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Facilitators and Barriers to Integrating Behavioral Health and Primary Care to Increase Mental Health Utilization and Access in the Asian American Community

Abstract

Background. Amongst Asian Americans with any mental health disorder within the last 12 months, 8.6% of individuals sought general care (e.g., primary care provider, religious leader), while only 3.1% actually intentionally engaged with specialized mental health services (e.g., licensed therapist, psychiatric, medication management).[1] The underutilization of mental health services is shown to contribute to worsening health outcomes for various diseases.[2] Previous literature has shown that integrating behavioral health and primary care may be effective in increasing mental health utilization and access.[3] However, there is limited information on supports needed by organizations and providers to implement integrated care. The aim of this study is to identify facilitators and barriers to integrating care. ***Methods.*** Interviews ($n = 6$) were conducted amongst providers and community-based organization (CBO) behavioral health administrators. Content analysis was conducted to identify the main findings from the transcripts. ***Results.*** Several barriers and facilitators of integrating care were identified. ***Conclusion.*** Recommendations were made on the clinical and systemic level to address barriers to integrating care.

Key words: *integrated care, Asian American, mental health access, mental health utilization*

INTRODUCTION

According to the National Latino and Asian American Study conducted between 2002-2003, Asian Americans experience a lifetime prevalence of 9.1% for depressive disorders, compared to 17.9% in non-Latino Whites.[1] Amongst Asian Americans with any mental health disorder within the last 12 months, 8.6% of individuals sought general care (e.g., primary care provider, religious leader), while only 3.1% engaged in specialized mental health services (e.g., licensed therapist, psychiatric, medication management).[4] There is a clear disparity and underutilization of mental health services when compared to the general population, which engages in specialized mental health care at 8.8%.[4] Despite the necessity for mental health services in the Asian American community, there continues to be significant underutilization of services.

There are various factors explaining the underutilization of mental health services in the Asian American community. Structural barriers include the high cost of services, language/cultural incompatibility with providers, low mental health literacy, difficulties navigating the healthcare system, and being underinsured.[5,6] Cultural barriers include the lack of culturally appropriate providers and mental health stigma.[6] Within the Asian American community, numerous studies cite mental health stigma as a significant barrier to mental health utilization.[6–10] Underutilization of mental health services often results in delays or absence of care. Delays in care consequently increase the morbidity and mortality of mental illnesses, worsening outcomes for comorbid conditions and potentially the prognosis of a mental illness.[11]

Mental and physical health are inextricably tied together. If an individual experiences mental health symptoms, it can negatively impact their ability to manage chronic illnesses. In a cross-sectional household survey on community-dwelling adults, researchers found that there were significant associations between mental disorders and increased risk of onset for many chronic physical illnesses.[2] For example, individuals with a comorbid diagnosis of depression and diabetes often experience a 1.5-fold increased risk of mortality.[12] This is potentially explained by a decline in healthy behaviors like exercise and proper nutrition, which may worsen the condition.[12] In addition to worsening health outcomes, there are also economic ramifications for untreated or delayed care.

Untreated or delayed care for mental illnesses often leads to a worse prognosis, which may incur additional health care costs. According to the National Alliance on Mental Illness, untreated mental illness cost the U.S. economy nearly $300 billion due to lost productivity, employee turnover, and higher medical and disability expenses.[13] For youth, untreated and delayed care lowers high-school completion rates, which leads to lower life-time earnings.[14] Consequently, lifetime per-patient healthcare burden is higher than for individuals that were able to complete school.[15] Undoubtedly, lower behavioral health utilization poses significant individual and societal consequences. However, integrating behavioral and primary care may address significant barriers to mental health access.

Previous literature indicates that integrating behavioral health care may be effective in increasing mental health utilization and access.[3,16] An example of this is the Collaborative Care Model (CoCM) from the Advancing Integrated Mental Health Solutions (AIMS) Center at the University of Washington. CoCM integrates behavioral health services into primary care settings through the use of a Behavioral Care Manager who links the primary care provider with a psychiatric consultant and coordinates all aspects of a patient's care.[3] Although the literature identifies integrating behavioral health care into primary care settings as effective, there's limited research

on the perspectives of primary care providers and behavioral health specialists on what is needed to support this work.

