Clinically Informed Consensus Guidelines for Improved Integration of Primary Care and Mental Health Services in California

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Overview

The following clinical guidelines were developed to address a common and growing problem in contemporary health care practice: how can people's coexisting general health and mental health care needs be best addressed with optimal efficiency and effectiveness. Recently, there has been increasing policy attention to this issue along with efforts at re-structuring service delivery systems and financing strategies as well as promoting cross-system collaboration—especially between organized primary care and specialty mental health care providers largely serving a MediCaid and medically indigent population often referred to as the "safety-net"[1]. These efforts are in response to a growing recognition that current practices often fail to adequately address individual patient and community needs.

However, in many instances there remains a striking lack of clinical consensus about the appropriate scope of mental health practice in the primary care setting, (primary mental health care) and the scope and role of specialty mental health care. Simply put, when is it appropriate for someone to be referred to specialty mental healthcare? What level of severity and complexity of mental health needs should be cared for in the primary care setting? When should someone receiving specialty mental health care be referred back to primary care for ongoing treatment and monitoring?

The lack of clarity about these simple but critical clinical questions must be addressed – along with policy and finance implications/barriers – if successful changes that will adequately address consumer and providers concerns can be made. Ideally, there is an iterative process in which over-time policy and finance reflect and support best clinical thinking.

The proposed guidelines that follow reflect the best thinking of approximately 25 clinical and administrative leaders from the county-operated public mental health system and primary care safety-net in California. Based upon the literature, experience and expert opinion, these guidelines begin to describe optimal clinical operations and practices most likely to successfully address the full range of people's health needs. In some instances, gaps and unresolved issues are also identified.

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[1] Safety-net refers to FQHCs, Community Health Centers, and other publicly-funded primary care provider organizations and the county-funded specialty mental health services who serve primarily Medi-Cal beneficiaries and uninsured individuals.

California Institute for Mental Health, and the generous in-kind contributions of providers and service delivery organizations from around the State. A list of the participants is included in Appendix A.

Introduction

In California, as in many other places, the publicly-funded primary health care and mental health care safety-net operates as two parallel systems, often with limited connection or interaction. The consequences of this fragmentation are significant. Recent data has clearly shown that people with severe mental illness die 25 years earlier than their peers, in part because of limited access to quality primary care, e.g. 60% of premature deaths for people with schizophrenia can be attributed to preventable or treatable medical conditions.

At the same time, there is data to suggest that many people with specialty mental health needs were served only in the general medical sector rather than accessing appropriate specialty mental health services. What are specialty mental health services? What distinguishes them from primary care mental health services? The answer to these questions is not entirely straightforward. And there are parallels in other fields—for example what are the differences between primary care cardiology and specialty cardiology provided by a cardiologist?

There are a range of mental health services including pharmacotherapy, psychotherapy and case management that can be provided in a number of settings by qualified providers who have had varying degrees of specialized training. For example, primary care providers and psychiatrists can provide both routine as well as complex psychopharmacology. Social workers and psychotherapists are found in both primary care as well as specialty mental health settings. For the purposes of this report, specialty mental health services are defined both by site/organization of services as well as scope with the recognition that in many instances there is some overlap with primary care.

What is clearly unique to specialty mental health is the team-based provision of integrated psychosocial rehabilitative services—largely funded by the Medi-Cal Rehab Option and the Mental Health Services Act—and Targeted Case Management Services. Individuals with complex severe and often persistent mental health needs are most appropriate for these

unique services that with some exception are principally the domain of the specialty mental health care system. These services are typically provided directly by County Mental Health Departments and their contracted providers. Increasingly – although not exclusively – access to these services is restricted to individuals who are Medi-Cal eligible.

There is an increasing recognition that traditional categorization of people's needs may not be the best approach. A large majority of primary care safety-net presentations and care involve some psychiatric or mental health component, and as noted above, individuals with severe mental illness who often turn first to the specialty mental health sector have significant general health care needs that go unmet. Barriers to access at the appropriate level or locus of care and coordination of services within and across systems substantially contribute to these problems.

While there is a substantial literature demonstrating improved general health and mental health outcomes with more collaborative and integrated approaches to primary care and mental health, successful integration remains a challenge in many settings and communities. As a result of the lack of interaction, access and appropriate referral and co-management of conditions that require integrated/coordinated care, operational inefficiencies and poor outcomes remain a common source of frustration for both consumers and providers.

