

## Integrating Health and Mental Health Services: A Past and Future History

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The authors trace the modern history, current landscape, and future prospects for integration between mental health and general medical care in the United States. Research and new treatment models developed in the 1980s and early 1990s helped inform federal legislation, including the 2008 Mental Health Parity and Addiction Equity Act and the 2010 Affordable Care Act, which in turn are creating new opportunities to

further integrate services. Future efforts should build on this foundation to develop clinical, service-level, and public health approaches that more fully integrate mental, medical, substance use, and social services.

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In his 1928 APA Presidential Address, Adolf Meyer reflected on the state of psychiatry during its early years and speculated on what lay ahead for the field. He described a profession that had moved past an administrative orientation toward asylum-based care to a clinical focus on pa-

tients in communities. He highlighted the importance of attending to “the various levels of integration—structural and functional—with total function (psychobiology) and part functions (physiology)—and physico-chemical, individual, and social” (1). More than 50 years later, one of us (H.H.G.) published a commentary in the *American Journal of Psychiatry* reviewing progress and outlining the then-current opportunities and challenges for integration between mental health and general medical services (2). The commentary concluded that there were still major clinical and organizational barriers to integrating services and that integration would occur only when a common purpose and new incentives existed to remove the long-standing barriers.

Comorbidity between mental and general medical disorders is the rule rather than the exception (3, 4). However, care for these types of problems has historically been provided by different providers, health care organizations, and funding streams (5). This fragmentation results in gaps in access, quality, and efficiency of care, resulting in high societal costs (6, 7), disability (8), and excess mortality (9). These

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#### Remembering Our Past As We Envision Our Future

##### July 1928: A President Takes Stock

Adolf Meyer: “I sometimes feel that Einstein, concerned with the relativity in astronomy, has to deal with very simple facts as compared to the complex and erratic and multicontingent performances of the human microcosmos, the health, happiness and efficiency of which we psychiatrists are concerned with.”

(*Am J Psychiatry* 1928; 85(1):1–31)

problems highlight the importance of improving integration at multiple levels across governmental agencies, health care organizations, clinics, and within individual patients (10).

Since the early 1980s, new treatments, service delivery models, federal policies, tech-

nologies, and trends in the broader health system have drastically reshaped the U.S. mental health service delivery system. With these changes has come a growing interest in integration among researchers, clinicians, health system leaders, and health policy makers. In this review, we examine these changes and their impact on service integration for people with mental illnesses since the early 1980s, with an eye toward future opportunities and challenges.

### 1980–1996: A GROWING RESEARCH BASE SUPPORTING MENTAL HEALTH INTEGRATION

The Epidemiological Catchment Area Survey was a groundbreaking systematic study documenting the epidemiology and treatment patterns for mental disorders in the United States (11). Implemented in five cities, it was the first such study to be conducted in more than a single community in the United States. Three key findings emerged from that study that had major implications for care integration. First, mental disorders

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were highly prevalent—more than a quarter of individuals had a diagnosable mental disorder in any given year. Second, fewer than half of individuals with a diagnosis received treatment in any given year. Finally, those who did receive mental health treatment most commonly received it not from specialty mental health providers but in the general medical sector. Taken together, these findings demonstrated the importance of more effectively diagnosing and treating common mental disorders in primary care settings.

During the 1980s and 1990s, new treatments and financing models affected the interface between primary care and mental health in the provision of care for mental disorders. Some factors brought them closer together; but others pushed them apart. The release of selective serotonin reuptake inhibitor antidepressants beginning in the late 1980s made it easier for primary care providers to provide first-line treatment for major depression and anxiety disorders (12). In the public sector, new grants helped drive a rapid growth of treatment of mental disorders in federally qualified health centers (13). At the same time, rising mental health costs spurred the growth of mental health “carve-outs” that provided mental health insurance benefits and treatment separately from general medical care (14, 15).

