Exploring ways to expand women's access to behavioral health

Policy recommendations to utilize reproductive health providers to expand behavioral health

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Executive Summary

Numerous studies and reports, including by the National Academy of Medicine and the U.S. Department of Health and Human Services, have found that women and men experience mental health issues differently. According to the Centers for Disease Control and Prevention, about one in ten women of reproductive age experienced at least one major depressive episode in the past year. But the majority of these episodes go undiagnosed: of those experiencing depression in the past year, nearly two-thirds of pregnant women and about three-fifths of nonpregnant women did not receive a diagnosis, and only about half of these women actually received treatment for depression.

Policymakers are missing an opportunity to address these behavioral health needs by encouraging greater integration of reproductive and mental health services. Many women of reproductive age (RA) consider their ob-gyn to be their primary care clinician. Nearly 60 percent of RA women reported seeing their ob-gyn on a regular basis, and a third of RA women viewed their ob-gyn as their main health provider. Further, 70 percent of women with undiagnosed and untreated mental health needs had contact with a healthcare provider in the previous year, many for reproductive health services. **Thus, reproductive health providers such as ob-gyns and nurse practitioners can play a unique and critical role in the diagnosis and treatment of mental health issues.**

But to do so, policymakers must invest in resources to ensure reproductive health providers have the capacity, ability, and resources to join efforts to integrate primary care and behavioral health to help RA women access the behavioral health services. Policies that reduce or even prevent reproductive health providers from participating in these efforts will only hurt efforts to improve outcomes, lower costs, and enhance patients' experiences.

Introduction

Due to many factors from the fragmented and complex nature of American healthcare to changes in science and culture, many healthcare stakeholders—health systems, communities, and patients and their families—have acknowledged decreasing costs, improving outcomes, and enhancing the individual experience will be unobtainable without addressing mental health and substance use disorders (SUDs).[1] This Triple Aim of healthcare has highlighted shifting healthcare from simply acknowledging mental health and SUDs to determining how they can be integrated into larger delivery and payment reform efforts. Without better integrating mental health and substance use services, it will be a challenge to achieve these goals as well as create a true culture of whole health.[2]

In 2009, the Office of Women's Health (OWH) within the U.S. Department of Health and Human Services (HHS) released a report, "Action Steps for Improving Women's Mental Health," which outlined the reasons to consider gender in the provision of mental health services as well as existing public and private resources. Of note, the report included a conceptual framework of issues affecting women's mental health with three being directly relevant to healthcare reform:

- As a health systems issue, the report notes "[f]amily planning and women with major mental illness" as a concern, and
- In regards to both access to care and insurance, the report notes both "[a]ccess to appropriate care through primary care providers and mental health specialists" and "effects of racial and ethnic disparities in health service access and delivery."[3]

The report though did not expand on the conceptual framework or on the various issues it touched on.

Since that report was released, current healthcare debates on everything from reform efforts to reproductive health are a stark reminder that how you enter into the healthcare system is different depending on who you are, your coverage, and your needs. Women often enter the

[1] Don Berwick et al, "The Triple Aim: Care, Health, and Cost," *Health Affairs* (2008), 759.

[2] Ben Miller et al, *Creating a Culture of Whole Health: Recommendations for Integrating Behavioral Health and Primary Care* (2016), available at http://farleyhealthpolicycenter.org/wp-content/uploads/2016/02/Culture-of-Whole-Health-Full-report.pdf.

[3] Office of Women's Health, "Action Steps for Improving Women's Mental Health," available at http://attcppwtools.org/ResourceMaterials/Action%20Steps%20for%20improving%20womens%20mental%20health.pdf. It is not entirely clear if the report is still available on the OWH website or if it has been removed.

healthcare system differently than men, and many women of reproductive age (RA)[4] consider their obstetrician-gynecologist (ob-gyn) to be their primary care clinician. The Affordable Care Act (ACA) includes many provisions to increase women's access to care, including requiring direct access to an ob-gyn[5] and codifying offices of women's health within HHS and its sister agencies.[6] The ACA also spurred along delivery system reform to encourage greater efficiency and care coordination, including ongoing efforts to increase access to primary care and mental health services. But despite the 2009 OWH report's cursory references to challenges to women's access to mental health services, there has been not been a robust discussion of how to link these efforts around delivery system reform. Thus, policymakers and healthcare systems should consider ways to include reproductive health providers in redesign efforts that improve women's access to comprehensive care, including mental health and substance use services.

This paper will explore:

- The relationships between mental health, SUDs, and overall health
- The gender differences in mental health needs
- Examples of integration efforts, particularly for mental health services
- Recommendations for policymakers and healthcare stakeholders to consider as they try to better integrate mental healthcare

For the purpose of this paper, behavioral health refers to both mental health and SUD services together. In discussing public policy around behavioral health, it is important to avoid stereotyping women, perpetuating misconceptions about gender and mental health, and further stigmatizing those seeking either behavioral health services or the full range of reproductive health services, including abortion. For example, the World Health Organization (WHO) has argued that

> Adding a gender and rights perspective helps to move away from a stereotyped conceptualization of reproductive health problems as "women's troubles." A gender and rights perspective moves beyond biological explanations of women's vulnerability to mental disorder to consider their vulnerability to a range of human rights violations. This vulnerability has little to do with biology and much to do with gender-based inequalities in power and resources. From a gender and

[4] For purposes of this paper, women of reproductive age are between 18 and 44 years old.

[5] Section 2719A(d) of the ACA.

[6] Section 3509 of the ACA. For more on these offices, see "Creation of Offices of Women's Health at the federal level," https://www.womenshealth.gov/30-achievements/17 (April 1, 2019).

rights perspective, improvements in women's reproductive mental health are contingent on the promotion and protection of women's human rights rather than the paternalistic protection of women as the "weaker sex." [7]

I. Clarifying some key terms for policy discussions

As policymakers and healthcare stakeholders think through opportunities to better integrate primary health providers to ensure their patients' behavioral health needs are addressed, it is important to have a good understanding of what may be meant by terms such as "behavioral health" or "integration" of behavioral health and primary care.

