EDITORIAL

Primary Care, Behavioral Health, and Public Health: Partners in Reducing Mental Health Stigma

The stress and fears of life in booming cities like Shanghai are often hidden behind the positive signs of China's rapid economic development. Printed with permission of Corbis.

The World Health Organization estimates that mental health conditions and substance use disorders taken together constitute the second largest cause of disease burden and disability worldwide.[1] In addition, mental health comorbidities substantially increase adverse health outcomes and costs for individuals as well as the broader population. Individuals with serious mental illness die 25 years earlier than the general population, and most commonly from causes such as cardiovascular disease, respiratory disease, and diabetes and other related conditions.[2] Stigma against mental illness and substance abuse disorders contributes to these worsening health outcomes and is a major public health problem. Furthermore, recent tragic events, including natural disasters, mass shootings, and other acts of violence, often highlight the necessity to act to address the stigma associated with mental illness and substance abuse disorders, and to work to improve our public mental health system.

Mental health and physical health are inextricably linked. Unfortunately, mental and behavioral health conditions have been artificially separated by conceptual and professional turf divisions. Whereas "brain diseases" are treated by neurologists, disorders of the "mind" are considered the domain of psychiatrists and other behavioral health professionals. Such distinctions are artificial in concept and biology. In reality, patients are often more likely to seek mental health treatment in primary care settings rather than in specialty mental health settings, especially older adults and minority populations, in part because of the stigma associated with mental health diagnoses and with receiving care from behavioral health specialists.[3] As a result, there are many opportunities to address mental health stigma through public health and primary care settings.

PRIMARY CARE AND BEHAVIORAL HEALTH INTEGRATION

The case for integration of primary care and behavioral health

care can be made in the framework of primary, secondary, and tertiary prevention to achieve optimal population health outcomes. Primary prevention would focus on nurturing individual resiliency and community strength. Secondary and tertiary prevention would require effective screening and treatment of conditions such as depression, anxiety, posttraumatic stress disorder, and alcohol and other substance use disorders as treatable risk factors, not only for reducing immediate suffering, but also as a strategy for preventing adverse long-term health outcomes at the whole-person and population health levels. Similarly, the need for bidirectional integration of primary care into community mental health centers and other specialty behavioral health settings can also be better conceptualized with the prevention framework. This is consistent with the chronic disease strategy of treatment, in which effective primary care is an essential element. Furthermore, by incorporating prevention strategies into the existing health care system, this framework could serve to decrease stigma associated with the diagnosis and treatment of mental and substance use disorders.

IMPROVING STIGMA BY FOCUSING ON HEALTH IMPROVEMENT

The benefits of integrating behavioral health and primary care can be understood in the conceptual framework of the Triple Aim approach described by Berwick et al.: (1) improving the patient experience of care (including quality and satisfaction), (2) improving the health of populations, and (3) reducing the cost of health care.[4]

From a patient-level perspective, stigma about mental illness (including self-imposed and perceived stigma) is a major factor that contributes to lack of treatment or undertreatment. Without effective primary care screening for behavioral health problems, patients may not share mental health concerns with their primary care providers. Even if diagnosed, patients may accept a referral from a primary care provider to a mental health specialist but choose not to keep the referral appointment because of stigma. By contrast, various trials of integrated or collaborative care models demonstrate that many patients can be effectively engaged and treated for mental health and substance use disorders within the primary care setting.[5] Furthermore, improvement in expectations of people with mental illness could be addressed through more open discussion in team-based care. Myths about patients with serious mental illness abound in issues related to tobacco cessation and other preventive interventions.[6]

Electronic health records present another opportunity to grow beyond the stigmatizing tradition of isolating mental health records from the rest of the medical chart. Integrating all health information in the same record could effectively equate mental health and substance use disorders with other physical illnesses and help to decrease stigma within the health system.[7] Although issues related to confidentiality must be appropriately addressed, secure communications between clinicians who have full access to view complete medication lists and all treatment notes will help to achieve more collaborative interdisciplinary team-based care.

POPULATION HEALTH OUTCOMES

Mental health and substance use comorbidities worsen population health outcomes, and have an even more immediate and magnified impact on those with underlying medical conditions. Effective diagnosis and treatment in primary care settings can substantially improve whole-person outcomes, not just mental health metrics. Measuring outcomes of care in a treat-to-target approach using screening tools and stepped care models can help overcome clinical inertia in depression care—in the same way that blood pressure is monitored and aggressively treated-to-target. Use of a nurse care manager or behavioral care expert can also ensure that patient-centered care goals are achieved and that continuity of care is assured. These strategies have been best tested in depression care and could be effectively expanded to address mental illnesses of mild to moderate severity.[8] Primary care specific approaches to alcohol misuse and addiction have also been well defined, including evidence-based practices such as SBIRT (Screening, Brief Intervention, and Referral to Treatment).

Because the risk factors for physical disease and mental illness are often the same, emphasis by primary care providers on healthy lifestyles and decreasing overall health risk factors for disease can also promote mental health. An emphasis on mental health promotion, rather than treatment of mental illness, can serve to reduce the overall stigma toward mental health disorders. For example, primary care providers can discuss with all patients the importance of avoidance substance misuse (including drugs, alcohol, and tobacco), as well as increasing health habits such as sleep hygiene, exercise, a healthy diet, and positive, supportive relationships. As primary care settings move toward whole-person, patient-centered approaches, these settings are ideal places to implement interventions that address resilience, recovery, and the promotion of wellness.

THE COST OF CARE

Financial barriers are often cited as challenges to implementing integration of behavioral health and primary care, but in fact, many studies show that this approach saves overall costs. Unfortunately, systemic fragmentation contributes to suboptimal treatment of mental illness in primary care settings. The primary care clinician often does not receive any return on the investment of staff time and resources devoted to care management and collaboration on behavioral health issues unless they participate in global capitation or in a risk-sharing accountable care organization. Furthermore, a sense of competing demands can make it difficult for the primary care provider to prioritize addressing time-consuming mental health concerns.[9]

Fee-for-service financial arrangements often incentivize procedures and services that are less conducive to the provision of quality mental health services, and may explicitly block payments for mental health and medical services in the same practice on the same date. Managed care behavioral health carve-outs are an example of systems-level stigma of mental illness and substance use disorders because they

represent separate and unequal funding mechanisms that contribute to the fragmentation and isolation of the mental health system.[10]

FUTURE DIRECTIONS

Some progress is being made. Passage of the Wellstone-Domenici Mental Health Parity and Addiction Equity Act helped to reduce stigma by mandating equality in insurance coverage. Measures embedded in the Affordable Care Act reward primary prevention and care management in the patient-centered primary care medical home, as well as a focus on whole-person population health outcomes through accountable care organizations. Behavioral health advocates and experts in primary care integration are working to assure that standards for certification of these primary care medical home and accountable care organization entities include measures related to care and outcomes of whole individuals with connected minds and bodies, individuals whose behavioral health needs cannot be "carved out" from their overall health. Society shares the responsibility to ensure the effective prevention of mental illness and promotion of mental health through a more effective mental health system of care. Integration of mental health, primary care, and public health is an essential strategy in our efforts to achieve less stigmatized, more optimal, equitable health outcomes for all. ■

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This editorial was accepted December 31, 2012.

doi:10.2105/AJPH.2013.301214

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R. Shim and G. Rust originated and researched the topic, and wrote the editorial.

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