyond the “one trick pony” of mental health provision. A timely example of this includes studies that examine behavioral health interventions for patients with multiple chronic conditions (LeRoy et al., 2014). From a payment perspective, systems must support the full range of services described to improve population health. Rather than limiting mental health dollars to support mental health interventions in PC, global payments will allow BHPs to address patients as they present. Integration thrives on a team-based care approach, which is more accessible to patients than fragmented, referral-based care (Collins, Hewson, Munger, & Wade, 2010; Croghan & Brown, 2010; Cunningham, 2009). The future of health care must better integrate behavioral health with primary care. In this context, if BHPs cannot fully utilize their skill set across the range of needs in PC, we will inadvertently limit the full potential of what integration has to offer, thus hindering our progress toward achieving the Triple Aim.

References


References


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