The Challenges of Behavioral Health Integration: The Persistence of the Mind–Body Problem

For centuries, philosophers, theologians, and scientists have grappled with the nature of the relationship between the mind and body. One prominent theory, the concept of dualism, attributed to the 17th-century French philosopher René Descartes, maintains a rigid distinction between the realms of the mind and body. Cartesian dualism played a fundamental role in removing the practice of medicine from church oversight (1). In the process, the biological aspects of human illness assumed a predominant role in medical science and practice.

In the United States, the provision of physical and behavioral care (mental health and substance use treatment) has been compartmentalized into 2 distinct and largely parallel systems. This separation persists despite 2 decades of research showing that integrating behavioral health into primary care practices in particular can enhance patient care, reduce costs, and improve social functioning of persons with depression (2). A 1996 Institute of Medicine consensus study report on primary care cautioned that mental health and primary care are inseparable, and any attempts to separate them leads to inferior care (3). It is evident that behavioral health services should be an integral part of comprehensive primary care. There is increasing recognition of the bidirectional nature of behavioral and physical health: 68% of persons with a mental health problem also have medical conditions, and persons with chronic illness are twice as likely to have mental illness (4).

Yet, the goal of integrating physical and mental health in our health system has not been widely realized in the 24 years since the Institute of Medicine's report, despite the subsequent emergence of national movements, such as the Institute for Healthcare Improvement's Quadruple Aim and the patient-centered medical home model, that have emphasized the importance of whole-person orientation in medical practice. In 2015, the American College of Physicians published a position paper on integrating behavioral health into primary care (5). The article encouraged members to address their patients' behavioral health problems and work with all stakeholders to remove payment barriers and reduce the stigma of mental health diagnoses. The recommendations also included supporting increased research to define the most effective models and greater attention to training all professionals involved in the care of persons with behavioral health concerns.

Malâtre-Lansac and colleagues report on factors influencing U.S. physician practices' adoption of behavioral health integration (6). They state that despite recent statutory and regulatory policy changes that may encourage adoption, behavioral health integration is still uncommon among U.S. physician practices. This qualitative study yielded important insights into physician practices' motivations for integration; implementation models; barriers to behavioral health, including substance use disorder treatment; and effects of payment models on integration.

The authors cite a recent study of U.S. primary care practices that found only 44% were physically co-located with behavioral health clinicians, including 12% of solo practices and 26% of rural practices. The implication is that co-location is the preferred model of providing integrated care. A study comparing the 2 predominant models—co-location and collaborative care—demonstrated a 14% reduction in Patient Health Questionnaire-9 scores (denoting improvement in depression symptoms) in the co-located practices compared with a 33% reduction in the collaborative care practices (7). Co-location has been shown to improve initial visit engagement but not depression outcomes, and it does not ensure effective collaboration. The collaborative care model uses a team, including a care manager, patient registry support, and psychiatric case review. It can also be adapted to a telemedicine-based model, which can be effectively used in many rural areas and in smaller practices. This is especially important in light of the changes in care delivery necessitated by the coronavirus disease 2019 pandemic.

Malâtre-Lansac and colleagues note that significant cultural differences, including expectations for patient visit lengths, supervision of staff, and the lack of a shared treatment vocabulary, can exist between behavioral and nonbehavioral health clinicians and serve as barriers to successful integration. Interprofessional hierarchies also presented challenges. Developing, supporting, sustaining, and growing integrated care teams is the best remedy to ameliorate these cultural differences. The effectiveness of the team and the degree of collaboration and synergy among team members are important parts of the therapeutic process (8). In any practice transformation, strong and consistent leadership paired with a clear vision and support of the desired outcome is critical to success.

The integration of physical and behavioral health into practice is not possible without investment of human capital and additional forms of payment for services. Malâtre-Lansac and colleagues cite several recent statutory and regulatory changes favorable to increased coverage. The Patient Protection and Affordable Care Act made possible one of the largest expansions of mental health and substance use disorder coverage in U.S. history. In states that expanded Medicaid under the Affordable Care Act, access to substance use disorder treatment has increased dramatically (9). Pay-

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ment parity for behavioral health services has been an important contributor to increased access.

One of the practice leaders interviewed for the study summed up the current situation well: "Philosophically, this [behavioral health integration] model is not meant to succeed in fee-for-service . . . ." The value that primary care and cognitive services bring to the U.S. health care system is underappreciated. For primary care to reach its potential for achieving better health for persons and populations, fundamental changes must occur in payment and delivery systems. The current pandemic has exposed the fragile state of primary care and underscores the need to strengthen the foundations of our system. Malâtre-Lansac and colleagues have provided us with excellent insights to continue our sacred work to improve care of the whole person.

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