Psychiatric conditions, including depression, anxiety, and substance use disorders are common in general medical practice, drive health care costs, and undermine positive outcomes [1, 2]. Transformational federal legislation such as the Affordable Care Act and the Mental Health and Addiction Parity Act leverage policy and financing to address behavioral health alongside and equally with physical health [3]. Aspirational health care delivery models, including the vision for population health and the patient-centered medical home, likewise embrace the values of more holistic care that are of preference to patients and families [4]. The premise for integrating behavioral health in primary care is rather simple: (1) meet patients where they seek health care; (2) identify those at risk, and offer preventative or early intervention services for emerging, mild or moderately severe problems; and (3) for those patients who have problems that are too severe or complex to manage effectively, link or coordinate care with specialists [5]. This stepped care process is identical to how physical health conditions, such as hypertension, diabetes or respiratory diseases, are approached: Identify, diagnose, and manage patients with emerging, mild, or moderate issues, and refer more acute or severe cases to specialists [5].

Evidence-based Practices

There are numerous evidence-based and effective approaches to the heterogeneous range of behavioral health conditions. As with most research-derived evidence, the most rigorous studies have been developed on relatively homogenous patient samples [6]. There are meta-analyses, Cochrane reviews, and systematic reviews supporting the efficacy of pharmacological and psychosocial approaches for singular disorders such as depression [7], bipolar disorder [8], generalized anxiety disorder, panic disorder [9], alcohol use disorder [10], and opioid use disorder [11]. In many of these studies, in order to maximize internal validity and sample homogeneity, patients with additional disorders were excluded from the clinical trial. Of course, this has a profound effect on external validity and routine clinical practice.

The Unified Model

In specialty mental health care situations, the clinical reality is that many if not most patients have more than one disorder. Therefore patients are more complex than the research-based evidence on which any single treatment might account for. This results in additive therapies, or in the best case scenario, the use of “broad-spectrum” therapies such as serotonin reuptake inhibitors (SSRI) for mood and anxiety disorders, addiction medications for alcohol, or opioid-related addiction, and psychosocial therapies such as motivational interviewing, cognitive behavioral therapy, or problem solving therapy for a variety of conditions [12, 13]. Although nuanced and complicated, it is expected that psychiatrists, clinical psychologists, and other mental health professionals can sift through the existing single-disorder-based treatment research evidence and deliver appropriate treatments matched to patient complexity and multi-morbidity [14]. Of critical importance is the limited recognition of high rates of substance use problems in primary care, even in settings that have “integrated” behavioral health care. Simple self-report screening measures such as the Patient Health Questionnaire (PHQ-9) or the Generalized Anxiety Disorder (GAD) questionnaire may identify patient concerns about mood or anxiety problems. Patients may be more willing to acknowledge these issues and primary care providers may be more willing to address them—particularly with an inventory of psychotropic medications with which to offer. Patients with substance use issues typically do not report, under-report, and/or minimize...
substance-related concerns on self-report measures such as the Alcohol Use Disorder Identification Test (AUDIT), Drug Use Disorder Identification Test (DUDIT), or Alcohol, Smoking and Substance Involvement Screening Test (ASSIST) [15–17]. Reasons include stigma, concerns about reporting illicit or illegal drug use, beliefs that the problems are not so severe, alternatives are not available, and that primary care is not the place to have these concerns addressed. Because substance use is highly prevalent, commonly comorbid with psychiatric disorders such as mood and anxiety, it undermines pharmacological and psychosocial treatment effectiveness for psychiatric disorders. Effective treatments exist, as cutting-edge, innovative integrated approaches that are unified—addressing both psychiatric AND substance use disorders within primary care. Psychotropic and addiction medications are prescribed, patients and family members are engaged in shared decision-making about treatment options and preferences, and broad-spectrum psychosocial therapies are delivered.

The predominant method of providing behavioral care as part of primary care is to simply co-locate a behavioral provider within a practice and have physicians refer patients for care. McGovern et al. [18], Khayal et al. [19], and Reiss-Brennan et al. [20] have challenged that simple strategy and independently described unified, multi-level, practical, and implementable models of behavioral health and primary care integration that address diagnostic heterogeneity, cultural and organizational issues, integrated care pathways, and metrics for services with primary care, or coordinated or referred for more intensive specialty psychiatric/addiction evaluation or treatment. McGovern et al. underscore the array of policies, services and workforce requirements for a unified model, Khayal and McGovern document a systems engineering approach to a unified pathway development, and Reiss-Brennan et al. report on the economic benefits, particularly when team-based care is the vehicle within which unified care is delivered.

**Team-Based Care**

Because primary care providers and other clinical staff members have significant demand on time and resources, and may not have the education, training, or expertise in behavioral health issues, adding dedicated personnel is a reasonable strategy [21]. Psychiatrists, clinical psychologists, psychiatric nurse practitioners, or masters’ level social workers or counselors are among the workforce often selected and embedded to provide evaluation and treatment services for patients identified with behavioral health concerns [22]. Because psychiatric physicians and psychologists are more expensive, masters’ level social workers and mental health counselors are more commonly deployed. Also, due to limited organizational attention and processes, integrated behavioral health clinicians, such as masters’ level clinicians, often have role confusion because they are often expected to manage not only behavioral health issues such as psychiatric, substance use, or health behaviors, but also social risk factors, including housing, social services, employment, transportation, or health insurance benefits. This role diffusion leads to unrealistic expectations, frustration, burnout, and workforce turnover [14]. Team-based care is a strategy that situates a structure and process for each primary care team member to maximize the scope of their practice within discipline, and together render efficient and effective services. The benefit of team-based care for the behavioral health clinician is an improved level of communication and role clarity. In the best instances, the behavioral health clinician may also support other providers (physicians, mid-levels, nurses, medical assistants, and consulting psychiatrists) in caring for patients without actually seeing them directly. Although team-based care approaches result in better outcomes, overall team functioning as well as variation in what the behavioral health clinician can and should do varies widely [23].

