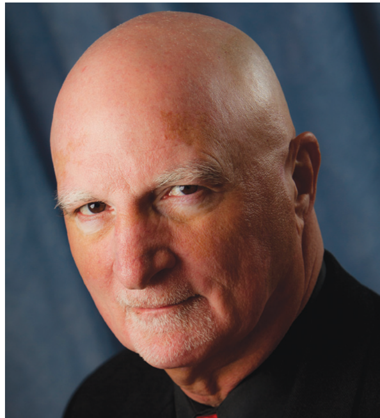
I Am Psyched; Are You?



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For the past two centuries, disorders of behavior have been held separate and distinct from manifestations of systemic disease that are more easily characterized by the science of the day. In the 19th century, individuals with behavioral disorders were confined to psychiatric hospitals, and in the 20th century, community mental health centers were established and funded under rules that were distinct from those of the evolving system of health care in the United States. The resulting segregation of mental health from primary care has created a crisis that plays out in the national media on a daily basis. Moreover, the continuing economic impact of maintaining this separation has profound implications for the future.

Change is upon us. Seeing the handwriting on the wall isn't the result of a delusion. It is hard to argue that mental health is not a cornerstone of an individual's overall well-being and the foundation of health. Behavior has a profound effect on organic pathologies, and pathologies impact behavior. To separate mental health from primary care makes little sense, and it is time to recognize that mental health is an important component of primary care.

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Consider the evidence. Any experienced health care practitioner recognizes the immense role that mental health plays in patient care. Simply looking at the waiting area of a community health center (CHC) provides stark evidence. The medical director for one CHC estimated that "at least 85% of the patients seen at my practice have some form of comorbid mental health and physical health chronic disease."[1] Others have suggested that half the individuals in a CHC waiting area are there primarily for some recognized or unrecognized mental health issue.[2] There is no doubt that this is also the case in America's emergency departments and other primary care clinics.

People with mental health disorders have a higher mortality rate and often die prematurely due to well understood and preventable diseases such as diabetes, hypertension, respiratory problems, and infectious disorders. One need look no further than a recent issue of *JAMA* to understand the impact of mental health comorbidities on diabetes. Diabetic persons with depression are poorly compliant, have poor glycemic control, and experience more diabetic complications and decreased quality of life. Moreover, the economic impact of this comorbidity is staggering when the costs of increased care, unemployment, and work disability are added to the physical toll.[3]

With arguments as compelling and apparent as these, why then has it been so difficult to achieve

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meaningful levels of integration? The barriers are many. Reimbursement, legislation, and role identities are familiar reasons that an out-of-date, inefficient system continues to be propagated. But these obstacles are beginning to crumble. Providing primary care without integrating mental health is literally caring for the body and ignoring the mind. Integration of primary and mental health is now the battle cry as systems define the medical homes of the future.

Anticipating the changing environment in health care, the Substance Abuse and Mental Health Services Administration (SAMHSA) has funded a series of studies that review the diversity of approaches to mental health services and attempt to define an optimum future framework that will bring mental health back into the domain of primary care. The results of these studies were recently published as a Rand Corporation Research Report.[4]

Yet even as vested parties seek to identify the best practices for this integration, it is clear that the biggest challenge relates to the workforce. The logic of integration is unimpeachable and the process already in motion (unlike most changes, this one is rapidly occurring), but the supply of qualified providers is woefully inadequate.

CHCs are the largest health care system in the US and provide the "safety net" for the country's approximately 25 million uninsured and underinsured individuals. Over the next five years, this number will grow to more than 35 million. About 70% of CHCs presently offer mental health services in some form.[1] A recent survey of CHC leaders found that their biggest fear is the tidal wave of mental health problems and their ability to adequately address the needs of these patients because of a severe shortage of properly educated providers.

Psychiatrists are rare in CHCs, and those that exist focus a majority of their time on the most acutely ill. Some centers have formed alliances with community-based mental health services, but too often patient referrals don't happen or the patient is lost to follow-up. The complex maze of reimbursement, prescribing, and follow-up makes the continued propagation of this inefficient approach unacceptable for the future.

What is needed are clinicians who are properly educated to begin to fill the gap. As such, the workforce challenges of this integration represent a significant opportunity, especially for PAs and NPs. With the exception of physicians, who are in increasingly limited supply, there are no other health care professionals who have the capability to bridge the gap between primary care and mental health. To meet the projected workforce needs, PAs and NPs will have to make a significant commitment to gain the necessary knowledge, skills, and behaviors required to treat mental health problems.

There are a number of excellent entry-level psychiatric nurse practitioner programs that prepare NPs to provide both primary and mental health care. However, most entry-level PA programs don't have the time to do more than skim the surface of mental health care as they prepare students to begin practice as broadly educated generalist caregivers.

Fortunately, about three years ago, the National Commission on the Certification of Physician Assistants (NCCPA) began to recognize the qualifications and promote the need for PAs with advanced skills in psychiatry and mental health. As of December 2013, almost 100 PAs had successfully received a Certificate of Advanced Qualification (CAQ) in psychiatry from the NCCPA. The nation needs more than 0.1% of all PAs with a credential that recognizes their expertise in mental health. It is time to set an aggressive goal of having 1% of all PAs with a CAQ in psychiatry within the next five years.

Any PA or NP planning their future should give serious consideration to the overwhelming demand for practitioners who can effectively link primary care and mental health. This opportunity for individuals is a current reality. But even greater is the opportunity for the professions to claim a very meaningful and needed position on the health care teams of the future.

I hope you agree. Please share your thoughts with me via CRNewsEditor@frontlinemedcom.com. **CR**

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