Integrating Mental Health Into the Primary Care Model:

The Kiev/Philadelphia Experience

By William E. Aaronson and Aurelia-Nicoletta Bizamcer

The community-based primary healthcare (PHC) model developed by AIHA partners as the basis for the new PHC partnerships is rooted in an expanded definition of health, whose premise is that a community-focused system of primary healthcare results in the greatest improvement of community health status. Considering the extent to which social and behavioral factors influence the health status of a community, such a strategy requires that providers address the mental, as well as the physical, needs of the population served.

The "global burden of disease" is an indicator that takes into account disability and mortality by comparing the toll of different diseases and establishing their importance as public health problems.[1] Disability is quantified by calculating disability adjusted life years for each disease category. A comprehensive study using this approach has shown that the global burden of mental diseases ranks as high as that of cardiovascular or respiratory diseases and surpasses cancer and HIV/AIDS. Taking into account the number of years lived with a disability, depressive disorders considered separately from other afflictions are the leading cause of disability worldwide. And yet the resources allocated to depression—and to mental health in general—are relatively small. Equally troubling is the fact that the World Health Organization has identified depression, anxiety, substance abuse, sleep disorders, chronic fatigue, and somatoform disorders as conditions that can be—but seldom are—appropriately and successfully treated within the primary care setting. A focus on diagnosing and treating behavioral disorders is thus an important strategy for improving community health status on a worldwide basis, as well as a natural extension of the PHC model.

The Collaborative Model of Care in Primary Practice

Mental disorders account for a high proportion of worldwide healthcare costs that are due not only to the mental disorder *per se*, but also to a highly inefficient use of medical care. A 1995 study[2] showed that primary care patients in the United States with depression or anxiety have annual healthcare costs twice those of unafflicted patients. These costs included pharmacy, laboratory, general, and specialized care expenses. Consequently, improved early detection and management of mental disorders has become a cornerstone of both managed care policies and the training of primary care providers during the past decade. The purpose of this approach is to offset costs by training family physicians to manage mental disorders, and non-physicians—nurses, social workers, etc.—to assess, educate, counsel, and monitor the treatment of mental disorders at the primary practice level.[2] This primary care/mental health partnership defines the collaborative model of care, a team-based approach that integrates mental health services into primary healthcare practices.

The collaborative model of care described above is most likely to offset costs for three categories of patients with mental problems: elderly medical patients, primary care patients with multiple and unexplained somatic complaints, and non-elderly alcoholic patients

Central to this model is a multidisciplinary team approach that brings together family physicians and mental health professionals to design a patient's therapeutic plan.[4] An effective team design requires a process that includes:

- informational input from the widest range of sources (patients, families, and other stakeholders);
- sufficient diversity of expertise;
- clear descriptions and job expectations for providers;
- all providers taking an active role in the decision-making processes;
- effective networking with other agencies within the community; and
- a responsible leader.[5]

Integration of Mental Health Services: The AIHA Mental Health Task Force

In the summer of 1999, a group of mental health professionals from Ukraine and Kazakstan visited the United States as part of an AIHA-sponsored Mental Health Study Tour. The purpose of the tour was to examine the delivery and financing of primary mental health services in the United States and to develop a strategy for the delivery of primary mental health services in their own country. As part of the study tour, participants met with members of AIHA's Kiev/Philadelphia partnership, including the Health Federation of Philadelphia; the Philadelphia Department of Health, Community Behavioral Health unit; the psychiatric intervention team at the Crozer-Chester Medical Center; and the behavioral health team at the Maria

de Los Santos Community Health Center. (For more information see "Mental Health Study Tour" and "Choosing the Path to Recovery" in the September 1999 issue of *Connections*.)

After the tour, the AIHA Mental Health Task Force (MHTF) was formed to look at ways to address mental health issues in Ukraine. Members of the task force include some Ukranians who attended the study tour as well as some American partners. Based on their observations, the MHTF recommended integrating mental health services into the PHC model and suggested that the Kiev/Philadelphia partnership take on the task of demonstrating the effectiveness of this approach by including these services in a PHC model center being developed for the Kharkiv Rayon of Kiev City.

The MHTF recommendations can be summarized as follows:

1. Train family physicians, nurses, psychologists, and social workers to:

- diagnose and treat persons with primary mental health or substance abuse problems;
- refer patients with more complex mental disorders to mental health specialists; and
- develop an approach based on joint family practitioner-mental health professional case management.

2. Develop Clinical Practice Guidelines to standardize the diagnostics, treatment, and case management of mental disorders in PHC settings, including guidelines for:

- initial assessment;
- diagnostic tools;
- referral protocols;
- treatment of disorders not requiring psychiatric intervention; and
- a team approach to case management.

The partnership accepted the challenge and agreed to integrate mental health services into its PHC work plan.

