BRIEF REPORT

# Mental Health Care Treatment Initiation When Mental Health Services Are Incorporated Into Primary Care Practice

*Rodger Kessler, PhD*

***Purpose:*** **Most primary care patients with mental health issues are identified or treated in primary care rather than the specialty mental health system. Primary care physicians report that their patients do not have access to needed mental health care. When referrals are made to the specialty behavioral or mental health care system, rates of patients who initiate treatment are low. Collaborative care models, with mental health clinicians as part of the primary care medical staff, have been suggested as an alternative. The aim of this study is to examine rates of treatment startup in 2 collaborative care settings: a rural family medicine office and a suburban internal medicine office. In both practices referrals for mental health services are made within the practice.**

***Methods:*** **Referral data were drawn from 2 convenience samples of patients referred by primary care physicians for collaborative mental health treatment at Fletcher Allen Health Care in Vermont. The first sample consisted of 93 consecutively scheduled referrals in a family medicine office (sample A) between January 2006 and December 2007. The second sample consisted of 215 consecutive scheduled referrals at an internal medicine office (sample B) between January 2009 and December 2009. Referral data identified age, sex, and presenting mental health/medical problem.**

***Results:*** **In sample A, 95.5% of those patients scheduling appointments began behavioral health treatment; in sample B this percentage was 82%. In sample B, 69% of all patients initially referred for mental health care both scheduled and initiated treatment.**

***Conclusions:*** **When referred to a mental health clinician who provides on-site access as part of a primary care mental health collaborative care model, a high percentage of patients referred scheduled care. Furthermore, of those who scheduled care, a high percentage of patients attend the scheduled appointment. Findings persist despite differences in practice type, populations, locations, and time frames of data collection. That the findings persist across the different offices suggests that this model of care may contain elements that improve the longstanding problem of poor treatment initiation rates when primary care physicians refer patients for outpatient behavioral health services. (J Am Board Fam Med 2012;25:255–259.)**

***Keywords:*** **Case Report, Comorbidity, Delivery of Health Care, Health Care Seeking Behavior, Mental Health, Primary Health Care**

More than 30 years of research conclude that the majority of patients with mental health or substance abuse issues have been identified or treated in primary care settings rather than the specialty mental health system.[1,2] In contrast, there are 10 systematic reviews that conclude that when mental health treatment is provided within primary care, mental health and general health outcomes improve. Another report further suggests that most support is from studies of a single model of depression care management and that little is known about specific elements that contribute to success.[3]

Efforts by physicians to identify and treat mental health problems within primary care are limited without available referral and treatment resources.[4–7] Ini-

This article was externally peer reviewed.
*Submitted* 27 May 2010; revised 16 February 2011; accepted 7 March 2011.
*From* the Department of Family Medicine, University of Vermont College of Medicine, Burlington, VT.
*Funding:* none.
*Conflict of interest:* none declared.
*Corresponding author:* Rodger Kessler, PhD, 89 Beaumont Avenue, Given Courtyard 4th Floor, Burlington VT 05405 (E-mail: Rodger.Kessler@uvm.edu).

**Table 1. Fletcher Allen Health Care Collaborative Care Model**

| | |
|---|---|
| Clinical | • Full-time primary care behavioral health clinician with clinical and care management responsibilities |
| | • Clinician availability for warm handoff and consultation |
| | • Brief evidence-supported treatment |
| | • Intensive training of behavioral health collaborative care clinician in the model, including treatment protocols for a broad range of psychological and medical problems amenable to behavioral health treatment |
| | • Population (panel)-based care using measurement-based stepped treatment and other resource availability |
| Operational | • Practice re-engineering of operational processes, including "warm handoffs" (personal introductions of behavioral clinician to patient by primary care physician) |
| | • Automated referral and patient scheduling |
| | • Training physicians and staff in behavioral care procedures |
| | • Appointment frequency and interval consistent with primary care |
| | • Shared electronic health record with mental health note availability |
| | • Care management coordinates referrals and information out to specialty care if greater intensity of care is needed; management of external information |
| Financial | • Brief interventions during brief time frames |
| | • Coordination of services and finances to optimize sustainability |
| | • Regular reports of performance, relative value unit, and financial data |

tiating behavioral treatment involves discrete steps including problem identification, access to appropriate treatment resources, referral, referral acceptance, and ultimately treatment initiation. Failure at any one of these steps results in failure to initiate treatment.

Referral to the specialty public or private mental health system generates a rate of appointment scheduling of less than 50% and even lower rates of contact.[8–11] Approximately two thirds of 6000 primary care physicians surveyed found specialty mental health services to be the most difficult medical subspecialty to access.[12]

It is important to understand whether treatment initiation after referral is improved when collaborative models of care with behavioral health clinicians functioning as part of the primary care office are available to primary care patients. Therefore, treatment initiation rates were analyzed in 2 collaborative primary care practices in which patients are referred to a behavioral health clinician who treats patients in the primary care office.