A. Clarifying mental health from behavioral health

Often the terms "behavioral health" and "mental health" are used interchangeably,[8] but there are important distinctions between the two.[9]

Behavioral health conditions can range broadly from anxiety, mood, and depressive disorders to SUDs.[10] They are also more common than many people may realize: nearly a third of adults met the diagnostic criteria for a behavioral health problem in the past year, and over half meet the criteria at some point in their lifetime. The Agency for Healthcare Research and Quality (AHRQ) describes behavioral healthcare as "[a]n umbrella term for care that addresses any behavioral problems bearing on health, including [mental health] and [SUD] conditions."[11]

Mental healthcare is "[c]are to help people with mental illness (or at risk) to suffer less emotional pain and disability," while care for SUDs includes "[s]ervices, treatments, and supports to help people with addictions and substance abuse problems suffer less emotional pain, family and vocational disturbance, [and] physical risks." Both types of care help those

[7] World Health Organization, *Mental Health Aspects of Women's Reproductive Health* (2009), 5. Such a frame may also help dispel or eliminate claims that seek to link depression and other mental health conditions with abortion or birth control.

[8] See, e.g., Mary Butler et al, *Integration of Mental Health/Substance Abuse and Primary Care* (2008) ("The terms mental healthcare and behavioral healthcare are often used interchangeably in the literature; in this report we used the term mental healthcare, which also encompasses substance use disorders."), *available at* https://www.ncbi.nlm.nih.gov/books/NBK38636/.

[9] A table of definitions is located in Appendix A.

[10] Kaiser Family Foundation, "The Role of Medicaid for People with Behavioral Health Conditions" (2012), available at https://kaiserfamilyfoundation.files.wordpress.com/2013/01/8383_bhc.pdf.

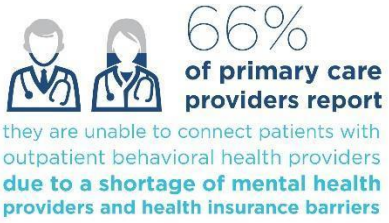
[11] AHRQ, *Lexicon for Behavioral Health and Primary Care Integration* (2013), 9.

suffering from either mental health or SUDs to "live healthier, longer, more productive lives."[12]

B. What is behavioral health integration?

AHRQ has defined behavioral health integration as:

> The care that results from a practice team of primary care and behavioral health clinicians, working together with patients and families, using a systematic and cost-effective approach to provide patient-centered care for a defined population. This care may address mental health, substance abuse conditions, health behaviors (including their contribution to chronic medical illnesses), life stressors and crises, stress-related physical symptoms, and ineffective patterns of healthcare utilization.[13]



Facilitating integration is garnering more attention from policymakers and healthcare providers interested in achieving the "Triple Aim," or improving population health and the care experience while reducing costs. [14] Given the fragmentation of our healthcare system and issues such as workforce challenges, approximately 66% of primary care physicians reported that they could not get a referral for their patients for mental health.[15] Integration could help respond to community needs and gaps in services by providing more ready access to behavioral health clinicians.[16]

An estimated seven out of ten of adults with a mental health condition also have at least one physical health condition.[17] Similarly, individuals with chronic conditions such as diabetes,

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[12] Id.

[13] Peek & National Integration Academy Council, 2013, p. 1

[14] Don Berwick et al, "The Triple Aim: Care, Health, and Cost," *Health Affairs* (2008), 759.

[15] Mark Olfson, "Building the Mental Health Workforce Capacity Needed to Treat Adults With Serious Mental Illnesses," *Health Affairs* (2016), 984.

[16] Institute for Healthcare Improvement, *90-Day R&D Project Final Summary Report: Integrating Behavioral Health and Primary Care* (March 2014), 2 ("In short, integration is associated with better physical and behavioral health outcomes, reduced costs,[3] and better patient experience of care.").

[17] David Kendall and Elizabeth Quill, "Treating the Whole Person: Integrating Behavioral and Physical Healthcare" (2015), available at http://www.thirdway.org/report/treating-the-whole-person-integrating-behavioral-and-physical-health-care.

arthritis, and heart disease are three times more likely to have depression.[18] For example, one-fifth of patients who have just had a heart attack suffer from depression, and if the patient's depression is left untreated, the chance of dying from a future heart attack triples.[19]

In delivery reform discussions, policymakers and stakeholders may mean different things when they discuss how to integrate behavioral health with primary care.[20] In practice, there are different ways that such services can be delivered to provide a patient with both primary care and behavioral health services:

> Behavioral healthcare may be *coordinated* with primary care, but the actual delivery of services may occur in different settings. As such, treatment (or the delivery of services) can be *co-located* (where behavioral health and primary care are provided in the same location) or *integrated*, which means that behavioral health and medical services are provided in one treatment plan. Integrated treatment plans can occur in co-location and/or in separate treatment locations aided by Web-based health information technology. Generally speaking, co-located care includes the elements of coordinated care, and integrated care includes the elements of both coordinated care and co-located care.[21]

AHRQ, too, has noted that integration must be something more than co-locating services in a healthcare practice.[22] Co-locating services "denotes shared space… not a specific service or kind of collaboration."[23] Rather, true integration should ensure that there is "no wrong door" for any problem that an individual brings to a primary care provider, a goal that is easier said than done.[24]

To provide a full continuum of care for RA women, policymakers must incorporate reproductive health providers into efforts to integrate primary and behavioral health services. Otherwise,

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[18] Id.

[19] Id.

[20] Benjamin Miller et al, "Creating a Culture of Whole Health: Recommendations for Integrating Behavioral Health and Primary Care" (2016), 11 ("For behavioral health and primary care integration, this definition has been elusive because integration may be interpreted differently depending on who you are, where you are, and what you do.").

[21] Chris Collins et al, Milbank Memorial Fund, *Evolving Models of Behavioral Health Integration in Primary Care*, 12, available at https://www.milbank.org/wp-content/uploads/2016/04/EvolvingCare.pdf.

[22] AHRQ, *Lexicon for Behavioral Health and Primary Care Integration* (2013), 9.

[23] Id.

[24] Id.

policymakers will fail to assist many women who enter the healthcare system through reproductive health providers. Additionally, policymakers must invest in reproductive health providers so that they have the capacity, ability, and resources to participate in these larger delivery system reforms.