Studies documenting the central role of general medical providers in treating mental disorders led to calls for improved diagnosis and treatment in those settings (16, 17). Initial studies focusing on screening (18), provider education (19), and time-limited consultation (20) proved disappointing in improving outcomes (21). In 1995, Katon et al. (22) published the first randomized trial of team-based collaborative care for treating depression in primary care. Collaborative care in many ways represented a return to the “liaison” dimension of consultation-liaison psychiatry that had gained popularity during the 1960s and 1970s, focusing on the role of psychiatrists as active members of medical teams helping to identify and address mental health problems across a clinic or hospital unit (23). Subsequent studies demonstrated these approaches to be effective in improving quality and outcomes of care across a range of other mental disorders and settings (24), for substance use disorders (25), and for management of general medical conditions in patients with serious mental illnesses (26).

## **1996–TODAY: HEALTH REFORM AND MENTAL HEALTH INTEGRATION**

Over the past two decades, passage of federal legislation has dramatically reshaped the health insurance and care delivery landscape. This legislation has had a major impact on mental health service delivery and its relationship to the broader health system.

### **Insurance Reform**

Prior to the passage of the Affordable Care Act, an estimated 12 million individuals with mental and/or substance use disorders lacked insurance (27). For those who had insurance, most behavioral health insurance benefits were separate and unequal compared with benefits for treatment of general medical and surgical conditions. Lack of parity raised the risk of bankruptcy or financial hardship due to mental health expenditures.

The 1996 Mental Health Parity Act barred separate annual and lifetime limits on coverage for treatment of mental disorders other than the addictions (28). The 2008 Mental Health Parity and Addiction Equity Act (MHPAEA) provided another step toward improving access to health insurance and reducing financial burden for patients with mental illnesses and substance use disorders by barring differential coverage limits, such as higher cost sharing, separate visit or hospitalization maximums, and unequal application of managed care techniques (29, 30). Parity was extended to plans that offered coverage for behavioral health conditions, but it did not mandate that insurance must have such coverage. In fact, most plans offered some coverage. Early results suggest that this legislation is helping drive improved richness of benefits and access to care for people with mental and substance use disorders (31).

For individuals with comorbid mental and general medical problems, financial access to mental health care is essential for optimizing medical as well as mental health outcomes (32). The improvement in insurance coverage is what allows integration to work (33). This legislation was also an important symbolic victory for advocates of integration, moving mental health benefits squarely into the center of medical insurance. Its underlying philosophy was a manifestation of the value of integration, that mental disorders ought to be treated like any other condition.

The Affordable Care Act of 2010 (ACA) built on the MHPAEA to expand health insurance coverage, to prohibit exclusion of care based on preexisting conditions, and to require that health plans include mental health and substance use disorder treatment and care as essential benefits (34, 35). These insurance protections and expansions were particularly important for people with mental illness, who were at elevated risk of being uninsured or underinsured. The requirement that insurance plans include mental health as an essential benefit complemented parity legislation in ensuring widespread access to mental health benefits (34). Early findings suggest declining rates of uninsurance for patients with mental and substance use disorders since these provisions were enacted, largely related to Medicaid expansion (36).

### **New Models of Care**

In addition to expanding insurance, the ACA included funding for demonstration projects to improve care for common mental disorders in primary care and for medical problems in public sector mental health settings. These demonstration projects were particularly important in the public mental health sector, including among Medicaid recipients and patients at community mental health centers.

Section 2703 of the ACA provided funding for states to design health homes to provide comprehensive care coordination for high-cost Medicaid beneficiaries with chronic conditions, including serious mental illnesses (37). As of June 2017, a total of 21 states had health homes, with nearly all of these programs including individuals with serious mental illnesses as a target population (38). These programs are mandated to provide care and coordination, health promotion, and referral to community social services—essential elements of care integration for patients

with serious mental illnesses. Most of the initial state health home programs are continuing to operate even after the initial 2-year federal matching funds have ended (39).

Several ACA programs have been targeted toward improving care integration at community mental health centers. The Protecting Access to Medicare Act (H.R. 4302) includes a demonstration program testing certified community behavioral health clinics (CCBHCs), which are required to address care coordination and develop “partnerships ... for primary care services to the extent these services are not provided by the CCBHC.” The ACA has provided ongoing funding for the Primary and Behavioral Health Care Integration program, which provides funding for community mental health centers to treat common medical conditions on-site or via referral (40).