## Methods

In a collaborative care pilot, Fletcher Allen Health Care, the academic medical center of the University of Vermont College of Medicine, tracked mental health referrals and treatment initiation as part of quality improvement efforts. Subsequent to the initial pilot in a family medicine practice, a second intervention was started in an internal medicine practice, providing the opportunity to report rates of attendance at initial mental health visit at a second site.

The collaborative care model at Fletcher Allen has been evolving for 10 years. Table 1 outlines the core elements of the current model. The model focuses on the clinical, operational, and financial elements of care and planning, and ongoing quality improvement is built into both implementation and operation. Model elements are drawn from best practices identified in the field. Patients referred to the primary care behavioral health clinicians are all office patients and are referred by office physicians and providers. There are no self-referrals.

I first reviewed a convenience sample of 93 consecutive patients referred and scheduled for psychological treatment at a family medicine office (sample A) in northern Vermont between January 2005 and December 2007. This rural practice has 5 physicians, a physician assistant, a nurse practitioner, and a part-time psychologist. The office billed approximately 50,000 patient visits per year during the sample period. The sample was generated as a quality improvement project to investigate the potential to conduct behavioral health–focused practice-based research. The sample size was small because the author, a clinical health psychologist, was only practicing 2 days per week. I selected the data collection period subjectively and all referrals within the time frame were tracked.

The referral and follow-up system has been consistent for 10 years. Behavioral health referral is generated and scheduled for the following week, on the basis of physician and patient agreement during the patient's visit, using the regular practice scheduling system. The behavioral health clinician is described as a member of the medical team. Referral diagnoses are typical for those seen in primary care, such as anxiety and depression, with approximately one third of referrals for psychological treatment of a specific medical issue such as primary insomnia, headache, or chronic pain.

A brief referral form completed by the physician identifies age, sex, presenting mental health, and medical problem. After completion, the top portion is handed to the patient to present for scheduling. After scheduling, the referral form is placed in the psychologist's practice mailbox. There is an automated phone appointment reminder to the patient before the scheduled visit. Data for this study were recorded from the referral forms and billing system list of completed patient appointments.

Sample B is an internal medicine office located in a suburb of Vermont's largest city. This suburban practice has 8 full-time equivalent providers, one full-time master of social work (MSW) behavioral health clinician, and had just fewer than 30,000 billed patient visits during the referral period. Mental health referral diagnoses were typical for those seen in primary care, such as anxiety and depression. Perhaps because of more extensive training in the collaborative care model provided to physicians in this practice, close to 60% of referrals were for treatment of a specific medical issue in addition to a mental health problem.

The collaborative care model evolved from the initial pilot and tracked the same referral and initiation data. The referral process and introduction of the behavioral health clinician role is consistent with office A. Because of a new electronic health record, all referral and scheduling data are now captured electronically in all practices. Therefore, the number of patients referred by the provider (256), as well as the number who scheduled an appointment (215) and the number who attended the first appointment (176), can be identified. The 256 referrals occurred between January 2009 through December 2009.

### *Analytic Plan*

Variables were described with frequencies, means, medians, ranges, graphs, and 95% confidence intervals, as appropriate. Treatment initiation rates for each practice were calculated and compared with rates published in the literature. Analyses were conducted using STATA statistical software (StataCorp, College Station, TX).

## Results

Age and sex are representative of primary care adult practice populations, and race is consistent with Vermont racial population distribution (Table 2). There was a greater percentage of women among sample B patients as well as higher rates of referrals with a combination of mental health and medical presentations. There were no available comparative data for the percentage of medical behavioral comorbidity in primary care behavioral health referral samples. In office A, 95.5% of patients who scheduled an appointment attended the first treatment visit. In office B, 82% of patients referred by their physician scheduled an initial appointment with the onsite mental health provider, and of those who were referred, 68.8% attended the initial appointment. Of those referred, 32.2% ultimately were not seen. In both practices a high percentage of patients who scheduled an appointment initiated mental health treatment, which is higher than that reported in the literature. In sample B the percentage

**Table 2. Sample Characteristics and Treatment Initiation Results**

| Sample Characteristics | Site A | Site B |
|---|---|---|
| N | 93 | 256 |
| Median age, years (range) | 50.4 (18–97) | 48 (20–86) |
| Women (%) | 58 | 78 |
| Non-Hispanic white (%) | 100 | 98.4 |
| Proportion of those who were referred and scheduled an appointment | — | 84% (CI = 79.5–88.5) |
| Proportion of those who scheduled and kept appointment | 95.5% (CI = 93.3–97.7) | 81.9% (CI = 76.7–87.0) |
| Overall referral success | | 68.8% (CI = 64–73.5) |

of patients who were referred for, scheduled, and kept the appointment was also high.

## Discussion

Nationally, primary care physicians often have not had access to adequate behavioral health referral, especially onsite. Out-of-practice treatment initiation rates are low,[10] with rates of attendance at an initial appointment reported between 30% to 47% in specialty care and one report of 71% in an integrated care research project for older adults.[8–11] There are no other reports of rates of attendance in community primary care settings.