**Psychiatry and Primary Care**

The Improving Mood-Promoting Access to Collaborative Treatment (IMPACT) approach is perhaps the best-known and widely adopted model of psychiatry and primary care integration. In this approach, particularly focused on mood disorders and measurement-based care using the PHQ-9, a consultant psychiatrist performs caseload review, “curbside” consultation, education, direct evaluations, and guidance to the team in the primary care clinic [24]. A nurse care manager, care coordinator, or non-psychiatrist behavioral health clinician directly manages the psychosocial needs and supports the patient. The primary care physician or other prescriber directly manages psychotropic medication. The IMPACT psychiatrist works most closely with the care coordinator in a PHQ measurement-based approach and a patient registry format. The psychiatrist’s involvement is escalated based on patient’s response. In this role, the psychiatrist provides expert guidance, support to primary care providers, and may or may not be a regular member of team-based care meetings. However, through the care coordinator or behavioral health clinician, nonetheless has a powerful influence on behavioral health care delivery. Furthermore, the psychiatrist often plays an important unofficial role, supporting the primary care team in their management of physical health conditions, by serving as the voice of understanding and “meaning-making” of the psychological, social, and emotional aspects of the whole person. In this regard, the psychiatrist can act as an educator, and is able to reach far more patients, families, and health care professionals than possible in the traditional office-based specialty practice model—for which most psychiatrists are trained and destined. As might be expected, typically driven by resources and psychiatrist availability, particularly in rural or impoverished areas, the interface of psychiatrist physicians
in primary care varies considerably and results in wide variation in outcomes. A recent effort in Minnesota to implement IMPACT across a wide range of non-academic primary care clinics did not find successful depression treatment effectiveness [25]. As Peek outlined in the agency for healthcare resources and quality publication [26], the role may range from no or minimal integration to full integration. Because reimbursement for indirect consultation may be limited, systems and practices are forced to define the value added in the positioning of the psychiatrist. An embedded psychiatrist with more significant full-time equivalent (FTE) may have an onsite panel of patients, be available to consult with primary care providers, and be readily available to review diagnoses, treatment plans, and medication options. A consulting psychiatrist with hourly or part-time FTE might perform some direct patient care but the role is primarily consultative. Caseload focused registry review, as in the IMPACT model, to identify patients who are not progressing, is common. Telephone or electronic consultation (e-consult) and video-conferencing for staff communication and patient care are technological options to increase access. In the more traditional, minimally integrated role, the psychiatrist conducts evaluations and patient care off site on a referral basis. This type of relationship between the primary care practice and the traditional psychiatrist varies widely and may extend to the psychiatric or mental health organization, clinic, group practice, or solo practitioner type of specialty care setting. The level of communication may range from referral with or without follow-up, consultation only with feedback, coordinated care or co-management of patients, or perhaps the specialist taking over primary responsibility for patient care.

Psychiatry and the Unified Model

Because addiction psychiatry is a sub-specialty, and one in which the general psychiatrist often feels lacking in expertise or self-efficacy, the unified model is a challenge for implementation. Optimally, the embedded, consulting, or off-site traditional psychiatrist has addiction psychiatry or addiction medicine expertise if not advanced credentials. In these instances, the addiction psychiatrist can support the primary care providers and care coordinators in the work with mild or moderately severe psychiatric and substance-related disorders. This may include measurement-based care using standardized measures such as the PHQ and/or Brief Addiction Monitor (BAM [27]), reviewing progress along with the care coordinator, and with escalating direct involvement as needed. Given the efficacy and safety of medications for alcohol and opioid addiction, this approach is syntonic with the IMPACT model for mood disorders [28]. In fact integrating the management of opioid addiction using buprenorphine, a stepped care and unified approach has been recently described by Korthius et al. [29], LaBelle et al. [30], and Nordstrom et al. [31].

The Future Opportunity

At present, addiction and other psychiatric disorders remain bifurcated by systems of care, policies, financing, and in the competence, attitude, and capability of the primary care and specialty care workforce, including psychiatry. Despite widespread awareness of the common prevalence of co-morbidity, the effectiveness of integrated treatments, and decades of striving to reorganize and unify addiction and mental health in specialty systems of care, we ignore this history. With the present-day “opioid epidemic” underway, including pressure to change prescribing behavior, there is an unprecedented motivation, financing, and resources for primary (and specialty care) to adopt addiction medications in routine practice—specifically buprenorphine and naltrexone. This opens the door further for the unified model of behavioral health and primary care integration. Otherwise, integrated models addressing only addiction will have reduced impact because of comorbid psychiatric and other medical disorders, and integrated models only addressing psychiatric disorders will have reduced impact because of comorbid substance use. A unified, broad-spectrum approach to the realities of patient complexity may have the best chance of improving outcomes, reducing cost, addressing patient preferences, and delivering patient-centered whole-person care.

Compliance with Ethical Standards

This commentary was composed and written in compliance with all ethical standards and considerations.

Disclosures

On behalf of all authors, the corresponding author states that there is no conflict of interest to disclose.

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