II. What are women's behavioral health needs?

The statistics on mental health both globally and domestically are quite daunting. According to the WHO, half of the ten leading causes of disability globally are related to mental health, with depression being the most common.[25] More than 150 million people experience depression each year worldwide.[26] According to AHRQ, untreated depression is responsible for "considerable functional impairment, poor adherence to treatment, adverse health behaviors that complicate physical health problems, and excess healthcare costs."[27]

In reviewing the literature on women and behavioral health, women have different needs for mental health and SUD services than men and may need a different way to access these services. For instance, the American Psychological Association (APA) released a set of guidelines in 2007 for providing care to women and girls, noting that "women are two times more likely than men to be depressed" and "two to three more likely to experience many types of anxiety disorders."[28] The guidelines stress intersectionality, urging clinicians to recognize how these intersections—race, ethnicity, socio-economic status, and other factors—have a role in influencing a woman's health and well-being.[29] Additionally, the APA guidelines recognize that reproductive health can be a factor in a woman's or girl's mental health: "issues associated with reproduction and childbirth can evoke a range of feelings from joy to fear in women and girls. Today, women have greater freedom of choice regarding whether to become a parent and how they want to manage childbirth… than they did decades ago."[30] Women can experience stresses due to "social pressures and negative stereotypes" due to reproductive health issues

[25] World Health Organization, *Mental Health Aspects of Women's Reproductive Health*, 1.
[26] Id.
[27] Thomas Crogan and Jonathan Brown, Agency for Healthcare Research and Quality, "Integrating Mental Health Treatment Into the Patient Centered Medical Home," 2, available at https://pcmh.ahrq.gov/sites/default/files/attachments/Integrating%20Mental%20Health%20and%20Substance%20Use%20Treatment%20in%20the%20PCMH.pdf.
[28] American Psychological Association, "Guidelines for Psychological Practice With Girls and Women," *American Psychologist* 949 (December 2007).
[29] Id. at 951.
[30] Id. at 955.

such as abortion, sexually transmitted diseases, or infertility concerns.[31]

Understanding these needs may help lead to the development of policy solutions to better meet RA women's mental health needs. Depression is the most frequent women's mental health issue and the leading women's health problem overall.[32] Worldwide, women experience depression approximately twice as often as men and commonly exhibit physical symptoms such as tiredness, dizziness, palpitations, sleep problems, and aches and pains.[33] Mental health conditions can negatively impact reproductive health functions, including avoiding pregnancy, becoming pregnant, and the pregnancy itself, as well as affecting an infant's health and development.[34]

In 2010, the Centers for Disease Control and Prevention (CDC) released a study on RA women and their mental health needs.[35] In a sample of such women, about one in ten women experienced at least one major depressive episode in the past year.[36] But the CDC found that most of these episodes go undiagnosed: of those experiencing depression in the past year, nearly two-thirds of pregnant women and about three-fifths of nonpregnant women did not receive a diagnosis.[37] According to a subsequent CDC study, only about half of women with depression actually received treatment for it, generally through medication or

Women and Substance Use Disorders (SUDs)

While addressing SUDs and reproductive health is beyond the scope of this paper, we wanted to highlight a few key points related to women's health.

In general, men are twice more likely to have a SUD than women, but women are more likely to experience adverse physical and mental effects from alcohol or other drugs. For example, men and women begin smoking for different reasons and respond differently to treatment options: men smoked more "for the reinforcing properties of nicotine" while women tended to smoke "to regulate negative affect and stress," and because most FDA-approved medications for smoking cessation target nicotine, women responded less positively to these medications than men.

Further, women are less likely than men to enter treatment although seemingly little difference between men and women in staying in treatment. Some studies suggest that gender-specific treatment programs produce better results for women; however, such programs are declining in availability, particularly in rural areas.

With the passage of the 2016 Comprehensive Addiction and Recovery Act and the 2018 Substance Use–Disorder Prevention that Promotes Opioid Recovery and Treatment for Patients and Communities Act, policymakers are rethinking the approach to SUDs. As these laws are implemented, policymakers should consider investing in more research into how women respond to SUDs and treatment options and utilizing SAMHSA's advisory committee on women's health.

counseling.[38]

Despite this prevalence, much of the research on RA women and their mental health needs seems to focus on them during pregnancy or on postpartum depression.[39] For example, a 2018 workshop at the National Academy of Medicine brought together governmental officials, clinicians, and researchers to consider women's mental health needs across their lifespan as well as needed changes to policy and practice.[40] Importantly, participants discussed the need for an intersectional approach that includes many factors, including but not limited to race, class, origin, migration status, and gender/sex.[41] Further, several participants referenced the importance of family planning as part of women's well-being.

Such discussions should be lifted up given how many women, particularly RA women, enter the healthcare system. Reproductive health providers can play a unique and critical role in the diagnosis and treatment of mental health issues. Nearly 60 percent of RA women reported

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[31] Id. at 955-56.

[32] World Health Organization, *Mental Health Aspects of Women's Reproductive Health*, 1.

[33] Id.

[34] Id. at 2.

[35] Sherry Farr, "Mental health and access to services among US women of reproductive age," *American Journal of Obstetrics and Gynecology* (2010), 542.e7 (describing the CDC study as the first report to review the mental health needs of nonpregnant women of reproductive age). One important note is that the CDC study used data from 2006 through 2007, prior to the passage of either the Mental Health Parity and Addiction Equity Act in 2008 or the ACA two years later. The ACA not only expanded coverage for many women through many states' Medicaid expansions and subsidized insurance offered through newly-created exchanges but also ensured that behavioral health was considered an essential health benefit that must be covered by insurance plans.

[36] Center for Disease Control and Prevention, "Mental Health among Women of Reproductive Age," 2.

[37] Id.

[38] Jean Ko et al, "Depression and Treatment Among U.S. Pregnant and Nonpregnant Women of Reproductive Age, 2005-2009," *Journal of Women's Health* (Aug. 2012), 830-36.

[39] Id.

[40] National Academy of Medicine, *Women's Mental Health across the Life Course through a Sex-Gender Lens: Proceedings of a Workshop in Brief* (April 2018). It is not clear what, if any, next steps will be taken from this workshop as repeated contacts to the NAM were not returned.