This fragmentation persists—especially in the publicly-funded safety-net – despite numerous but isolated examples of success in collaborative and integrated care. This has been attributed to many factors including stigma, discrimination, outmoded understanding by providers, highly variable practice standards/expectations, mental health carve-outs in insurance programs, and inadequate funding – all complicated by a lack of clarity about the appropriate scope of practice/care in both the primary care and mental health setting.

There are problems in language and terminology that contribute to the confusion. Safety-net primary care practice routinely involves providing mental health care—either by primary care providers or by mental health specialists (e.g. psychiatrists, social workers, therapists, etc.) who are co-located and/or integrated into the primary care setting and treatment team. For the purposes of this report, we shall refer to this as "primary care mental health".

The public mental health system is frequently referred to as the "specialty mental health system". It is largely distinguished from primary care mental health by the availability of intensive case management, psychosocial rehabilitation and "wrap-around" teams, crisis

intervention, and 24-hour residential/inpatient services for individuals with significant levels of functional impairment as a result of a mental disorder. In addition, there are many mental health subspecialties that address the needs of specific populations e.g. forensics, children and adolescents, seniors, etc.

What level of complexity and severity of mental health needs can and should appropriately be addressed in the primary care setting? When is referral to specialty mental health the best option? What distinguishes specialty mental health from primary care mental health? When should patients "step-down" from specialty mental health care and receive ongoing services in the primary care setting? These are not merely rhetorical questions, yet there is not a general agreement or consensus in response across the two service delivery settings/systems. This lack of clarity about the appropriate scope of practice/care has significant implications at the level of service delivery system design as well as individual care. It impacts the consistency and quality of care, the financing of services, the allocation/distribution of resources, and carries significant implications for education, training, certification and workforce development in both service systems.

California law is also a factor in the lack of clarity about the appropriate level and setting of care for individuals. Title IX of the California Code of Regulations pertaining to Rehabilitative and Developmental Services states that Medi-Cal beneficiaries (who make up a large proportion of the safety-net population) are only eligible for specialty mental health services (for all intents and purposes this means county mental health) when "*[their] condition would not be responsive to physical health care based treatment.*" However, there are no consistently applied clinical criteria for determining how and when and by whom the 'responsiveness of their condition' is to be determined. In an environment where the trend is towards an increased number of mental health professionals embedded in the primary care setting, what constitutes 'physical health care based treatments'?

In 2008, the California HealthCare Foundation (CHCF) funded the California Institute of Mental Health (CIMH) to address the lack of clarity about the appropriate scope of practice/care and clinical criteria for referral from one care setting/system to another. A nine month long project was designed and implemented to: 1) develop a consensus set of clinical guidelines for care in the California safety-net for referral and coordination of care of patients who have co-occurring mental health and general health needs; 2) identify existing or emerging best practice models, and 3) disseminate the findings to mental health and primary care leadership, practitioners, educators, and policy makers.

Methods

Project activities to develop a consensus set of clinical guidelines clinical included:

1) a review of the available literature on clinically based guidelines and systems designed to direct, coordinate, and integrate care for individuals with co-occurring mental health and physical health needs[2];
2) convening a group of approximately 25 statewide experts from the mental health and primary care safety-net in order to review the literature, identify best practice sites, and recommend as well as review proposed guidelines;
3) collaboration with a concurrent CiMH Policy Initiative funded by the California Endowment to identify policy issues and barriers related to primary care and mental health integration; and
4) visits to best practice sites in California and Utah in order to observe, analyze and document essential elements of their success.

Site Visits

Several organizations at various stages of development in primary care and mental health collaboration and integration provided an opportunity to observe firsthand their clinical operations and meet with key persons responsible for policy and implementation related to mental health and primary care services. These sites included:

- InterMountain Health in Salt Lake City, UT
- Santa Clara County Departments of Health and Mental Health
- San Bernardino County Departments of Health Services, Public Health and Mental Health
- La Clinica de la Raza, Oakland, CA
- Life Long Medical Center, Oakland/Berkeley CA
- LA Care Health Plan

[2] An annotated bibliography of this literature review is included as an appendix.