In the initial preliminary investigation in one family practice with an organized system of behavioral health availability, referral, scheduling ease, and behavioral health clinician and physician communication, most scheduled behavioral health appointments after primary care referral resulted in higher rates of attendance at the initial mental health treatment appointment (95.5%) than those identified in the literature. In the second (internal medicine) practice, which has a similar system of care, most patients referred scheduled an appointment (82%), and most scheduled appointments resulted in attendance at an initial mental health treatment appointment (69%). This new finding suggests that in this sample, although there was some drop off in patient referral scheduling and attendance (31%), a large proportion of patients navigated the multiple steps needed to attend mental health services. The similar results in disparate settings suggest the potential generalizability of the finding that patients referred for behavioral health services that are part of primary care offices have high rates of appointment scheduling after physician referral and high rates of attendance for treatment initiation.

These findings suggest a potential solution to a highly frequent, time-consuming problem: accessible behavioral health referral and treatment engagement that is acceptable to primary care patients. It should be mentioned that these services are in a fee-for-service environment. All patients are eligible, including those with Medicaid and Medicare. Uninsured patients are seen, with financial assistance based on income. The program is financially sustainable from billings.

In addition, the data suggest that the model of care may provide access to services for a large sector of patients whose health status and effectiveness of medical care could be enhanced by the provision of evidence-based psychological and mental health treatments but who rarely receive such care. The literature suggests that medical patients with untreated psychological problems experience lower health status, ineffective medical treatments, high utilization of health care, and increased cost.[13,14]

There are obvious limitations of location, sample, and population, though small medical offices are representative of provider settings in considerable segments of the United States and other countries. Although rates of attendance are considerably higher than reported, some patients did not follow through with the physician recommendation for care. In addition, for those who did initiate care, initiation is not equivalent to treatment success, and this investigation cannot respond to the question of outcomes of care.

A method is needed to ask the same questions in larger numbers of office settings that have enhancements organized similar to those in primary care mental health. These results must be confirmed and the issues raised in this investigation further investigated. The author is currently involved in a 6-site practice-based research network study examining similar questions with the intention of subsequently engaging large numbers of collaborative care practices if the viability of the methodology is demonstrated. What is quite clear is that primary care has increasingly greater degrees of responsibility for patients' whole-person health. We need to pay particular attention to the large group of patients with mental health needs if we are to generate better patient outcomes of care.

## References


1. Regier DA, Narrow WE, Rac DS, Manderscheid RW, Locke B, Goodwin F. The de facto US mental health and addictive disorders service system: Epidemiologic Catchment Area prospective. Arch Gen Psychiatry 1993;50:85–94.
2. Kessler R, Stafford D, eds. Primary care is the de facto mental health system. In: Kessler R, Stafford D (eds). Collaborative Medicine Case Studies: Evidence in Practice. New York: Springer; 2008:9–21.
3. Butler M, Kane RL, McAlpin D, Kathol RG, Fu SS, Hagedorn H. Integration of mental health/substance abuse and primary care. Rockville, MD: Minnesota Evidence-based Practice Center; 2008: 09-E003.

4. Korsen N, Scott P, Dietrich AJ, Oxman T. Implementing an office system to improve primary care management of depression. Psychiatr Q 2003;74:45–60.
5. Coyne JC, Thompson R, Palmer SC, Kagee A, Maunsell E. Should we screen for depression? Caveats and potential pitfalls. Appl Prev Psychol 2000; 9:101–21.
6. Gilbody S, Sheldon T, House A. Screening and case-finding instruments for depression: a meta-analysis [see comment]. CMAJ 2008;178:997–1003.
7. Kessler R. Identifying and screening for psychological and co morbid medical and psychological disorders in medical settings. J Clin Psychol 2009;65:253–67.
8. Fisher L, Ransom DC. Developing a strategy for managing behavioral health care within the context of primary care. Arch Intern Med 1997;6:324–33.
9. Bartels SJ, Coakley EH, Zubritsky C, et al. Improving access to geriatric mental health services: a randomized trial comparing treatment engagement with integrated versus enhanced referral care for depression, anxiety, and at-risk alcohol use [see comment]. Am J Psychiatry 2004;161:1455–62.
10. Younes N, Gasquet I, Gaudebout P, et al. General practitioners' opinions on their practice in mental health and their collaboration with mental health professionals. BMC Fam Pract 2005;6:18.
11. Younes N, Passerieux C, Hardy-Bayle MC, et al. Long term GP opinions and involvement after a consultation-liaison intervention for mental health problems. BMC Fam Pract 2008;9:41.
12. Cunningham PJ. Beyond parity: primary care physicians' perspectives on access to mental health care. Health Aff 2009;28:w490–w501.
13. Katon WJ, Von Korff M, Lipscomb P, Russo J, Wagner E, Polk E. Distressed high utilizers of medical care; DSM-III-R diagnoses and treatment needs. General Hospital Psychiatry 1990;12(6):355–362.
14. Simon GE, Katon WJ, VonKorff M, et al. Cost-effectiveness of a collaborative care program for primary care patients with persistent depression. American Journal of Psychiatry Oct 2001;158(10):1638–1644.