[41] Id. at 2. Intersectionality is also recognized in the aforementioned APA guidelines.

seeing their ob-gyn on a regular basis.[42] Further, many women consider their ob-gyn to be their primary care provider, and nearly half of all ob-gyns consider themselves to be delivering primary care.[43]

On the other hand, some policy reports fail to acknowledge gender differences: for example, the March 2016 report by the President's Mental Health and Substance Use Disorder Parity Taskforce does not contain the words "women," "female," or "gender." Focusing on mental health needs beyond just when a woman is pregnant also would recognize that depression has not only consequences for a woman's health but also for socioeconomic indicators such as work, education, and interpersonal relationships.[44]

RA women may be more forthcoming to—and be very interested in talking to— reproductive health providers about their mental health. A CDC study noted that "70% of these undiagnosed and untreated women had contact with a healthcare provider in the previous year, many for reproductive health services."[45] However, the CDC did not know whether the women's mental health conditions went undiagnosed because reproductive health providers did not ask their patients about mental health concerns—because of a lack of time, training, or referral options— or whether these patients did not want to volunteer such information. Relatedly, another survey found that RA women are more likely to be honest and open with their ob-gyn than with other providers (56% to 40%).[46] Similarly, the survey found that RA women also felt that their ob-gyn was more likely to talk to them about intimate topics than other providers (47% to 23%) but less likely to engage in mental health issues (21% to 25%). Since RA women are speaking to their ob-gyns about critical issues that may be sources of stress—their relationships, their ability to start a family, being diagnosed with an STI—there is room to recognize the link between reproductive and mental health.

Further, it is critical to recognize there are significant mental health disparities for women of color. The CDC found that women "with a high prevalence of undiagnosed depression were

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[42] Planned Parenthood and PerryUndem, "Women + OB/GYN Providers" (2013), 9, available at https://www.plannedparenthood.org/files/4914/0656/5723/PPFA_OBGYN_Report.FINAL.pdf.

[43] Amritha Bhat et al, "The Obstetrician-Gynecologist's Role in Detecting, Preventing, and Treating Depression," 129 *Obstetrics & Gynecology* 157 (Jan. 2017).

[44] Centers for Disease Control and Prevention, "Mental Health among Women of Reproductive Age," available at https://www.wvdhhr.org/wvhomevisitation/prenatal/Mental_Health_Women_Repo_Age.pdf (last visited Oct. 29, 2017).

[45] Farr at 542.e7.

[46] Planned Parenthood and PerryUndem, "Women + OB/GYN Providers" (2013), 9, available at https://www.plannedparenthood.org/files/4914/0656/5723/PPFA_OBGYN_Report.FINAL.pdf.

younger (65.8%), African American (73.1%), Hispanic (68.0%), of other racial and ethnic groups (67.6%), and uninsured (65.8%)."[47] In another study, Latinas are nearly twice as likely to be diagnosed with either a mood or an anxiety disorder as Latinos but are less likely than women of other ethnic groups to use mental health services.[48] Language is a barrier for many Latinxs: immigrant and Spanish-only-speaking Latinxs have less access to mental health services than other ethnic groups and US-born Latinxs.[49] In part, these disparities may be due to "double stigma," or the barriers to care impacting many communities of color that are then compounded by stigma around mental illness within the African American and Latino communities.[50]

Women of color also are more likely to experience stressors and other social determinants of health that have an impact on mental health: African American women are at a higher risk for depression than white women because of factors such as income, education, job security, physical health, and stigma around mental illness.[51] RA women of color are more likely to live in communities that lack access to mental health services.[52] Addressing these disparities will require policymakers and stakeholders to think innovatively and to recognize how RA women come into the healthcare system.

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[47] Ko at 830-36.

[48] Laila Hochhausen et al, "Community-Based Mental Health Service Utilization Among Low-Income Latina Immigrants, *Journal of Community Mental Health* (2011), 14.

[49] Id.

[50] Sarah Vinson, "Mental health," Kelly Report on Health Disparities (2015), 116, available at https://robinkelly.house.gov/sites/robinkelly.house.gov/files/2015%20Kelly%20Report.pdf; see also Mental Health America, "Black & African American Communities and Mental Health" ("Research indicates that Black/African Americans believe that mild depression or anxiety would be considered 'crazy' in their social circles. Furthermore, many believe that discussions about mental illness would not be appropriate even among family."), available at http://www.mentalhealthamerica.net/african-american-mental-health.

[51] Rhonda Boyd et al, "A Pilot Investigation of the Rates and Predicators of Mental Health Services Utilization Among Depressed African American Mothers and Their Children," *Journal of the National Medical Association* (2009); Diane Brown, *In and Out of Our Right Mind* (2003), 3-5; see also Vinson at 116 ("While there is often more emphasis placed on the 'supply' side of delivering services once an illness has developed, there are also great opportunities for lawmakers to impact the 'demand' side of the equation by governing with the social determinants of mental health, environmental issues which increase risk of mental illness and its symptoms, in mind. Some of these social determinants of mental health include childhood trauma, adverse features of housing and neighborhoods, unemployment, food insecurity, and poverty.").

[52] Lynn VanderWielen et al, "Not Near Enough: Racial and Ethnic Disparities in Access to Nearby Behavioral Healthcare and Primary Care," *Journal of Healthcare for the Poor and Underserved* (2015), 1039 ("Therefore, primary care physicians located in urban communities with high percentages of minority and uninsured populations experience the greatest unmet need for geographically-proximate behavioral health professionals.").

III. Where are the advances in delivering mental healthcare?

Even prior to the ACA, many healthcare leaders were debating how and when to incorporate mental health into primary care and other systems reform. For example, the Health Resources and Services Administration (HRSA) and the Substance Abuse and Mental Health Services Administration (SAMHSA), two agencies within HHS, had coordinated efforts through the Center for Integrated Health Solutions and leveraging the two agencies' resources to provide technical assistance to providers interested in integrating primary care and mental health services.[53] Also AHRQ launched the Academy for Integrating Behavioral Health and Primary Care "to collect, analyze, synthesize, and issue actionable information that providers, policymakers, investigators, and consumers can readily use and apply."[54]

At the same time, states, foundations, and academic medical centers are producing research for evidence-based models for integration efforts.[55] For example, the Advancing Integrated Mental Health Solutions Center at the University of Washington has developed the Improving Mood – Promoting Access to Collaborative Treatment (IMPACT) model of care. IMPACT provided the foundation for Collaborative Care, a successful model that has been shown to be effective for not only caring for those with depression but also for other conditions such as anxiety and co-morbid conditions such as heart disease, diabetes, and cancer.[56] Another example of IMPACT in practice is the Depression Improvement Across Minnesota, Offering a New Direction (DIAMOND) program, a partnership between providers, commercial payers, and the Minnesota Department of Health Services.[57] DIAMOND integrates a care manager and a consulting psychiatrist into primary care clinics to offer services such as screening for depressions, a patient registry, treatment, and relapse prevention. The state health department found that DIAMOND's "results are five to 10 times better than for patients with depression treated under 'usual' primary care."[58]

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[53] SAMHRA-HRSA Center for Integrated Health Solutions, "About Us," available at http://www.integration.samhsa.gov/about-us/about-cihs.

