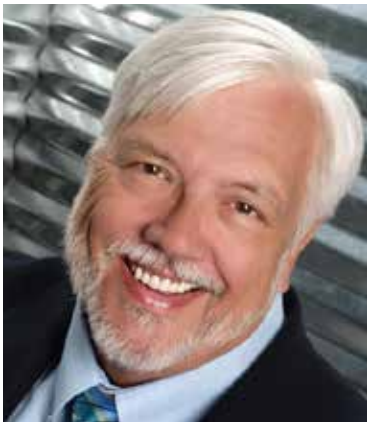
Mental Health: A Forgotten Facet of Primary Care



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One of the biggest disparities in health care today is the separate treatment of mind and body, despite their known integration.[1] While mental and behavioral health conditions are frequently diagnosed and treated within primary care settings, fragmentation persists between the mental and physical health care systems—creating barriers in the quality, outcome, and efficiency of care.[2] Since half of Americans with mental health conditions go without essential care, reform of our nation's mental health system is a priority issue for NPs and PAs and the patients we serve.

Some progress has been made to implement change—the *Now Is the Time* initiative, launched in 2013, increased federal funding for behavioral health care workforce training in an effort to support more providers in mental and substance use disorder treatment. The Affordable Care Act (ACA) has worked to improve behavioral health coverage for Americans in three ways: ending insurance company discrimination based on pre-existing conditions, requiring health insurance coverage for mental and substance use disorder services, and expanding mental health parity. This has improved coverage and access to mental and substance abuse services for more than 60 million Americans.[3] In January 2016, President Obama proposed a $500 million investment to increase access to mental health care.[4] The most recent presidential election creates an uncertain future for mental health—particularly if the ACA is repealed. We do know, fortunately, that mental health care reform is part of the platform published by President-elect Trump.

Regardless, more work has to be done to guarantee that Americans have the access they need. Sadly, even with these advancements in behavioral health coverage, only about half of children and less than half of adults with diagnosable mental health disorders get the treatment they need.[4] A 2016 report from the Rural Health Research Center revealed that more than 15 million Americans face behavioral health issues without access to the necessary care.[5]

Psychiatric providers (like most other specialists) tend to be located in urban areas, limiting access in rural areas and even some underserved urban communities. Only 43% of family physicians in this country provide mental health care.[6] The team-based care that NPs and PAs provide has great potential for bridging this gap in mental health coverage.

NPs and PAs are an important but underutilized resource for improving mental health care access—but how can primary care NPs and PAs work to enhance the delivery of mental health care in our country? In the preprofessional area, it would be prudent to entice qualified individuals in the mental health field—particularly those who are licensed clinical social workers, licensed professional

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counselors, or marriage and family therapists—into NP and PA programs with preference.

Clinical rotations in behavioral health (BH)/psychiatry should be encouraged—even mandated—in professional education. We should ensure this content is taught in the didactic portion of NP/PA professional education, as well as bolstering psychiatric pharmacology in coursework.

Postprofessional education should encourage primary care NPs and PAs to gain additional self-directed education in BH/psychiatry. This can be achieved via a focused psychiatry "boot camp" (for PAs following the CAQ blueprint, found at **www.nccpa.net/psychiatry**) or a competency-based online postprofessional certificate in BH/psychiatry (such as—shameless plug—the one offered at my institution; **www.atsu.edu/postgraduate-certificate-in-psychiatry-and-behavioral-health-online**).[7,8]

This psychiatric background is fundamental throughout primary care but is crucial in community health centers, correctional health care centers, and Veterans Administration hospitals. Of course, in order to make a difference, we must remove the barriers that prevent psychiatric NPs and PAs from being considered mental health providers and adjust reimbursement accordingly.

Do you have ideas on how to increase the knowledge base of primary care NPs and PAs and enhance the provision of mental health services in this country? Will the political change in leadership in January 2017 increase opportunities to make a difference in mental health care? Please share your thoughts by contacting me at PAEditor@frontlinemedcom.com. **CR**

REFERENCES

1. deGruy F. Mental health care in the primary care setting. In: Donaldson MS, Yordy KD, Lohr KN, Vanselow NA, eds. *Primary Care: America's Health in a New Era*. Washington, DC: Institute of Medicine; 1996.
2. Simon GE, Katon WJ, VonKorff M, et al. Cost-effectiveness of a collaborative care program for primary care patients with persistent depression. *Am J Psychiatry.* 2001;158(10):1638-1644.
3. Enomoto K. Improving access to mental health services - President's FY 2017 Budget proposes new investments to increase access. http://abilitychicagoinfo.blogspot.com/2016/02/improving-access-to-mental-health.html. Accessed November 3, 2016.
4. Enomoto K. Improving access to mental health services. www.hhs.gov/blog/ 2016/02/09/improving-access-mental-health-services.html. Accessed November 3, 2016.
5. Rural Health Research Center. Supply and distribution of the behavioral health workforce in rural America. http://depts.washington.edu/fammed/rhrc/wp-content/uploads/sites/4/2016/09/RHRC_DB160_Larson.pdf. Accessed November 3, 2016.
6. Miller BF, Druss B. The role of family physicians in mental health care delivery in the United States: implications for health reform. *J Am Board Fam Med.* 2013;26(2):111-113.
7. National Commission on Certification of Physician Assistants. Psychiatry CAQ. www.nccpa.net/psychiatry. Accessed November 3, 2016.
8. A.T. Still University. Postgraduate certificate in psychiatry and behavioral health online. www.atsu.edu/postgraduate-certificate-in-psychiatry-and-behavioral-health-online. Accessed November 3, 2016.