The aim of this project was to:

1. Identifying factors that increase mental health access in the Asian American community
2. Identifying supports to facilitate mental health access at in integration in primary care settings

METHODS

Participants and Setting

Convenience and snowball sampling were conducted from November 2022 to March 2023. Semi-structured interviews were conducted in English with various health care providers (e.g., primary care providers, social workers, therapists) and health care administrators (e.g., outpatient behavioral health program directors) (*n= 6*) in the Seattle metropolitan area. Participants came from three CBOs or outpatient clinics. One behavioral health CBO had partnerships with other primary clinics, another primary care clinic integrated care within their organization, and the third primary care clinic was in the process of expanding and integrating behavioral health services into their primary care setting. Two out of the three clinics served a primarily Asian American and Native Hawaiian and Pacific Islander community.

Interviewers were between 25-45 minutes. Both providers (*n = 4*) and administrators (*n = 2*) were recruited to provide a holistic perspective on barriers and facilitators of behavioral health and primary care integration on the individual and organizational/systemic level.

Interview Guide

The semi-structured interview guide was developed in consultation with the Pacific Hospital Preservation and Development Authority. There were two versions of the guide, aimed at healthcare providers (e.g., primary care physician, licensed mental health therapists, social workers) and health care administrators (e.g., behavioral health directors). The interview guides (see Appendix A and B) explored four domains: 1) participants' backgrounds, 2) role of the organization or provider in behavioral health care, 3) facilitators to successful integration, and 4) areas of additional support. Based on participant responses, the interviewer would probe additional areas of interest.

Data Analysis

A codebook was created deductively, based on the interview guide.[17] Deductive coding was then used to code each transcript. As there is only one coder, a constant comparative method was used to code interviews.[18] The primary coder selected the first transcript based on the richness of content and length of interviews. Using a qualitative coding software, Dedoose 9.0.107, each transcript was coded and recoded as the codebook was updated.[18] The final codebook contained 14 codes, and 4 concepts were identified: 1) openness to behavioral health services differed by age and requires different levels of support to engage individuals in behavioral health , 2) facilitators and barriers to integrating behavioral health services and access, 3) systemic recommendations, and 4) clinical recommendations.

RESULTS

Openness to behavioral health services differed by age and requires different levels of support to engage individuals in behavioral health

A couple participants indicated generational differences between older and younger patients. Older patients were generally less open to behavioral health services, knew the least about the purpose of a behavioral health provider on mental well-being, at times confused about the purposes of a behavioral health referral and appeared less trusting of behavioral health providers.

> *"…Many of… them, they… kind of… look puzzle, like, 'Where am I at?...Who are you?... They just don't know why they're here, and so it'll take the case manager some… effort to explain to them. What… we do and what are our…roles".* – Outpatient behavioral health clinic therapist, LMHC

The challenges of engaging patients and building rapport were exacerbated by the COVID-19 pandemic as services were provided over telehealth or phone. When behavioral health providers attempted to engage with patients, some patients felt their emotional distress were problems that should and could not be resolved by "outsiders", such as professionals. Stigma was a commonly cited barrier to openness towards mental health services.

> *"…Patients tend to say, 'Oh, it's just like a me problem… It's something that I can just deal with. It's not really that big of a deal'… They seem to act like it's more of a deficit with themselves[,] that they need to deal with than something that a behavioral health provider can really help them with".* – Outpatient primary care provider, MD

Factors needed to engage patients with behavioral health referrals

Several participants mentioned various barriers for patients engaging with a behavioral health referral. Reasons include time constraints of a provider, limited staffing (e.g., no dedicated staff member to coordinate inter-organization referrals), infrastructure and limited language/interpretation support. These factors affect a provider's ability to do warm hand-offs even within a clinic, which poses significant barriers for clients to engage with the referrals.

> *"Yeah, so it's just been really hard… I think I've only been successful 1 out of...probably 20 times that I've tried [providing warm hand-offs]."* – Outpatient primary care provider, MD

> *"I think the success… [is] the thoughtfulness of the recommendation. Where they actually sit down and talk to you[,] acknowledging your symptoms, struggles[,] and talk about… the specific symptoms that you're listing or troubles that you're listing"* – Outpatient behavioral health clinic therapist, LMHC

Some participants shared that their clients appeared less than keen on engaging in behavioral health services when a provider does not speak their language, but were more accepting when of services when their patients knew they could communicate with their provider.