[54] AHRQ Academy for Integrating Behavioral Health and Primary Care, "About Us," available at http://integrationacademy.ahrq.gov/about-us.

[55] AHRQ Innovations Exchange Team, "Integrating Behavior Health with Primary Care" (2013) (discussing efforts in California, Colorado, North Carolina, and Vermont as examples), available at https://innovations.ahrq.gov/perspectives/integrating-behavioral-health-primary-care.

[56] Jacqueline Garry Lampert, "Local Examples: Innovations in Behavioral Health" (2015), available at http://www.thirdway.org/memo/local-examples-innovations-in-behavioral-health.

[57] Minnesota Department of Health Services, "Successful Model: Mental/Behavioral Health," available at http://www.health.state.mn.us/divs/orhpc/models/pdf/diamond.pdf.

[58] Id.

Some states used Medicaid waivers and managed-care contracting to move toward integration: for example, under a 2009 Medicaid waiver, two of Tennessee's Medicaid managed care organizations—which operated under a full-risk, capitated payment for all services—could manage behavioral health services and reduce administrative burdens on providers.[59]

The ACA has accelerated innovations by expanding insurance coverage, easing consumers' use of behavioral health benefits, and prompting payment reforms to encourage collaboration. One key provision is Section 2703 of the ACA, which recognizes behavioral health as part of new Medicaid health homes. Under this section, states receive a 90% federal Medicaid match for two years of health home services. Medicaid beneficiaries are eligible to participate in a health home if they have two chronic conditions, having one chronic condition and being at risk of a second, or having one serious and persistent mental health condition.[60] Medicaid health homes must offer comprehensive care management, care coordination, health promotion, transitional care out of the inpatient setting, individual and family support, community and social service referrals, and the use of health information technology if possible.

Additionally, the Centers for Medicare and Medicaid Services (CMS) is encouraging value-based payments and delivery reform efforts, and the agency awarded several states with State Innovation Model (SIM) and Delivery System Reform Improvement Program (DSRIP) grants to foster transformation in their Medicaid programs. Several states used these opportunities to encourage greater integration of behavioral health into primary care. For example, Colorado used its SIM grant to pursue a statewide behavioral health initiative with a goal of ensuring that 80% of residents have access to integrated behavioral healthcare in primary care settings by 2019.[61] Pennsylvania launched two regional pilot programs under its Serious Mental Illness Innovations for Medicaid beneficiaries with behavioral health and at least one chronic medical condition to focus specifically on physical and behavioral health integration and foster collaboration among providers.[62] The results of the pilots found that coordinating care for this population significantly reduced emergency department visits and psychiatric inpatient admissions.[63]

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[59] Lampert at 8-9.

[60] Barbara Ormand et al. Urban Institute, "Health Homes in Medicaid," (2014) at 4.

[61] Lampert at 3.

[62] Center for Healthcare Strategies, "Early Lessons from Pennsylvania's SMI Innovations Project for Integrating Physical and Behavioral Health in Medicaid" (2012), available at http://www.chcs.org/resource/early-lessons-from-pennsylvanias-smi-innovations-project-for-integrating-physical-and-behavioral-health-in-medicaid/.

[63] Center for Healthcare Strategies, "SMI Innovations Project in Pennsylvania: Final Evaluation Report" (2012),

While none of these programs is gender-specific, few pilot or demonstration programs specifically mention women. For example, a report on mental health innovations only presents two examples of notable projects that mention women, with one in the context of pregnancy. The first example discusses a medical home operated by Lone Star Circle of Care, a federally-qualified community health center in central Texas. According to the report, Lone Star offers "primary, integrated mental health [as well as] women's health…. Integrated behavioral healthcare is available to patients of all ages and medical and mental healthcare providers collaborate to address the complete picture of patient needs." The second example is the Massachusetts Child Psychiatry Access Project (MCPAP), which includes MCPAP for Moms to assist providers serving pregnant and postpartum women and their children in preventing, identifying, and managing depression.

In addition to speeding up delivery system reform efforts, the ACA encourages greater utilization of preventive care, both for the general population overall and for specific groups such as women.[64] Many of these reforms were categorized in a 2015 report that HHS delivered to Congress on efforts to improve women's health under the ACA.[65] While the report mentions the need to integrate primary care and mental health, it failed to note that many women considered their reproductive health provider (such as an ob-gyn) to be their primary care provider.[66] The report includes activities by the Office of Population Affairs (OPA), which oversees the Title X family planning program, to educate Title X grantees about the ACA.[67] The report's section on CMS discusses its role in coverage and includes a brief mention of an innovation grant being awarded to the Washington State medical school to increase access to "long-acting reversible contraception," but there is little about CMS's role in family planning through Medicaid.[68] While the report shows much progress at the time toward improving women's health, it also misses the connection between family planning and mental health.

Professional societies such as the American College of Obstetricians and Gynecologists (ACOG) have noted that reproductive health providers are in a strong position to detect depression and

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available at http://www.chcs.org/resource/smi-innovations-project-in-pennsylvania-final-evaluation-report/; see also Kaiser Family Foundation, "The Pennsylvania Healthcare Landscape" (2016), available at http://kff.org/health-reform/fact-sheet/the-pennsylvania-health-care-landscape/.

[64] Bhat, supra note 43, at 157-58.

[65] U.S. Department of Health and Human Services, *HHS Activities to Improve Women's Health As Required by the Affordable Care Act* (2015).