Each of these sites are at varying stages of development and implementation of primary care and mental health systems and reflected changes and innovations in both sectors. Across programs there was a clear sense that the efforts to reduce access barriers and better coordinate care were vital aspects of a quality health system that improved patient and provider satisfaction and clinical outcomes. However, each site's efforts were clearly a response to local circumstances and opportunities; for the most part they were pilot projects or service initiatives for special populations and were not system-based changes. From this it was difficult to identify a generic "solution" that could be broadly applied even within or across counties—with perhaps one exception: InterMountain Health.

InterMountain Healthcare is a highly respected integrated not-for-profit healthcare system and is the largest healthcare provider in the Intermountain West. This comprehensive service delivery system has embraced the integration of mental health and primary care as a core value and has, for all intents and purposes, implemented a medical/healthcare home model. This approach to care is a system-based effort, *by design,* and includes both preventive as well as treatment services, and after 10 plus years of effort is beginning to show measureable results with improved outcomes. They have developed clinical tools, processes and information systems as well as staff capacity and co-location to support their commitment. By attending to necessary changes in the design of the service delivery system, self-management support, information technology, and decision-support they have succeeded in creating a model which appears to be robust and replicable in a number of sites and systems across the country. The leanings from InterMountain Health were shared with the workgroup and substantially contributed to the guidelines that were developed.

Guidelines

An integration of the data and suggestions gathered from multiple sources resulted in the development of a set of clinically informed consensus guidelines for better integration of primary care and mental health. These guidelines include advice about the organization and provision of care as well as the design and operation for the safety-net service delivery system as detailed below.

While in some instances these guidelines and recommendations may not be strictly clinical, they all have a potentially direct impact on care and outcomes. The primary audience for these guidelines includes providers, clinicians, supervisors and administrators with day-in and

day-out responsibility for providing care—with the recognition that there may be financial, operational or even regulatory barriers to their implementation.

Care integration is a dynamic issue accompanied by significant debate and uncertainty about best solutions accompanied by efforts at innovative solutions around California as well as the United States and internationally. There is a high level of interest in the person-centered medical home as a new service delivery model, but exactly what is intended by this approach is unclear—particularly with regards to how and where mental health services should be provided within that framework. Many in the specialty mental health sector feel that they should expand their role and scope to include primary care for those who use the specialty mental health as their primary if not exclusive point of contact with the health care system and prefer the term "health care home". In some settings, like San Bernardino County, the role of Public Health Services as part of a safety-net are being considered in the solution to better access, coordination and outcomes. How to improve access for strained publicly-supported systems is a challenge everywhere. As the Federal government tackles the issue of healthcare reform in general, the landscape may change substantially with new financial incentives and service delivery models that will further shape efforts at integration.

The guidelines that follow should be taken as the best thinking and general agreement of a group of experts at a point in time and should not be considered definitive or static—they are offered as a starting point for local discussions about solutions that work for communities, consumers and providers. New solutions will emerge through trial and error as well as formal study of best practices. But these guidelines can hopefully assist in overcoming barriers today and tomorrow; there is some degree of power and energy created by consensus of a multidisciplinary group of experts whose local circumstances and clinical standards differ.

The conversations that led to the development of the guidelines inevitably generated a lot of ideas and questions as well as debate. There was good agreement on related issues that really weren't guidelines, but certainly would impact systems change and in many instances were even precursors for the use of guidelines. Some of these ideas and comments included the following:

- Primary care is an essential service and everyone should have access to primary care. Many individuals who have significant mental health treatment needs often have difficulties in accessing primary care resulting in poor health and premature mortality.

- There is no health without mental health—while access to primary care is essential, so is access to mental health care.
- Coordinated care is better than fragmented care.
- Issues related to type of care should not necessarily be restricted to or confused with issues related to locus of care; while there is a need for having two systems, and particular services located exclusively in one system or setting, we ought to be person-centered in our responses to individuals and having 'hard boundaries' may not be optimal in all circumstances.
- Providers do not necessarily have all the skills they need to provide an expanded range of services. So that primary care providers have the knowledge, skills and abilities to provide mental health care in the primary care setting, education and training of primary care providers in mental health should include not only traditional didactic training but also employ practical or experiential learning through mini-fellowships, shadowing, and instructive consultation, etc.
- Changing practice and systems is hard. There are good examples of the successful impact of a local leader or clinical champion who can develop expertise, be a local resource, and provide a practice role model. Having a clinician in the primary care setting who "owns" mental health can make a difference; likewise making primary care liaison an identified responsibility in the specialty mental health system can do much to reduce barriers and fragmentation.