> *"Having Cantonese and Mandarin speaking providers…. [It] really… help[s] push people towards accepting going there [outpatient behavioral health][,] because… before people*

weren't really too keen on the idea of going there and having…, [to] talk through an interpreter." – Outpatient primary care provider, MD

Another provider noted how overwhelming it can be for their clients to independently initiate referrals they were given because of how difficult navigating the healthcare system can be as a non-English speaker. Patients calling primary and behavioral health clinics face significant barriers,

"…[F]or integration of any kind of care, the complexity of the medical system… [can] really prevent… people who don't speak English, to even get started with the navigation… you have to understand English to reach a point that you can request [an]interpreter… I have clients who don't even know the 26 letters. So if you don't speak English at all, it's just like you just have to have someone else to help you out…" – Outpatient behavioral health director, MSW

There are several facilitators, which include: training for providers on the processes of behavioral health organizations, internal systems that gauge behavioral health provider availability in the moment, warm handoffs from the primary care provider, language and cultural concordant therapists, client-led and client-centered care, normalizing mental health symptoms/diagnoses, and having access to different types of providers within the same clinic.

Facilitators and barriers to integrating behavioral health services and access

Most participants mentioned these facilitators to behavioral health integration and access includes: 1) thoughtful recommendations to behavioral health services from providers, 2) walking with patients through every step of a referral process, and 3) allowing patients agency over their treatment goals. Structurally, increased staffing and facility resources, and creating 'one-stop-shop' clinics, where there are different types of specialties, would increase collaboration and integration between providers. Consequently, this would improve client care.

"Patients seem to be more open to hearing about mental health and behavioral health issues when you bring in how they're connected to physical issues." – Outpatient clinic primary care provider, MD

"If they are not ready to accept… the term mental health needs, then you focus on their presenting problems. And that's how you build the relationship. I hear you. It must be really hard for you to have that problem. So let's work on that." – Outpatient behavioral health director, MSW

"I'll tell them… if you're sleep is so bad, then the damage from the harm from not getting enough sleep actually overweigh the side effects of medication… I think this a lot of times… [it] helps them to switch their mindset and realize, 'Oh… yes, if I'm not sleeping well… my body is getting… harmed… and… damaged'." – Outpatient behavioral health clinic therapist, LMHC

Commonly cited barriers to behavioral health integration and access include: primary care provider time constraints, limited culturally appropriate staffing, limited resources for more severe or specialized cases in clinics that integrate care, and funding requirements. Funding requirements dictate patient eligibility and reimbursement rates for services. This limits access to patients who may have missed cut-offs or patients who aren't making linear progress.

> *"There's certain metrics that we're beholden to… And if we don't [meet those metrics], we don't get reimbursed at the same rate. Well, the problem with that is a lot of these models are built on folks… [with] some level of privilege, right? So say I'm experiencing homelessness... I come back the next week… and I still have the same score, and that continues. For us, that's considered a failure… But for me, I look at my patient population and I'm like… this person in the interim… experienced an episode of violence. Somebody harmed her… some other trauma occurred. So actually her depression staying at an even level rather than getting much more exacerbated is a sign of success"* – Outpatient primary clinic director, LICSW

During primary care appointments, providers must address patient needs, while parsing out whether symptoms are attributed to mental or physical etiology. Consequently, there is limited time to explain the role of behavioral health services. Additionally, limited staffing and resources resulted in fewer successful warm handoffs. One provider shared that their patient is less likely to engage in behavioral health services if a warm hand-off was not successful during the primary care appointment.

It was suggested that more training on how behavioral health organization's function would help primary care providers better ease patient concerns about navigating the referral process. This was corroborated by a therapist at a behavioral health organization, who felt primary care providers had limited knowledge of how behavioral health services function.

> *"It's- it's kind of hard because I'm like, well, call this number. And I'm like, 'I don't know what happens after you call that number'…It [would be] helpful to know a little bit about the intake process for things… I think being able to discuss it with the patient, so they know what to expect, and it doesn't seem like something… so scary and daunting to them."* – Outpatient primary care provider, MD

> *"Definitely more training [and] education, especially when we talk to someone who apparently don't know… any type of… community behavioral health organizations."* - Outpatient behavioral health therapist, MSW

RECOMMENDATIONS

Systemic

1. There is a need for integrated care models that are more flexible and able to serve individuals with more intensive mental health care needs.

2. Incentivize care coordination either through providing grant-funding that allows organizations to hire dedicated individuals that coordinate referrals or incentivize care coordination by primary care providers by providing reimbursement. This is because primary care providers and behavioral health specialists face significant time constraints.

3. Broaden who can be considered on the care team (e.g., increasing the role of peer specialists) and provide reimbursement for their services.

> *"We also need to be able to broaden who can be on our care team and be reimbursed for their work. Not everybody wants to go to school for a thousand*

years… Folks who come from specific communities who know how to sit there and hold that space are incredible partners to clinicians… [they] work with us to help us better understand how to support folks… we need the ability to broaden our care teams and not just be a bunch of middle aged white ladies." – Outpatient clinic director, LICSW

4. Enable the community to become clinicians – offering pathways to enter and move up without years of schooling *or* providing tuition assistance for Masters degrees.