[66] Id. at 79.

[67] Id. at 125-26.

[68] Id. at 99-100.

other mental health issues.[69] While efforts are being made to develop a mental health component of women's medical homes[70] and to create bundles of services for maternal mental health,[71] others are uncertain that ob-gyns receive sufficient training in mental health.[72]

IV. Policy issues for consideration

Clearly there is an unmet need for behavioral health services, particularly for those that serve RA women. Likewise, policymakers and the health sector are interested in improving mental health services to better serve those seeking assistance. But it is a good question whether those policies and efforts are aligned with the needs of women, particularly those of reproductive age. Further, it is important to assess if policies work towards more active integration or inadvertently keep behavioral health services separate from other healthcare services.

This final section attempts to address that question by first looking at recent legislation that could offer some opportunities for reproductive health providers to play a role in new efforts in behavioral health. Second, this section will offer suggestions where policymakers could make these existing efforts, including some of the aforementioned innovations, more accessible for RA women by incorporating reproductive health providers.

A. Potential opportunities as new legislation is implemented

Several new laws may provide opportunities for reproductive health providers. In the 114th Congress, policymakers pushed through several key behavioral health reforms as part of two pieces of legislation, the Comprehensive Addiction and Recovery Act (CARA) and the Helping Families in Mental Health Crisis Reform Act.

As part of a law called 21st Century Cures, Congress passed the Helping Families in Mental Health Crisis Reform Act.[73] While the legislation does not provide new funding, it contains new authorizations and reauthorizations of discretionary programs and new requirements for

[69] Bhat, supra note 43, at 157.
[70] Ellen Poleshunck and James Woods, "Psychologists Partnering With Obstetricians and Gynecologists," *American Psychologist* 344 (May-June 2014).
[71] Susan Kendig et al, "Consensus Bundle on Maternal Mental Health," 129 *Obstetrics & Gynecology* 422 (March 2017).
[72] Abigail Garbarino et al, "Current Trends in Psychiatry Education Among Obstetrics & Gynecology Residency Programs: A Cross-sectional Survey of Program Directors," 43 *Academic Psychiatry* 294 (June 2019).
[73] Hereinafter, the Helping Families in Mental Health Crisis Reform Act, as passed in the 21st Century Cures Act, will be referred to as "Cures" to reflect the omnibus final legislation.

technical assistance that may be of interest to reproductive health providers.

In the 115th Congress, legislators again turned to the opioid epidemic, passing a second package of reforms called the Substance Use–Disorder Prevention that Promotes Opioid Recovery and Treatment (SUPPORT) for Patients and Communities Act. While critics noted that SUPPORT "makes a lot of legal and regulatory tweaks that will attempt to make addiction treatment more accessible, try to make it more difficult for illicit synthetic opioids like fentanyl and carfentanil to slip through the border, and boost research on non-opioid pain treatments," SUPPORT does not contain long-term, sustainable funding for an "expansion of addiction treatment, which is the policy approach that many experts argue is necessary."[74]

Relevant provisions of these laws are summarized in a table in Appendix B.

B. Remaining policy gaps for consideration

There are several areas where both policymakers and the health sector can move efforts to integrate behavioral health services to align better with women's health needs and how women, particularly RA women, enter the healthcare system.

First, health policy tends to focus on care for the chronically ill, given their high healthcare costs and utilization. Relatedly, while there has been more interest in ensuring that this high-cost, high-utilizer population's behavioral health needs, particularly mental health needs, are being met, the focus tends to be on serious mental illness (SMI). As SAMHSA has noted, legal definitions of SMI may gloss over the seriousness of a patient's actual health needs and not match clinical appropriateness:

> Mental disorders typically meeting criteria for serious mental illness include schizophrenia, schizoaffective disorder, psychotic disorders, major depressive disorders, bipolar disorders, and borderline personality disorder. Anxiety disorders (such as obsessive compulsive disorder and panic disorder) or eating disorders… can also meet criteria for serious mental illness….
>
> Many mental health advocates and administrators point out that… all mental illnesses have the potential to produce impairment, interfere with the quality of

[74] German Lopez, "Trump just signed a bipartisan bill to confront the opioid epidemic," *Vox* (Oct. 24, 2018), https://www.vox.com/policy-and-politics/2018/9/28/17913938/trump-opioid-epidemic-congress-support-act-bill-law.

life, or qualify as "serious" according to the federal usage of the term.[75]

Similarly, if policymakers recognize that certain conditions may not rise to the level of SMI but are still serious, this would help move the system toward recognizing the mental health needs of RA women.[76] Such system transformation would account for women's experiences and build in outcomes relevant to RA women. As aforementioned, depression can have a serious effect on a woman's reproductive health and general physical health, but the majority of the women who have experienced a depressive episode go undiagnosed. When and if debates happen over the ACA and the implementation of the mental health section of Cures, advocates will have an opportunity to discuss the need for preventive health interventions in the mental health area generally and for women specifically.

Second, policy and research into RA women's mental health needs should extend beyond the focus on postpartum depression. While postpartum depression is an important and serious issue, the CDC study found that RA women may experience a depressive episode regardless of being pregnant. Given that ob-gyns are the most common health providers that RA women see, there is a great opportunity to reach women, particularly women with an undiagnosed episode, and help them find care.

Finally, at the federal level, HHS should reassess its commitment to women's mental health. At a minimum, this reassessment should include reconvening the OWH taskforce that produced the 2009 report in light of programmatic changes due to the ACA's passage and implementation. This taskforce should include agencies that were not part of the drafting the 2009 report—most notably, CMS and OPA must be included and should report on efforts to address RA women's mental health as part of delivery system reform efforts. Ideally though, the HHS Secretary ought to place an Office of Women's Health within CMS; this agency was not included in Section 3509 of the ACA. Given CMS's wide jurisdiction over issues affecting women's health—from Medicaid coverage to oversight of the ACA insurance exchanges to state delivery state reforms—CMS should have a high-level office to coordinate these policy issues

[75] SAMHSA, "Behind the Term: Serious Mental Illness," 2-3, available at http://www.nrepp.samhsa.gov/Docs/Literatures/Behind_the_Term_Serious%20%20Mental%20Illness.pdf.

