

A New Kind of Homelessness for Individuals With Serious Mental Illness? The Need for a “Mental Health Home”

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Individuals with serious mental illness often are unable to access consumer- and family-oriented community care, resulting in repeated hospitalizations, incarceration, and homelessness. The “medical home” concept was developed in primary care to provide accessible and accountable services for individuals with chronic medical conditions. Building on the work done in primary care, the authors propose a “mental health home.” The model of care incorporates medical home characteristics, such as access to and coordination of services, integration of primary and preventive care, adoption of recovery orientation and evidence-based practices, and family and community outreach. Barriers to and strategies for implementation of mental health homes are discussed. (*Psychiatric Services* 60:528–533, 2009)

To quote Robert Frost, “Home is the place where/When you have to go there/They have to take you in.” In the beginning of the last century, many state psychiatric hospitals in the United States provided a full range of social, occupational, and mental health services to long-term residents

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(1). Unfortunately, well-run “asylums” devolved into custodial care because of poor administrative oversight, funding cutbacks, and social stigma. Many public psychiatrists became pessimistic about the system’s ability to provide therapeutic benefits to those with mental illness. In 1963 the Community Mental Health Centers Act set out to revolutionize services for individuals with serious mental illness by emphasizing community life grounded in social and vocational pursuits. This movement, too, did not realize its hoped for impact because of a diffuse, overly ambitious vision, cost-shifting from the federal government to states, and too limited community services and resources (2).

Over the past decade, a recovery model of mental health services has emerged as a guiding vision for individuals with serious mental illness (3). This approach emphasizes self-determination and shared decision making, with evidence-based interventions for managing symptoms plus skill and vocational development (4,5). More individuals are now seeking a life in the community that is marked by job attainment, good quality of life, good health, and rewarding social relationships.

However, many individuals with serious mental illness still do not receive adequate community-based care. Studies indicate that only half receive mental health treatment (6,7). Even when engaged in treatment, its appropriateness and effectiveness are dubious, with estimates that as little as 7% of persons receive evidence-based practices (8). Medication nonadherence is also a major

concern, with studies showing that 30%–60% of individuals with serious mental illness do not take medications as recommended (9). The consequences of poor engagement in care and unmet treatment needs are devastating to individuals, families, and society: emergency room recidivism (10,11), high rates of psychiatric hospitalization (12,13), homelessness and incarceration, and increased health care costs. Marcus and Olfson (14) suggested that improving treatment adherence could lower Medicaid hospital days by 13.1%, with over \$100 million in annual savings for the national Medicaid system.

In 2007–2008 several highly publicized violent incidents in New York City involved individuals with serious mental illness. In response, government officials convened a panel to examine cases, consider opinions of experts, and recommend actions to improve services and promote the safety of all New Yorkers. The 2008 *New York State/New York City Mental Health–Criminal Justice Panel Report and Recommendations* (15) highlighted the difficulties that individuals with serious mental illness encounter with the public mental health (and criminal justice) systems. Even with delivery of services such as assertive community treatment and intensive case management, there was wide variability in quality, limited access and accountability, and poor coordination of care (15).

The public mental health system might be described as “a tale of two cities.” One group of individuals with serious mental illness is offered a range of effective treatments and

services. However, the public mental health system, as a means of managing its most intensive and comprehensive (and expensive, short of hospitalization) care, usually does not allow access to these services until individuals fail routine community care and experience treatment lapses, multiple hospitalizations, or involvement with criminal justice programs. The good news is that individuals with enhanced service programs generally engage in care and are able to be supported in a meaningful and sustained recovery.

The other group of individuals includes those who fall through the cracks of a fragmented system where accountability is not clearly and responsibly owned. This group typically includes those with severe and persistent mental illness, often with co-occurring substance abuse, who experience difficulty engaging and remaining in treatment. These individuals live on the fringes of our communities and their families and can be thought of as “homeless” from a system-of-care perspective.

The medical home

Pediatrics and family practice emphasize preventive and wellness approaches for children and adults; in fact, most individuals seen by these practitioners are without significant medical problems. Over 30 years ago, pediatricians knew that children with special health care needs are at high risk of fragmented care, with multiple providers, inadequate communication, and insufficient coordination of services contributing to family dissatisfaction and poor outcomes. The “medical home” concept was introduced in 1967 to meet the need for a single repository of medical records to promote communication and collaborative treatment among care providers for children with chronic medical conditions (16).