   "If we value lived experience, we should have leaders and our orgs with lived experience. Like, there should be a pathway forward for them that's not dependent on formalized education." – Outpatient primary clinic director, LICSW

   "I think [that] systematically… we have to address staffing shortage, staffing compensation, workforce issues… If I cannot find staff, I cannot do a good job integrating the program… [or] providing culturally competent services. And this staffing shortage and workforce issues is coming from the nature of…[the] work we're doing… It's… about the respect, and the compensation for the people who are working in the field." - Outpatient behavioral health director, MSW

5. Valuing and respecting behavioral health providers on a similar level to medical providers (e.g., doctors, nurses) – offering more compensation for community-based behavioral health employees.

   "…Providing an ability to pay behavioral health as well as we do medical providers… We're raising up our awareness of the importance of behavioral health and how it's actually not just better for patients, but a tremendous cost saving… we have to start… shifting the paradigm of what we value and paying attention to people providing that care, and then just helping folks be able to access the education needed to get there" – Outpatient primary clinic director, LICSW

   "We cannot do our job if we cannot pay our staff well. People are not going to come into the field because you don't get paid well, you don't get respect for the important work that you are doing… The whole world [is] recognizing behavior health is an integral part of people's whole health. They should get paid way better than now, so that we can really do a good job providing these services to our clients." – Outpatient behavioral health director, MSW

   "… They feel like [the] social worker can be… disrespected…You don't have to respect [the] social workers' opinions… That happened probably quite often in the medical setting, like when they work as a team… Doctors think they… have the biggest perspective, the biggest picture of the patient, the case, and they don't have to listen. Like they welcome social workers input, but they- they don't value it much… That kind of like problem is still existing and that is… reflected on the pay as well… If your workers get paid much less than other providers, you will be devalued… your opinion, your input, your involvement in client's care will be dismissed... You are not any nurse who is calling in… with a professional knowledge…" – Outpatient behavioral health clinic therapist, MSW

6. Enabling a pay structure that allows providers to spend more time with patients.

Clinical

1. Standardized online electronic health record systems are needed for inter-organization care coordination. Furthermore, there needs to be more ways to bring organizations together to build trust and familiarity with other outside providers. Better communication between community organizations, partners and clinics is critical to integrating care, increasing access to behavioral services. which would result in higher quality care.

   > *"…My God, it's just so hard to… exchange information. People think that, 'ohhh, you guys are using EPIC.' That doesn't mean that we can share the information together. It's a complicated system … UW has its own EPIC. We have… EPIC, managed by this… company called OCHIN… there other providers using EPIC by… Providence. …We cannot communicate. We cannot community… [I]f… somehow we can make… so that we can communicate and coordinate through EHR system that will be also very wonderful…"* – Outpatient behavioral health director, MSW

2. Providing education on mental health topics through commonly used platforms such as WeChat, local language concordant newspapers for different Asian American communities, or funding for CBOs to facilitate mental health education workshops for non-English speaking individuals.

   > *"I think more education, more education… because… Chinese communities here, they… use WeChat a lot. They heavily rely on… WeChat. And to a lot of seniors, i[t] is… pretty much the only information source."* – Outpatient behavioral health clinic therapist, LMHC

3. Client-centered, client-led care that allows client the agency to partner with providers on their treatment, which will foster trust, therapeutic rapport and receptiveness to provider suggestions.

4. Integrating mental health symptoms into physical health to help clients conceptualize how mental health will physically affect their body.

5. Training for primary care providers on the behavioral health organizations referral processes, and training for social workers/therapists on navigating the broader healthcare system.

CONCLUSION

Integrated care has the potential to destigmatize and increase access to behavioral health services, while improving patient outcomes because of its whole-person approach. However, there remains several barriers that providers and community-based outpatient clinics with integrating care. Significant challenges and areas of needed support include designing a standardized system and incentivizing inter-organization care coordination and collaboration. This would result in more efficient use of limited community resources. Furthermore, the strength of inter-organization collaboration and integration often affect a patient's openness to behavioral health services.

Having culturally responsive providers (beyond interpretation services), who are well respected, from the community and valued is crucial to the success of integration. Finally, emphasizing the importance of client-centered, client-led interventions and treatment plans is crucial to developing trust between providers and individuals.