The guidelines include 15 primary recommendations organized into 5 clusters as follows:

- Continuum of Care
- Care Settings
- Clinical Care Guidelines
- Bi-Directional Transitions
- Determining Levels Of Care

Consensus Guidelines

for Improved Integration of Primary Care and Mental Health Services

1. Continuum of Care

- Each community should establish a continuum of collaborative care across primary care and mental health with mechanisms for stepped-care back and forth across the continuum.
- The continuum should range from basic care of mental health needs by the primary care provider to specialty mental health services traditionally provided by the public mental health system.
- The continuum should include multiple levels of care with increasing availability of a range of mental health specialists in the primary care setting that are responsive to the changing complexity and severity of patients' needs.

2. Care Settings

- Primary care, with appropriate staffing and resources, is usually the most appropriate setting for the large majority of mental health care when mental health specialists are integrated into the primary care team and service delivery system.
- Specialty mental health is the appropriate setting for individuals who require intensive case management, psychosocial rehabilitation, inpatient, crisis services and residential psychiatric care.

3. Clinical Care Guidelines

- The continuum should range from basic care of mental health needs by the primary care provider to specialty mental health services traditionally provided by the public mental health system.
- There are many available guidelines for providing mental health care in the primary care setting for a range of diagnoses/conditions including not only depression, but also schizophrenia, bipolar disorder, attention deficit disorder and many others.
- Guidelines for the general scope of medical care to be provided in the specialty mental health setting (e.g. treatment of simple medical conditions, laboratory screening/monitoring, preventive services, etc) should be adopted or created.
- Each community (e.g. county) should select and consistently use one of the existing guideline sets or locally agree on what guidelines they will use.

4. Bi-Directional Transitions

- The determination of the appropriate level or step of care should anticipate changes in need over time and the bi-directional transition of patients between levels/steps.
- There is general agreement that the level of functional impairment, more than symptoms, complexity of care or diagnosis, should determine the need for specialty mental health services outside of the primary care setting.
- Transitions between primary care and specialty mental health are best facilitated by the mental health specialists in the primary care setting based on local conditions, resources and relationships.
- Establishing and maintaining effective communication and ongoing relationships between administrators and clinicians in primary care and mental health is often a key ingredient of success.
- This can be accomplished by the identification of a change champion within systems and/or communities.
- Developing shared access to clinical data can facilitate transition.

5. Determining Levels of Care

- There is a need for a standardized "objective" method or approach for determining the level of complexity/severity and/or functional impairment to assist in the determination of the most appropriate level of care. However, at this time there is not general agreement within or across service systems about what method should be used
- There should be explicit agreement on referral/acceptance criteria for facilitating integration of patient care across primary care and specialty mental health systems, based upon a level of care instrument that can be easily applied in all settings.
- Ease of use of any method must be balanced with reliability and validity.
- Candidate measures/instruments/tools that show promise are included in the list below. The relative advantages and disadvantages of each approach are summarized in *Table 1* on the following page.
    - LOCUS/CALOCUS—the adult and child and adolescent (CA) Level Of Care Utilization Scale developed by the American Association of Community Psychiatrists (AACP)
    - The PHQ9
    - The Multnomah Community Abilities Scale
    - SF-12/36
    - DSM-IV Axis 5 (Global Assessment of Functioning--GAF)

Table 1: Advantages and Disadvantages of Candidate Measures/Instruments/Tools

Instrument	Advantages	Disadvantages
LOCUS/ CALOCUS	• Public domain • Integrates assessment of physical, mental health and substance abuse needs • Specifically identifies level of care	• Time consuming and somewhat difficult to use • Probably needs to be completed by a mental health specialist • Not in routine use
PHQ9	• Well accepted and established in many primary care practices • Easy to use • Demonstrably effective in improving depression outcomes • Public domain	• Not routinely used in mental health • No evidence for reliability/ validity for diagnoses other than depression
Multnomah	• Multi-dimensional assessment of patients' function • Public domain	• Lengthy to complete • Not commonly used
SF-12	• Based on patient self report • Integrates physical and emotional well being • Focuses on perception of function • Available in multiple languages, culturally normed	• Not in public domain • Not currently in routine use
DSM-IV Axis 5	• Easy to use • Public domain	• Not considered to be reliable

Next Steps

There are several next steps that should be considered to build upon these consensus guidelines. This includes but is not necessarily limited to the following:

- Further dissemination of these guidelines to clinical and policy leaders for purposes of further evaluation and refinement;
- Pilot projects to test their application and implementation with subsequent revision as informed by experience;
- Pilot testing/research to identify, adapt or create a "universal" level of care instrument; and
- Development and implementation of curricula and training programs to build primary care provider competencies in mental health to prepare mental health professionals for working in primary care settings.