[76] Ben Miller et al, "Payment Reform in the Patient-Centered Medical Home: Enabling and Sustaining Integrated Behavioral Healthcare," American Psychologist, (2017) 57-58 ("[S]egregated benefit management by states has downstream unintended consequences in clinical delivery…. Specifically, contracted behavioral health organizations are required to complete certain intake processes and to meet the needs of the most complex patients, which can lead them to prioritize care for complex patients leaving little money for prevention work or care for less complex patients. These disjointed and fragmented financial structures construct unnecessary barriers to whole-person care.").

both internally and across HHS and its agencies.

Conclusion

For many women, particularly RA women, the focus on integrating behavioral health and primary care is leaving out many RA women given that they are more likely to enter the healthcare system through a reproductive health provider. Thus, policymakers and stakeholders must begin to recognize that reproductive health needs should be included in such integration efforts specifically and in delivery system reforms more broadly.

Although the political terrain appears difficult for reproductive health providers for the near future, we offer a few recommendations for policymakers to consider in delivery system and payment reforms:

- **Redefining the scope:** First, policymakers should recognize that efforts to promote mental health must include a focus on women's health. While postpartum depression is a critical health issue, more clinical research should focus on women's behavioral health outside of pregnancy. By focusing and treating women's behavioral health needs throughout their lives, providers and policymakers will likely help reduce healthcare costs and improve patient care both in the short-term and in the long-term. Policymakers sympathetic to women's health and reproductive health issues should look for opportunities to focus broadly on the link between these issues and behavioral health challenges facing RA women.

  Additionally, funding—in the form of grants, pilots, or demonstration programs— must be available for research in this area. While there are models of integration occurring, it is not clear how women's health generally and RA women's health specifically are being measured or addressed.

- **Engaging in discussions around preventive care:** Parallel to the first recommendation, policymakers and other stakeholders should encourage the inclusion of mental healthcare as part of basic preventive care. While SMI is clearly an important and critical topic for policymakers and the health system to address, additional attention should be paid to the role of behavioral health services, particularly mental health, in preventive and primary care.[77]

[77] Miller et al, supra note 58.

The ACA encouraged greater utilization of preventive care through enhanced reimbursement and elimination of co-pays, and similar efforts could be made to ensure that preventive care means more than just physical health services. Such efforts will likely help both RA women and their providers include some level of behavioral health services as part of RA women's care because many women consider their reproductive health provider as their main health provider and the high level of trust placed in them.[78]

- **Foster an environment where behavioral health and reproductive health providers' services are integrated**: It is likely that many reproductive health providers are offering some level of mental health services but not being recognized or reimbursed appropriately for this contribution. They should survey their own offerings as well as what relationships they have with behavioral health providers in order to provide a baseline for future research or delivery system reform efforts. Policymakers and payers should foster an environment where these relationships can develop, grow, and be financially sustainable to better serve RA women.

All providers looking to provide comprehensive healthcare are considering the role that behavioral health plays in their patients' well-being. Similarly, policymakers, payers, and purchasers, too, must create an environment where providers can better address mental health generally but also the unique needs of patient populations like RA women specifically. Policies and practices that reduce or even prevent the ability of reproductive health providers to participate in these efforts will only hurt efforts to improve outcomes, lower costs, and enhance patients' experience.

[78] Planned Parenthood and PerryUndem, "Women + OB/GYN Providers" (2013), 9, available at https://www.plannedparenthood.org/files/4914/0656/5723/PPFA_OBGYN_Report.FINAL.pdf.

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Appendix A
Glossary of Key Terms

The following definitions come directly from the AHRQ Lexicon for Behavioral Health and Primary Care Integration.[79]

Integrated Behavioral Health: The care that results from a practice team of primary care and behavioral health clinicians, working together with patients and families, using a systematic and cost-effective approach to provide patient-centered care for a defined population. This care may address mental health, substance abuse conditions, health behaviors (including their contribution to chronic medical illnesses), life stressors and crises, stress-related physical symptoms, and ineffective patterns of healthcare utilization.

Mental Healthcare: Broad array of services and treatments to help people with mental illnesses and those at particular risk of developing them—to suffer less emotional pain and disability and live healthier, longer, more productive lives. Although often defined separately, substance abuse services sometimes are regarded as part of mental healthcare.

Chemical Dependency/Substance Use Care: Services, treatments, and support to help people with addictions and substance abuse problems of all kinds suffer less emotional pain, family and vocational disturbance, and physical risks and live healthier, longer, more productive lives. Sometimes included under "mental healthcare."

Behavioral Healthcare: A very broad category often used as an umbrella term for care that addresses behavioral problems bearing on health, including patient activation and health behaviors, mental health conditions, substance use, and other behaviors that relate to health. In this sense, behavioral healthcare is the job of all kinds of care settings, and is done by clinicians and health coaches of various disciplines or training, including but not limited to mental health professionals. It is a competency of clinics, not only of individuals.

[79] The Lexicon is available at https://www.ahrq.gov/professionals/systems/primary-care/lexiconannounce/index.html.

Appendix B
Review of recent legislation for provisions favorable to reproductive health

In 2016, Congress passed two massive bills that had dramatic implications for behavioral health. First, the Comprehensive Addiction and Recovery Act (CARA) was an attempt to address the national opioid epidemic through a series of new programmatic authorizations and statutory changes. However, some stakeholders criticized CARA because Congress did not include actual funding to implement these new programs. Second, although predominantly aimed at fostering medical research, the 21st Century Cures Act (Cures) became a vehicle for passing a stalled mental health bill, the Helping Families in Mental Health Crisis Act, as well as new funding for CARA. The passages of Cures and CARA marked a huge step forward in how our nation would address mental health and substance use disorders.

The following tables discuss provisions of Cures and CARA laws that may be of interest to reproductive health providers.

Noteworthy Sections in the Comprehensive Addiction and Recovery Act (P.L. 114-198)		
Section	Description	Potential action
302	authorizes new "Building Communities of Recovery" grants for community organizations to develop statewide strategies to provide recovery services	Such services could include building recovery service and support networks with primary care providers and other health services or conducting education and awareness campaigns to reduce the stigma around substance use disorders and seeking treatment. Reproductive health providers could look to join such networks of primary care providers as well as be a part of public education campaigns.
501	reauthorizes grants for residential treatment programs for pregnant and postpartum women needing care for a substance use disorder	While there is no explicit mention of family planning or STI screening and counseling, reproductive health providers could make a strong case to provide assistance with such services to grantees to provide

		more comprehensive care to women being treated.