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Appendix A

PHPDA Interview Guide 2022 #1

Target Interview Population: Primary care providers (PCP) include family physicians, family medicine residents, internists, nurse practitioners, DNPs, LMHCs, case managers and physician assistants.

Introduction

Hello, my name is _____ , I am a UW Masters of Public Health Candidate and a Health Equity Scholar for the Pacific Hospital Preservation and Development Authority. Today, I will interview you about increasing mental health access through integrating behavioral health and primary care services. Thank you for agreeing to participate in this interview. I really appreciate you taking the time to talk with us.

Complete Consent Process Before Starting Interview

Before we start, I would like to go over the verbal consent process and address any questions or concerns you may have. The interview should take no more than 1 hour and is completely voluntary. You can opt out at any time.

Would it be okay if I record the audio for this interview? The recording won't be shared with anyone outside our team and is used to aid notetaking. If at any point you want to make a comment off record, I will stop the recording and restart when you finish your comment.

Finally, I wanted to let you know that this interview is confidential, and all the interviews will be combined with information from other participants. Your responses will be anonymous.

Aims:

- Identifying factors that increase mental health access in the Asian American community
- Identifying supports to facilitate mental health access in primary care settings

Questions

Background

1. What is your job title and role at your organization?
2. What percentage of your patients do you typically refer to behavioral health services?
3. When a client is in need of mental health services, what does this referral process look like, is it a warm handoff or it is limited to a referral?
4. Does your clinic integrate care between physical and behavioral health (e.g. BH services are located within the clinic)?

Role in Behavioral Health Care

5. Do patients address their BH concerns with you?
6. How do you approach sensitive BH topics with your clients? How do patients respond when discussing these topics?

Barriers and Limitations to BH Access and Integration

7. Ideally, what do you believe facilitates a successful referral and initiation of BH services in your patients?
8. Do you feel you have the training needed to accurately identify and refer patients to mental health services while centering their cultural needs?

Areas of Support

9. What support do you need as a provider to integrate BH and physical healthcare services?
10. What additional resources would your organization find helpful in providing culturally responsive mental health referrals (care)?

Additional Questions from Interview Guide V1

→ Do you feel equipped as a provider to identify BH problems?
→ What constraints do you have in providing culturally responsive mental health referrals?

CONCLUDING REMARKS

Thank you for your valuable insight and time. Again, all information is kept confidential. We'll use this interview to better understand factors that increase mental health access in the Asian American community. Is there anything else you'd like to add before we conclude?

Appendix B

PHPDA Interview Guide 2022 #2
Target Interview Population: Behavioral Health Directors

Introduction

Hello, my name is _____ , I am a UW Master's of Public Health Candidate and a Health Equity Scholar for the Pacific Hospital Preservation and Development Authority. Today, I will interview you about increasing mental health access through integrating behavioral health and primary care services.. Thank you for agreeing to participate in this interview. I really appreciate you taking the time to talk with us.

Complete Consent Process Before Starting Interview

Before we start, I would like to go over the verbal consent process and address any questions or concerns you may have. The interview should take no more than 1 hour and is completely voluntary. You can opt out at any time.

Would it be okay if I record the audio for this interview? The recording won't be shared with anyone outside our team and is used to aid notetaking. If at any point you want to make a comment off record, I will stop the recording and restart when you finish your comment.

Finally, I wanted to let you know that this interview is confidential, and all the interviews will be combined with information from other participants. Your responses will be anonymous.

Aims

- Identifying factors that increase mental health access in the Asian American community
- Identifying supports to facilitate mental health access in primary care settings

Questions

Background

1. What is your job title and role at your organization?
2. Does your clinic integrate care between physical and behavioral health (e.g. BH services are located within the clinic)?
3. When a client is in need of mental health services, what does this referral process look like, is it a warm handoff or it is limited to a referral?

Role in Behavioral Health Care

4. What role does your organization play in facilitating behavioral health services?
5. How does your organization approach sensitive BH topics with patients? How do patients respond when discussing these topics?

Barriers and Limitations to BH Access and Integration

6. Ideally, what do you believe facilitates a successful referral and initiation of BH services in patients?
7. Do you feel the organization's non-behavioral health providers have the resources needed to accurately identify and refer patients to mental health services while centering their cultural needs?

Areas of Support

8. What support does your organization need to integrate BH and physical healthcare services?

9. What additional resources would your organization find helpful in providing culturally responsive mental health referrals (care)?

CONCLUDING REMARKS

Thank you for your valuable insight and time. Again, all information is kept confidential. We'll use this interview to better understand factors that increase mental health access in the Asian American community. Is there anything else you'd like to add before we conclude?