One additional outcome from this project was identified by multiple participants: there is tremendous value in the opportunity for dialog about these issues between safety –net clinical leaders from primary care and mental health both locally, regionally and on a statewide basis. An additional next step to consider is to create a forum that will promote this kind of learning dialog and exchange of ideas and experience on a regular basis.

Contributors and Participants

The following leaders from California gave generously of their time and energy to make these guidelines possible. Their contributions, ideas and dedication are much appreciated.

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Annotated Bibliography

National Institute for Mental Health in England (2006). *Designing Primary Care for Mental Health Service.* BMJ, vol 330:April 9,2005: 839-842

This guidebook is designed to assist those wishing to plan, organize and manage primary care mental health services with the recognition that the context within which individual services operate must be taken into account. As a consequence, different services will choose different mechanisms and structures to deliver their desired outcomes. Key design features and outlines for the choices that have to be made when designing services are included and considered as follows:

- Which people will use the service?
- What interventions and activities will be offered?
- Who should deliver the care and what will be the different roles and service skill mix?
- How will the delivery of the service be organized?
- How should note keeping be organized and what outcome measures should be used?

Bower, P. and Gibody, S. (2005). *Managing Common Mental Health Disorders in Primary Care: Conceptual Models and Evidence Base.* BMJ, vol 330:April 9,2005: 839-842

This journal article illustrates the way in which conceptual models can assist in the application of evidence from systematic reviews to policy. Using the example of mental health care in primary care the authors consider how the trend towards greater use of research evidence (especially systematic reviews) influences the development of health policy. Systematic reviews have traditionally been designed for clinical decision-making, and linking such evidence to the broader perspectives and goals of policy makers is complex, making conceptual models useful.

Butler, M., Kane, R.L., McAlpine, D., Kathol, R.G., Fu, S.S., Hagedorn, H., Wilt, T.J. (Prepared by the Minnesota Evidence-based Practice Center under Contract No. 290-02-0009.) (2008). *Integration of Mental Health/ Substance Abuse and Primary Care*. Rockville, MD. Agency for Healthcare Research and Quality No. 173 AHRQ Publication No. 09-E003.

This report describes models of integrated care used in the United States, assesses how integration of mental health services into primary care settings or primary health care into specialty outpatient settings impacts patient outcomes and describe barriers to sustainable programs, use of health information technology (IT), and reimbursement structures of integrated care programs. The report finds that integrated care programs have been tested for depression, anxiety, at-risk alcohol, and ADHD in primary care settings and for alcohol disorders and persons with severe mental illness in specialty care settings. Although most interventions in either setting are effective, there is no discernable effect of integration level, processes of care, or combination, on patient outcomes for mental health services in primary care settings. Organizational and financial barriers persist to successfully implement sustainable integrated care programs. Health IT remains a mostly undocumented but promising tool. No reimbursement system has been subjected to experiment; no evidence exists as to which reimbursement system may most effectively support integrated care. The report concludes that integrated care achieved positive outcomes. However, it is not possible to distinguish the effects of increased attention to mental health problems from the effects of specific strategies, evidenced by the lack of correlation between measures of integration or a systematic approach to care processes and the various outcomes. Efforts to implement integrated care will have to address financial barriers.

Annotated Bibliography *cont.*

American College of Mental Health Administration; prepared by Barbara Mauer and Ben Druss (2007). *Mind and Body Reunited: Improving Care at the Behavioral and Primary Healthcare Interface.*

This paper reviews the history, structure, and current developments of care at the primary care/ behavioral health interface. It focuses on care in the public sector, where high rates of comorbidity, regulatory burdens, and lack of resources create particular challenges in providing care at that interface. It is built on the premise that improving coordination, communication, continuity and comprehensiveness at the primary care/behavioral health interface is necessary, but not sufficient for improving the quality of care received by persons with MH/SU disorders. Attention is also needed to improve the delivery of care and provider training within each of these sectors.