The ACA also incentivized the development of new organizational and payment strategies that hold the potential for more widespread implementation of integrated care models in Medicare. Within traditional fee-for-service Medicare, new billing codes for collaborative care are likely to help address barriers to financing these services (41).

The legislation created mechanisms to fund new models of payment, including accountable care organizations that include care management fees or shared savings arrangements to incentivize quality and efficiency of care (42). To date, the update of mental health services in many of these new models of care has been slow (43–45). Additionally, these models may create some incentives for plans to exclude high-cost groups, including enrollees with mental disorders (46).

If parity represented the integration of mental health into the mainstream of health insurance, the ACA represented the integration of mental health into federal health care policy. To a greater extent than in earlier health reform efforts (47, 48), mental health had a central seat at the table in the design and implementation of the ACA (49).

## THE FUTURE OF MENTAL HEALTH INTEGRATION

The trajectory toward increasing service integration is likely to continue in the coming years. Key trends driving changes in the organization of the broader health system, financing models, and new health technologies will likely create new opportunities for further service integration in both primary care and specialty settings. However, vigilance will be needed to fully implement these policies and to maintain the gains that have been made in the face of a shifting policy and care delivery landscape.

### The Gap Between Policy and Practice

The passage of the MHPAEA in 2008 provides a useful reminder of the many steps between federal legislation and practice change. Even after final regulations were issued in 2013, the requirement that mental health benefits be “no more restrictive than ... medical and surgical benefits” proved challenging to define operationally, particularly for nonquantitative aspects of care management (30). Currently, litigation

(50) and enforcement efforts by the U.S. Department of Labor (51) are helping to further clarify the final scope and details of this legislation.

The past year saw a number of efforts to repeal or scale back the ACA (52). While these were ultimately not successful, ongoing policy and regulatory developments are likely to weaken the ACA’s potential benefits for patients with mental disorders. The 2017 Tax Cuts and Jobs Act removed the individual mandate requirement, which could destabilize the health insurance exchange marketplace (53). For Medicaid, the Department of Health and Human Services is considering granting states more flexibility in determining the scope and structure of Medicaid benefits through block grants, spending caps, and/or waivers (54). Decisions about continuing or expanding demonstration programs, such as the Medicaid health homes program, will largely rest with individual states and with the Department of Health and Human Services. All of these changes disproportionately affect individuals with mental illnesses, who were more likely to be uninsured, to rely on Medicaid, and to experience fragmented care prior to the passage of the ACA (27, 55).

These developments highlight the notion that federal and state policies, while vitally important, rarely progress in a linear fashion and are subject to shifting political winds. Furthermore, policies are only the first step in changing practice. Attention is needed to regulations that flow from these policies, to their implementation by insurers and health organizations, to care by clinicians who deliver treatment, and to patients who are the recipients of that care. As more data become available on the impact of this federal legislation on quality and outcomes of medical care, it will be important to use the data to inform future policies, regulations, and clinical practice.

### Trends in the Broader Health System

Regardless of the fate of these policies, several trends reshaping the health system will have important implications for the integration between mental and medical care. The health care system is undergoing a phase of rapid consolidation, with mergers across hospitals, between hospitals and physician practices, and between pharmacies and health insurers (56–58). These large organizations should have an incentive to focus on high-cost groups, including individuals with mental illnesses, and they possess the economies of scale to care for them. However, as with accountable care organizations, it appears that these new organizations have been slow to fully incorporate care for mental health disorders. For instance, the recent acquisition of Aetna by CVS is not currently projected to provide mental health care or screening in its retail clinics (58).

### The Growth of Health Technology

New technologies are reshaping the architecture of the health system and of integration between general medical and mental health care. Electronic health records coupled with a registry function can track and monitor symptoms for

patients who are not improving (59). Telehealth can improve access to specialty services for rural and other hard-to-reach populations (60, 61). Integrated data warehouses can be used to identify high-utilizing patients for quality improvement efforts and track their movement across different sectors of care (62). Smartphone-based mobile health can support patient self-management between provider visits (63). These technologies can serve as platforms on which to develop and disseminate high-quality, integrated-care interventions (64). However, the improved communication facilitated by these technologies may also come at the expense of patient privacy (65), which can be particularly problematic for substance use disorders and other stigmatized conditions (66).