The Partnership Project

In July 1999, the Kiev/Philadelphia partners identified the development of a model family practice center (FPC) as the primary goal of their partnership. Because the model was to include a teaching component as well as service delivery, it was agreed that a family medicine residency program along with training programs for nurses and other health professionals would be developed. The project is particularly challenging because the concept of family medicine is in its infancy in Kiev and the traditional approach to residency training was mainly didactic regardless of speciality. The integration of a primary mental health services component into the model made it even more difficult. Still, we agreed to work toward the development of an FPC that includes mental health and health promotion and prevention services along with the more traditional medical responsibilities assumed by primary care practitioners. We also agreed to plan a working conference at the end of the first year of the partnership to discuss the process and suggest strategies for replicating the model that we were about to develop.

Among the Philadelphia partners, both the Center for Family Health (CFH) and Delaware Valley Community Health Inc. have in recent years pursued strategies of integration of mental health services into their primary care delivery modalities, and were thus able to share their knowledge and experience. The Kiev partners provided the foundation upon which to build the collaborative model. The Medical Territorial Unit (MTU) of the Kharkiv Rayon is responsible for the delivery of all ambulatory services within that rayon and provides the managerial structure for the FPC, including the designation of the FPC director. In addition, MTU met with and organized local NGOs, which worked with various members of the community, such as Chernobyl victims and veterans of the war in Afghanistan.

The partnership faced a substantial number of problems. First, while psychiatry in Ukraine is as advanced as in most nations, few mid-level providers and primary care physicians are knowledgeable in the delivery of primary mental health services. Second, as in any startup operation, behavioral health services have the potential to be overwhelmed by the larger goal of developing a model FPC.

Building the Collaborative Model of Care

The partners were acutely aware that a successful, collaborative model requires a team approach that includes a specific mix of trained professionals. If there are insufficient professional resources, a strategy to expand the pool or retrain current professionals to fill the newly created roles needs to be identified. This, in turn, requires the understanding and acceptance of an integrated approach to care delivery. Staffing proved quite a challenge.

First, while psychiatric nurses have expertise in the treatment of persons with mental disorders, they lack experience and training in primary care. Likewise, psychologists and social workers are inadequately prepared for work in primary medical care settings. Second, while nurses and psychologists are available for hire, the labor market for social workers is quite tight. Ukraine, like many other transitional countries, has been the recipient of much foreign assistance, especially in support of NGOs. Social workers, already in limited supply, are in great

demand by foreign managed or supported NGOs, which pay more than local, government-sponsored healthcare facilities.

Unfortunately, the partnership was unable to identify a social worker to participate on the team. However, we did hire a recently graduated psychologist and a psychiatric nurse as the mental health providers. The nurse also agreed to be trained as a social case manager.

The "Mini Internship"

To build team focus and specific professional skills, six Ukranian healthcare professionals from the staff of the future Kharkiv Rayon FPC were sent to Philadelphia in May 2000 for intensive training. The were taught to recognize mental disorders prevalent in primary practice; to assess psychosocial aspects of illness; to practice basic counseling skills; and to function in a multidisciplinary team. The group included two family physicians, two nurses, and the two mental health professionals.

The theoretical foundation for the training was based on WHO's "Programme Guidelines: Mental Disorders in Primary Care" manual. According to Dr. Bedirhan Ustun of WHO's Division of Mental Health, the manual is clinician-friendly, management-oriented, and flexible enough to be applied in many different countries. The materials were developed specifically to assist primary care providers in diagnosing and managing common mental disorders by improving the knowledge, skills, and behavior of the primary care providers. While the manual does define "provider," it does not provide guidance in the implementation of the collaborative model.[6]

The training program itself focused on teaching primary care providers counseling, cognitive-behavioral, and problem-solving techniques using standardized case studies of Russian-speaking patients who illustrate the types of mental health disorders frequently encountered in primary practice, specifically depression, anxiety, and somatization. The multidisciplinary team practiced collaborative interactions during simulated case conferences.

One of the more important behavioral health issues seen in the primary care setting is domestic violence. The Kiev partners requested training in this area because primary care providers tend to be reluctant to discuss this subject with their patients. The Philadelphia Family Violence Coordinating Council has developed a program called RADAR:[7] A Domestic Violence Intervention for Health Care Providers, specifically designed for the primary care setting. The training package includes several easy-to-use guides for the assessment of and response to suspected domestic violence. The manual was translated into Russian and is available upon request.[8]

During an interactive teaching exercise that is commonly used in US medical schools, the healthcare professionals from Kiev had the opportunity to interview four standardized patients—all native Russian speakers—who mirrored common physical complaints that often result from mental health concerns such as depression, physical abuse, and addiction.