Noteworthy Sections of Note in the 21st Century Cures Act (P.L. 114-255)		
Section	Description	Potential action
6004	codifies the Center for Behavioral Health Statistics and Quality, the lead federal agency for behavioral health statistics.	Reproductive health providers could urge the Center to provide greater information on women by age category and mental health needs.
6005	requires SAMSHA to develop a strategic plan every four years.	Reproductive health providers should push to include a specific strategy on reaching RA women who may be in need and involving providers that serve their reproductive health needs.
6008	updates advisory councils serving SAMHSA and its Centers for Mental Health Services, for Substance Abuse Treatment, and for Substance Abuse Prevention.	Reproductive health providers should identify clinicians who satisfy the educational and experience requirements that can also bring attention to the behavioral health needs of RA women.
6021	requires the Assistant Secretary for Planning and Evaluation to provide recommendations to HHS and Congress on improving mental health and substance use disorder treatment and prevention programs. The new law requires the Assistant Secretary to make recommendations on evaluating programs within 180 days of enactment.	Reproductive health providers should offer input to ASPE on issues specific to RA women as a criteria for evaluation.
7001 and 7002	authorizes funding for a new "policy laboratory" to promote evidence-based practices and service delivery models and	If Congress appropriates funding, reproductive health providers may want to look to this laboratory for

	to ensure information and findings are accessible to states, nonprofit entities, and other stakeholders.	funding for projects related to the mental health needs of RA women, and they should look for information and technical assistance as they develop their own models.
8001 and 8002	reauthorize the Community Mental Health Services Block Grant and the Substance Abuse Prevention and Treatment Block Grant.	While most reproductive health providers are unlikely to qualify for these grants, they may want to look to grant recipients for potential partnerships for referrals and possibly even co-locating in some circumstances.
9010	reauthorizes mental health awareness training grants, which are available to state and local governments and nonprofit entities to train staff to recognize signs of mental illness and to be knowledgeable about community resources.	Reproductive health providers may wish to study whether they are eligible for such grants or whether they could work with a state or local government grantee to receive training.
10005	creates a new grant program for states to establish new maternal-depression screening programs or to maintain or improve an existing screen program for either pregnant women or women who have given birth in the previous year. Priority is given to states interested in supporting programs in primary care settings.	While this provision again emphasizes the policy basis toward equating women's mental health needs with pregnancy, this provision may be of interest depending on a reproductive health provider's patient population.
12001	clarifies that nothing in the Medicaid statute prevents a beneficiary from receiving both mental health and primary care services in the same day. This clarification is intended to encourage states to remove billing restrictions that limit	While this new policy may help reproductive health providers interested in offering mental health services, it might also be a model for reform due to any lingering concerns stemming from an HHS

	collaborative care models.	Inspector General's inquiry into billing for family planning and STI in the same visit.

Noteworthy Sections in the SUPPORT for Patients and Communities Act (P.L. 115–271)		
Section	Description	Potential action
1001	Changes Medicaid eligibility for at-risk youth by allowing states to suspend, but not terminate, a youth's Medicaid coverage while incarcerated	
1002	Requires states to ensure former foster youth can retain Medicaid coverage across state lines until the age of 26	
1005	Requires HHS to issue guidance on improving care for infants with neonatal abstinence syndrome and their mothers, and GAO to review gaps in Medicaid coverage for pregnant and postpartum women with SUD	GAO should also consider women's access to behavioral health services prior to pregnancy
1007	Clarifies Medicaid coverage for care to infants with neonatal abstinence syndrome in residential pediatric recovery centers and for counseling and other services for mothers or caretakers	
1009	Requires CMS to issue guidance on Medicaid coverage of telehealth services to address SUDs	
1012	Clarifies Medicaid coverage for pregnant and postpartum women who are receiving care in an institution for mental disease (IMD) for services outside the IMD	Family planning providers could establish relationships with IMD to provide reproductive health
1017	Requires HHS to issue a report on state Medicaid programs' innovations in housing assistance and efforts to reduce homelessness for those with a SUD	Family planning providers may want to find ways to partner with such housing initiatives to provide in-home care
5022	Requires Children's Health Insurance Programs (CHIP) to cover mental health benefits, including SUD services, for eligible pregnant women and children with no financial or utilization limits on such	Family planning advocates should ensure postnatal care is also covered in their state CHIP plan

	services that are lower than those placed on physical health services	
5032	Requires HHS to convene a stakeholder meeting and produce a report on healthcare needs of individuals transitioning out of public institutions	The report should be representative of the needs of females transitioning out of institutions, including their family planning and reproductive health needs.
6001	Encourages health information technology (IT) incentive payments for behavioral health providers	Family planning providers that do integrate mental health into their practice should consider if this option could provide opportunities for robust health IT infrastructure
7061	Requires HHS to issue a report on pain management during pregnancy and preventing, identifying, and reducing opioid-related and other SUDs during pregnancy	
7062	Requires HHS to periodically issue a report on prenatal opioid use and neonatal abstinence syndrome	
7063	Requires SAMHSA and CDC to develop educational materials for pregnant women on pain management	
7064	Authorizes HHS to collect and analyze data related to prenatal use of tobacco, alcohol, and other substances	
7065	Authorizes HHS to provide grants to states to improve plans of safe care for substance-exposed infants, including training professionals, establishing partnerships, and improving technology	Family planning providers should assess their role in safe care planning and whether they can be included in reforms
7071	Authorizes funding for HHS to offer loan repayment program for professionals working in SUD treatment in either mental health professional shortage areas or counties found to be hardest hit by drug overdoses	

7102	Requires HHS to work with the Education Department to disseminate best practices on preventing or recovering from SUDs in children, adolescents, and young adults	Advocates should ensure that such materials recognize intersectionality of youth's experiences and are based on evidenced-based approaches
8083	Authorizes grants to state to build capacity for family-focused residential treatment	Family planning and reproductive health should be part of services offered by a treatment program
8212	Expands grant authorization under CARA to include entities focus on addiction and that specialize in family and patient services, patient advocacy, and educational information	