CSIP North West Regional Development Centre (2006). *Treating Common Mental Health Problems through Stepped Care: Informing Commissioning, Provider Management and Practice Based Commissioning in Primary Care. UK.*

This paper complements the overview of stepped care service provision outlined within CSIP's recent publications, 'Primary Care Services for Depression: A Guide to Best Practice' (CSIP, 2006). The findings from this audit complement the ideal framework of stepped care, as laid out in this publication. It also aims to provide an understanding of the real benefits of localized approaches to stepped care service provision for treating common mental health problems (including anxiety and depression). A brief overview of stepped care is offered in 'What is Stepped Care?' but readers are also advised to review CSIP's recent publications for more detailed information on 'Improving Primary Care Mental Health Services — A Practical Guide' (CSIP, 2006).

Department of Veteran's Affairs (2008). *Uniform Mental Health Services in VA Medical Centers and Services.* Veteran's Health Administration, Washington, DC.

This Veterans Health Administration (VHA) Handbook lays out minimum requirements for VHA Mental Health Services. It delineates the essential components of the mental health program that is to be implemented nationally, to ensure that all enrolled veterans, wherever they obtain care, have access to needed mental health services. It also specifies those services that must be accessible through each VA Medical Center and each Community-based Outpatient Clinic (CBOC). By building the requirements for services on specifications of what must be available to each veteran, no matter where in VHA that they receive care, it is designed to focus on the patient's perspective, and on meeting the care needs for each veteran. The Handbook is a reflection of the high priority that VHA places on enhancing mental health services for veterans and includes integration or coordination between the care of substance use disorders and other mental health conditions for those veterans who experience both, and for integration or coordination between care for mental health conditions and other components of health care for all veterans.

Annotated Bibliography *cont.*

Health Management Associates; prepared for the Robert Wood Johnson Foundation (2007). *Integrating Publicly Funded Physical and Behavioral Health Services: A Description of Selected Initiatives; Final Report.*

This report illustrates the variety of integration goals and approaches undertaken by providers, payers and public agencies in the pursuit of improved service integration. This report also highlights commonalities across a number of initiatives, including the existence of a conceptual framework, the use of improved communication tools and processes, the consistent use of screening tools, collaboration in the use of identified clinical approaches, the identification of funding mechanisms, and the need for sustainability planning. It also identifies considerations for future planning. These include the need for communicating about effective strategies, understanding opportunities to take advantage of "low-hanging fruit," developing sufficient funding to test various strategies, identifying training resources to support implementation of promising practices and actively engaging payers in dialogues about integration expectations. Findings suggest that sustainable integrated service initiatives were able to either connect financial costs and resultant benefits within a single health care payer or to broaden the range of participating stakeholders beyond health services payers.

Hogg Foundation for Mental Health (2008). *Connecting Body and Mind: A Resource Guide to Integrated Health Care in Texas and the United States*

This report summarizes various approaches to integration and what is known about their effectiveness. It also describes integrated health care programs in Texas and nationally and identifies resources to assist with developing and implementing integrated care systems. There is a call across the country and in Texas to improve health care systems through integrated care. Integrated health care is the systematic coordination of physical and behavioral health services. The idea is that physical and behavioral health problems often occur at the same time and that integrating services will provide the best results and be the most acceptable to individuals receiving services. However, the health, mental health and substance abuse treatment systems developed independently, are physically separate and typically are financed separately. Shifting to integrated care requires substantial changes to existing service systems and is a challenging endeavor.

National Collaborating Centre for Mental Health and the National Institute for Health and Clinical Excellence (UK) (2006). *Bipolar Disorder: The Management of Bipolar Disorder in Adults, Children and Adolescents, in Primary and Secondary Care.*

This guideline will be of relevance to adults and children of all ages who experience bipolar disorder and covers the care provided by primary, secondary and other health care professionals who have direct contact with, and make decisions concerning the care of, bipolar disorder sufferers. The guideline briefly addresses the issue of diagnosis, and does not make evidence-based recommendations or refer to evidence regarding diagnosis, primary prevention or assessment. The guideline is intended for use by:

- professional groups who share in the treatment and care of people with bipolar disorder, including psychiatrists, clinical psychologists, mental health nurses, community psychiatric nurses (CPNs), other community nurses, social workers, counsellors, practice nurses, occupational therapists, pharmacists, general practitioners and others;
- professionals in other health and non-health sectors who may have direct contact with or are involved in the provision of health and other public services for those diagnosed with bipolar disorder. These may include A&E staff, paramedical staff, prison doctors, the police and professionals who work in the criminal justice and education sectors; and
- those with responsibility for planning services for people with bipolar disorder and their carers, including directors of public health, NHS trust managers and managers in primary care trusts.