(Left) During a standardized patient role play, Dr. Oksana Yashchenko (right) interviews a young woman—really an actor—who is presenting with physical manifestations of a mental disorder.

(Below) Alla Melnick (left), a psychiatric nurse/social worker, gently questions a "patient" presenting with symptoms of irritable bowel syndrome about her home life to determine if her complaints are rooted in stress and depression.

Photos: Kathryn Utan.

Three healthcare organizations in the Philadelphia area offered the human and logistic resources for the training: Maria de Los Santos Community Health Center, Crozer-Keystone Health System, CFH, and Elwyn Inc, an internationally known organization devoted to providing services to the mentally and physically disabled.

The training continued in June, with more emphasis on the collaborative aspects of care as well as on the clinical supervision of mental health professionals. The latter is particularly important since the mental health providers working in the FPC will require ongoing training and supervision. It is therefore important to have clinical mental health consultants in place. Consultants who work in a psychiatric institution were identified and oriented to the project. The clinical supervision team will be provided with further training through the partnership. In addition, all of the FPC staff participated in a management workshop in July, which focused on team-

building and collaboration, and completed the initial phase of the training process.

The FPC opened October 27, 2000. The collaborative model will be implemented and supported through ongoing training of the providers. During the coming year, partners will focus on identifying barriers to collaboration, developing specific training programs to overcome these barriers, and developing profession-specific skills necessary for primary mental health care delivery.

The Future of the Collaborative Model

The Kiev/Philadelphia partnership and the Ukranian MHTF reiterated in June 2000 the need for further training in areas such as clinical supervision, counseling, depression, anxiety, handling of chronic cases, domestic violence, substance-related disorders, management of HIV-related conditions, post-traumatic disorders, and continuous quality improvement. These topics were covered at the AIHA-West NIS Behavioral Health Conference held September 2000 in Kiev (see October 2000 *Connections* and the Winter 2001 *CommonHealth* for more information on the conference). The purpose of the conference is to present our collaborative model to the other PHC partnerships in West NIS.

The mental health integration project was a natural extension of the PHC model developed by AIHA, which embodies current primary healthcare provision trends.[9] These trends include the movement from inpatient to outpatient, and from specialty to primary care. Given that support for these trends requires a focus on consumer needs, community health, and underlying behavioral factors, primary care in the future will be based on collaborative teams. The Kiev/ Philadelphia PHC partnership has been built on this premise and will continue to grow in this direction. Replication of the mental health integration project will depend on the ability of other partnerships to adopt a collaborative approach to primary care delivery.

In the coming months, the partners intend to develop the collaborative model further. This will require additional training of the entire Kiev team engaged in the delivery of, or referral to, primary mental health services. Use of standardized patients—a term that describes actors or clinicians who role play the part of a patient during an educational exercise—and simulated case conferences will continue with the clinical leaders of the CFH assuming more of the training and supervisory responsibility. In particular, the mental health team will require ongoing clinical supervision from mental health professionals. Effort will be devoted to the training of the consultation and supervision team, consisting of one psychologist and one psychiatrist. As learned through our experience with mental health integration into primary care in Philadelphia, this supervisory team is the key link in the process of integration of mental health services. While we have great faith in this model, only a through evaluation will tell us whether the model works. Therefore, monitoring and evaluation will be the last, and perhaps most important, aspect of next year's work plan.

Photo: Kathryn Utan.

Dr. John Zapp, director of the Crozer-Keystone (Philadelphia) Family Practice Residency Program, explains the Center's function as a teaching facility and its audio-visual system, which allows for the taping and review of resident-patient interviews.

References

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2. L.V. Rubenstein *et al.*, "Evidence-based care for depression in managed primary care practices," Health Affairs, **18** (5), 89-105 (1999).
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5. S. Onyett, "Community mental health team working as a socially valued enterprise," J. Mental Health, **8** (3), 245-251 (1999).
6. The manual can be viewed on-line at www.who.int/msa/mnh/ems/primacare/edukit/index.htm.
7. RADAR is an acronym standing for: R = Routinely screen female patients; A = Ask direct questions; D = Document your findings; A = Assess patient safety; R = Review options and referrals. RADAR has been translated into Russian as РАДАР: Р = Рутиное обследование; А = Абсолютно прямые вопросы; Д = Документируйте собранные данные; А = Адекватно оценивайте безопасность пациента; Р = Рассматривайте варианты и направления.
8. The RADAR Domestic Violence Training Project is led by Martha Davis, MS, and Janice Asher, MD. Information about the project and the organization that has developed it (the Institute for Safe Families) can be found at http://hometown.aol.com/psrphila.
9. D.B. Seaburn *et al., Models of Collaboration: A Guide for Mental Health Professionals Working with Primary Care Practitioners* (Basic Books, 1996).

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