### **Bridging the Divide Between Integration and Specialization**

Taken together, these trends provide an opportunity to revisit a long-standing debate within mental health about the relative merits of integration versus specialization. Specifically, many advocates have argued that mental health care requires unique expertise that can best be provided by specialty mental health clinicians, providers, or organizations. They have expressed concern about a choice between “drowning in the mainstream or [being] left on the bank” (67, 68).

New clinical and organizational models are increasingly making this dichotomy less problematic. Collaborative care and medical home models seek to facilitate continuity and coordination of care while still ensuring access to specialty expertise. New health technologies can help guide care and facilitate communication across providers.

However, there will always be patients whose problems are best managed in specialty settings. Primary care providers may not be equipped to manage medication or provide evidence-based psychotherapies for patients with complex mental disorders (69). Patients with serious, disabling mental illnesses also may require psychosocial services such as housing and employment support that are not available in primary care settings (70). The optimal balance between generalist and specialist care will vary based on provider expertise, patient case mix, and available community resources (71).

### **Addressing Integration at Multiple Levels**

The future will likely see growing integration at multiple levels—within patients, and across systems, payers, agencies, and communities. Most current models of integration have focused on addressing comorbid mental and medical problems within patients or particular health care organizations. Psychosomatic medicine emphasized the biological and psychological linkages between mental and physical health within individuals, and consultation psychiatry addressed individual psychiatric problems that were identified in medical settings. Collaborative care addresses needs of patients in health care clinics or provider organizations, targeting treatment based on mental health symptoms (72).

There is a growing interest in further broadening this perspective to address mental health integration in a public

health context (73). These approaches would examine strategies for improving mental health outcomes within general populations, while optimizing overall health in subgroups with more serious mental disorders. Accomplishing these goals would require identifying and tracking populations both within and outside of health care settings; recognizing the importance of social and community factors as determinants of health; addressing comorbid substance use; and expanding the range of outcomes from symptom-based measures to broader indicators of health-related quality of life and recovery. This expanded focus could complement current efforts to incorporate social determinants such as housing and food insecurity into health care for general medical populations (74–76).

A public health approach to integration harkens back to the moral treatment movement of the 19th century and the community mental health movement of the 1960s, each of which emphasized the importance of social and environmental factors as antecedents and consequences of mental illnesses (77). Both of these movements, which began with great optimism that the early treatment of mental illness would prevent long-term disability, ultimately faced criticism for their failure to accomplish that goal. Over the years, some reformers have focused on the social and political dynamics of communities to the exclusion of concern about clinical treatments (77, 78). As we move to expand integration to achieve these broader public health goals, we must ensure that these efforts are coupled with attention to high-quality clinical care.

## **CONCLUSIONS**

When we reflect on the many changes that have occurred since the early 1980s, it is clear that great progress has been made in the integration between mental health and general medical care. Mental health has moved from the margins to the mainstream of health care policy, financing, and care delivery. However, it should also be noted that many of the problems that these integrated approaches were developed to address, such as rates of comorbidity (4), disability (79), and early mortality due to suicide (80, 81) and general medical conditions (9), have persisted or worsened over time. Effectively addressing these problems will require public health approaches that address the underlying social and behavioral causes and consequences of these problems and also ensure access to high-quality integrated care for individuals with comorbid conditions.

Four decades from now, how will we know if we have succeeded? At a public health level, we will need to know whether we have been able to improve these distal outcomes in individuals with mental disorders and medical comorbidity. At a policy level, we will need to track the impact of new federal and state laws and ensure that they are successfully implemented and sustained. At a clinical level, we will need to continue to support widespread dissemination of effective treatments in both the public and private sectors. And for patients with mental disorders, we will need to ensure that they are receiving care that meets their needs

and helps them improve both their physical and mental health and well-being.

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