Annotated Bibliography *cont.*

National Collaborating Centre for Mental Health and the National Institute for Health and Clinical Excellence (UK) (2003). *Schizophrenia: Full National Clinical Guideline on Core Interventions in Primary and Secondary Care*

This guideline was developed to advise on the treatment and management of schizophrenia. The guideline recommendations were derived from a team of health care professionals, service users, carers and researchers after careful consideration of the best available evidence. The guideline should assist clinicians and others to provide high-quality care for people with schizophrenia and their families, while also emphasizing the importance of the experience of care for service users and carers. This guideline addresses the major treatments and services for people with schizophrenia. It is neither comprehensive nor definitive, and is necessarily limited given the size of the task.

National Collaborating Centre for Mental Health and the National Institute for Clinical Excellence (UK) (2004). *Depression: Management of Depression in Primary and Secondary Care.*

This guideline provides advice on the treatment and management of depression and related conditions. Recommendations were developed by a multidisciplinary group of healthcare professionals, researchers, patients and their representatives, after careful consideration of best available evidence. The guideline is intended for clinicians and service commissioners providing and planning high quality care for those with depression and also emphasizes the importance of the experience of care for patients and carers.

National Council for Community Behavioral Healthcare; prepared by Barbara Mauer (2006). *Behavioral Health/ Primary Care Integration: The Four Quadrant Model and Evidence- Based Practices*

This discussion paper was prepared for policy makers, planners and providers of healthcare and behavioral healthcare services. It provides a conceptual model for the integration of behavioral health and healthcare services. The behavioral healthcare system has historically been a specialty care system, and the work to be done by behavioral health clinicians in primary care is distinctly different from their work in the specialty system. The specialty medical and surgical healthcare system also is an arena where behavioral healthcare skills may be helpful as there is increasing research regarding depression and the need for behavioral healthcare as a care component for specific medical and post surgical interventions. The appear includes a crosswalk to Evidence-Based Practices (EBPs) to demonstrate that the integration of behavioral healthcare and healthcare services is not a separate layer of activity, but rather an essential component of appropriate clinical service delivery that is based on assessment of behavioral health and physical health risk and complexity.

National Council for Community Behavioral Healthcare; prepared by Barbara Mauer (2008). *Behavioral Health / Primary Care Integration and The Person-Centered Healthcare Home*

This paper proposes that the national dialogue regarding the patient-centered medical home be expanded to incorporate the lessons of the IMPACT model, explicitly building into the medical home model the care manager/ behavioral health consultant and consulting psychiatrist functions that have proven effective in the IMPACT model. A related idea is the proposed renaming of the patient-centered medical home as the person-centered healthcare home, signaling that behavioral health is a central part of healthcare and that healthcare includes a focus on supporting a person's capacity to set goals for improved self management. Having articulated the role of behavioral health in the person-centered healthcare home, this paper emphasizes the need for a bi-directional approach, addressing the integration of primary care services in behavioral health settings as well as the need for behavioral health services in primary care settings. Two models are proposed for behavioral health providers who envision a role as a healthcare home: a unified program similar to the Cherokee model in Tennessee; and focused partnerships between primary care and behavioral health providers.

Annotated Bibliography *cont.*

World Health Organization (2008). *Integrating Mental Health into Primary Care: A Global Perspective.*

This report on integrating mental health into primary care, which was developed jointly by the World Health Organization (WHO) and the World Organization of Family Doctors (Wonca), presents the justification and advantages of providing mental health services in primary care. At the same time, it provides advice on how to implement and scale-up primary care for mental health. There are 10 key messages included in the report: 1. Mental disorders affect hundreds of millions of people and, if left untreated, create an enormous toll of suffering, disability and economic loss. 2. Despite the potential to successfully treat mental disorders, only a small minority of those in need receive even the most basic treatment. 3 . Integrating mental health services into primary care is the most viable way of closing the treatment gap and ensuring that people get the mental health care they need. 4. Primary care for mental health is affordable, and investments can bring important benefits. 5. Certain skills and competencies are required to effectively assess, diagnose, treat, support and refer people with mental disorders; it is essential that primary care workers are adequately prepared and supported in their mental health work. 6. There is no single best practice model that can be followed by all countries. Rather, successes have been achieved through sensible local application of broad principles. 7. Integration is most successful when mental health is incorporated into health policy and legislative frameworks and supported by senior leadership, adequate resources, and ongoing governance. 8. To be fully effective and efficient, primary care for mental health must be coordinated with a network of services at different levels of care and complemented by broader health system development. 9. Numerous low- and middle-income countries have successfully made the transition to integrated primary care for mental health. 10 Mental health is central to the values and principles of the Alma Ata Declaration; holistic care will never be achieved until mental health is integrated into primary care.

