

The role of mental health is receding in favor of behavioral health care and now, primary health care; this trend will continue:

Mental health services have declined in the last 10 years, along any service measure used, both in total expenditure for mental health services, and for the value of mental health service in the health care marketplace. For the past 10 years, limitations on caps and deductibles in health plans have not changed. This decrease in mental health services is seen in the way benefits are designed, with nearly one-half of the health plans imposing annual visit limitations in 1997, up from one-quarter of the health plans in 1988. Even with the passage of the Mental health parity act, there is an uneven "patchwork of coverage" in the states for behavioral health care, which may or may not include coverage for substance abuse treatment as well. Mental health care is being reduced both for outpatient and inpatient services, and in the number of office visits made to psychiatrists. There has been a decrease in ambulatory mental health visits from 313 per 1000 encounters in 1991 to 285 encounters per 1000 in 1996. There has been an 86% reduction in the average length of stay for patients needing psychiatric hospitalization in 1996. Additionally, mental health is losing its distinctiveness under managed care arrangements with "Behavioral health care" redefining traditional mental health services, broadening it to include substance abuse; developmental disabilities, and, forensic mental health services. Behavioral health care activities for each of these disorders can range from emergency care to rehabilitation. According to Mechanic the stigma of mental illness and substance abuse are reflected, in part, in this shrinking pool of resources and services allocated to behavioral health care. For example, behavioral health care contracts may only pay for less attractive type of service, e.g., group therapy instead of individual therapy; or only for social work clinicians instead of a psychiatrist. In addition, confidentiality and anonymity are lost to patients in managed care organizations who may be concerned about continued employment or health benefits, when their diagnoses become known through automated billing and medical records.

Specific states have developed either one of two models for the provision of Medicaid mental health/substance abuse (MH/SA) services under managed care. One model delivers MH/SA service separately from physical health care. The other model integrates some MH/SA services into the provision of physical health care. Both models have changed the delivery of MH/SA services, and states have had to implement various systems for the dissemination of MH/SA funds as a result of these changes. One model, the carve out approach, places Behavioral Health Managed Care Organizations (BHMCOs) in control of the provision of MH/SA services under a separate capitation rate, or arranges with other authorized organizations to provide MH/SA services. The other model, the partial carve out approach, continues to offer some MH/SA services under the physical Managed Care Organization's (MCOs) capitation rate, and contracts with BHMCOs or other organizations to offer services not covered in the capitation rate.

Under the best of circumstances, primary care providers in MCOs are trained to screen and recognize mental health/substance abuse problems and to either treat or refer appropriately. In reality this "gatekeepers" role is minimal. Patients coping with depression, anxiety, substance abuse, or domestic violence are not often queried as to their quality of life, and their MH/SA needs. Indeed, the limited patient encounter time available to a provider (often 10 minutes or less) under managed care serves to work against comprehensive care, especially dealing with the complex human service needs of patients with MH/SA disorders.

Most authorities agree that patients' access to services and patient health outcomes are positively impacted when MH/SA is integrated into primary care practice, which is a goal of managed care organizations. Primary care practitioners now provide the majority of mental health services. Health outcomes of people with such illnesses as diabetes and cardiovascular disease have been shown to improve when a 'patient-centered' approach incorporating MH/SA service is implemented in primary care settings. The primary care practitioner must have the knowledge, capability and skill to assess patients for mental disorders. Primary care practitioners also recognize the need to increase their clinical competence in assessment, diagnosis and treatment of acute and/or chronic mental disorders in order to appropriately treat patients themselves.

The literature has conflicting findings about the effectiveness and efficacy of one type of mental disorder, major depressive disorder, when treated by primary care providers. For example, one study showed that patient characteristics may affect the willingness of a patient to be assessed for mental health problems in a primary care setting. A comparison between treatment modalities for depressive disorders showed no statistical significance in treatment outcomes in one instance. In another instance, it was the mental health intervention that produced better treatment compliance and outcomes than the intervention by the primary care provider. Another study looked at the amount of time a practitioner spent with a patient depending upon the

patients' source of payment, and concluded that there was more counseling of the fee-for-service patients than of the prepaid patients in the same practice setting. Currently, there are ongoing studies of the effectiveness of the Agency for Health Care Policy and Research practice guidelines in treating major depressive disorder in primary health care and in mental health settings, which is an evaluation of "evidence based" practice. The field of managed care primary health care in mental health services is relatively young compared to the experience of traditional mental health providers. There are many issues to be sorted through in these new forms of health care service delivery.

Is a merger of mental health and primary care in the offing with the amalgamation of behavioral health services? It may be too early to answer that question. However the trends show that managed care is influencing not only clinical practice, but the medical school and health education curriculums. A population-based perspective rather than an individual treatment perspective is gaining credence in medical education. Primary care clinicians are being trained in "evidence-based, epidemiologically sound medicine" with traditional public health courses such as Epidemiology, Biostatistics and the Biopsychosocial basis of mental disorder added to the medical school curriculum. There is also a movement toward developing a Managed Care Medicine curriculum, which highlights interdisciplinary training between Medical School Departments, and partners with Managed Care Organizations.

Managed behavioral health care with its emphasis on screening and on a preventive approach has implications for the MHSIP project. Patient satisfaction can be increased if new treatment modalities imposed by the managed care approach increase levels of functioning, increase customer satisfaction and address patients with dual diagnoses such as mental disorder and substance abuse in one setting. The collection of MHSIP data may well change under these new arrangements, because patient data elements may change. There may be new referral sources and utilization patterns that patients may experience as a result of primary care practice. In addition, organizations' data elements may also have to be broadened to include substance abuse treatment services, and primary health care services. If primary health care further redefines mental health treatment provided by primary care practitioners along the dimensions of severity of condition and functional level of the individual, then a new vocabulary may be needed to classify mental disorders within primary care practice.