Bazelon Center for Mental Health (2004). *Get it Together: How to Integrate Physical and Mental Health Care for People with Mental Disorders.*

This report examines model programs for improving integration and coordination of behavioral health and primary health services for adults and children with serious mental disorders who rely on the public mental health system for their care. It summarizes findings of a series of studies and offers recommendations for policymakers. There is an extensive body of literature and demonstration projects to improve integration of mental health in primary care for individuals with mild to moderate mental disorders. The Bazelon Center's study fills a gap by focusing primarily on integration of care for people with serious mental illnesses.

Mauch, D., Kautz, C., and Smith, S. This project was supported by the Center for Mental Health Services (CMHS), a component of the Substance Abuse and Mental Health Services Administration (SAMHSA) (2008). *Reimbursement of Mental Health Services in Primary Care Settings.*

In 2005–2006, the Substance Abuse and Mental Health Services Administration (SAMHSA) and the Health Resources and Services Administration (HRSA), with guidance from the Centers for Medicare & Medicaid Services (CMS), jointly sponsored a study to identify the barriers to, and possible solutions for, reimbursement of mental health services provided in primary care settings. The Federal Action Agenda, emanating from the 2003 report of the President's New Freedom Commission, "Transforming Mental Health Care in America," includes direct reference to addressing barriers to reimbursement for mental health in primary care. This study, in response to that identified need, was divided into two main efforts to better understand the payment policies and practices that may prohibit or discourage the provision of mental health services in primary care settings.

Annotated Bibliography *cont.*

Parks, J. et al, for National Association of State Mental Health Program Directors (2006). *Morbidity and Mortality in People with Serious Mental Illness.*

This report concluded that people with serious mental illness (SMI) die, on average, 25 years earlier than the general population. State studies document recent increases in death rates over those previously reported. This is a serious public health problem for the people served by our state mental health systems. While suicide and injury account for about 30-40% of excess mortality, 60% of premature deaths in persons with schizophrenia are due to medical conditions such as cardiovascular, pulmonary and infectious diseases. The report also found that people with serious mental illness also suffer from a high prevalence of modifiable risk factors, in particular obesity and tobacco use. Compounding this problem, people with serious mental illness have poorer access to established monitoring and treatment guidelines for physical health conditions.

Unützer, J. et al for the IMPACT Study Coordinating Center (2004). *IMPACT: Late-Life Depression Treatment Manual.*

This manual provides guidelines for the treatment of depression in the primary care setting based on the findings from 7 study sites.

New Zealand Ministry of Health (2008). *Primary Mental Health Care in New Zealand.*

This update provides information on developments in primary mental health care, particularly those led by the Ministry of Health. Much of this March issue is dedicated to discussing the potential policy direction of primary mental health care and some of the principles underlying the policy development.

Parks, J., and Pollack, D., for National Association of State Mental Health Program Directors (2004). *Integrating Behavioral Health and Primary Care Services: Opportunities and Challenges for State Mental Health Authorities.*

The report integrates two conceptual models that assist in thinking about population-based and systemic responses. The first, *The Four Quadrant Clinical Integration Model*, is a population-based planning tool developed under the auspices of the *National Council for Community Behavioral Healthcare (NCCBH)*. Each quadrant considers the Behavioral Health (SA and MH) and physical health risk and complexity of the population subset and suggests the major system elements that would be utilized to meet the needs of the individuals within that subset of the population. Additionally, the report references *The Care Model*, which summarizes the basic elements for improving care in health systems at the community, organization, practice and patient levels. *The Care Model* was developed by the *Improving Chronic Illness Care Program* to speed the transformation of healthcare, from a system that is essentially reactive — responding mainly when a person is sick — to one that is proactive and focused on keeping a person as healthy as possible.

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