Over the next decade the medical home concept expanded to incorporate a range of principles vital to children with special health care needs. In the 1970s the American Academy of Pediatrics issued policy materials describing the medical home as a locus of care that is accessible, compassionate, comprehensive, coordinated,

culturally responsive, and family centered (17). The medical home was not a specific place but rather an approach with a range of processes and attitudes toward care. In the 1980s, pilot projects were funded by federal and private agencies to stimulate the development of pediatric and primary care medical homes (18). These projects demonstrated that clinics could better meet the needs of all individuals, including children with chronic medical conditions and the elderly population. Subsequently, on the premise of the model of a medical home, several states passed legislation mandating that disabled children have access to services (16).

In 2007 the American Academy of Family Physicians, the American Academy of Pediatrics, the American College of Physicians, and the American Osteopathic Association published their *Joint Principles of the Patient-Centered Medical Home* (19). These principles emphasize enhanced access to care, an ongoing relationship with a personal physician, whole-person orientation, a team approach to care, coordinated and integrated care, and commitment to quality and safety.

States with greater commitments to these principles spend less on Medicaid, have lower acute care utilization rates, and show improved quality of care and consumer satisfaction (18). Government agencies and third-party payers have piloted programs to reimburse primary care providers for care coordination (20,21), and the Medicare Tax Relief Act of 2006 mandates the Centers for Medicare and Medicaid Services to implement a medical home demonstration project by 2010, which is to include methods of compensation for this form of care. To support these efforts, organizations have developed strategies for measuring the effectiveness of medical home implementation projects. The National Committee for Quality Assurance has published standards and guidelines (22), and the Center for Evaluative Clinical Services at Dartmouth College developed a Medical Home Index that rates clinics in areas such as organizational capacity, chronic condition management, care coordination, community outreach,

data management, and quality improvement (23).

Many experts have noted that the medical home concept remains a work in progress. Berenson and colleagues (24) noted inconsistent medical home definitions in various reports, with some emphasizing care for individuals with chronic illness and others focusing on creating a more efficient and coordinated system of care. There are also concerns about the cost-effectiveness and scalability of medical home models in real-world environments (25–27). A recent study of medical home infrastructure components among large primary care and multispecialty medical groups revealed that depending on the size of the medical group, only 15%–45% of groups have the resources to support a comprehensive medical home initiative (28). Other concerns include the shortage of primary care providers as well as the potential reluctance of specialists to support medical home approaches that may limit referrals and decision-making authority (25). Many questions remain to be answered as medical homes are implemented.

The need for a “mental health home”

Many individuals with serious mental illness repeatedly fall through gaps in care. These individuals are even less likely to engage with primary care providers and are “medically homeless.” Strategies for better engaging these individuals will require mental health practitioners to expand their commitment to medical home principles, including accountability, continuity of care, family involvement and support, and the promotion of self-management and shared decision making. Medical homes rely on practitioners to act as generalists and to work effectively with specialty providers (29). Clinicians working with individuals with serious mental illness will need to function more like generalists, working with the entire individual and coordinating care among a range of behavioral and rehabilitation service providers. A clinical setting that provides services for individuals with serious mental illness and adopts these principles can be

thought of as a “mental health home.”

A mental health home would not be a new type of service. Instead, existing clinics, assertive community treatment teams, psychiatric rehabilitation programs, and partial hospitalization or day treatment programs would become mental health homes by practicing a core set of principles, outlined below.

Enhanced access and coordination of care

A mental health home makes a commitment to knowing each recipient's clinical status and whereabouts as well as to coordinating emergent and routine care. An essential feature is priority access to services for new referrals, homeless individuals, and those whose mental illness has contributed to contact with the criminal justice system, because these individuals are at the greatest risk of poor outcomes and continued disability.

Mental health homes greatly extend the concept of case management. In the mental health home, treatment providers are directly involved with the individual's primary care team and do not confine themselves to the mental health community. Care coordination is preeminent in the treatment plan. For example, when an individual receives services from more than one program (such as day treatment, intensive case management, or rehabilitation services), the mental health home team takes responsibility for knowing and coordinating all services. A primary mental health clinician maintains communication with all other service providers, incorporating service providers' recommendations into the primary care plan and informing other providers when there are significant updates or changes in the plan of care.

A psychiatric or medical hospital admission of an individual requires greater involvement by the mental health home team. The mental health home primary clinician works actively with the inpatient team to ensure continuity of care and a safe and thoughtful transition back to the community.

Another example of how this model expands the case management concept is that when an individual

does not follow through with treatment or disengages from care, the mental health home team increases outreach activities, intensively pursuing reengagement and efforts to ensure the safety of the individual and the public.

A mental health home with resources highly focused on the individual can create a critical mass of advocacy and support. For example, some states have adopted single-point-of-access approaches to essential resources such as housing or case management services, with priority access often granted to specific populations, such as individuals residing in state psychiatric hospitals. With the knowledge that there is a treatment team committed to providing continuous, good-quality care, state administrators will be more likely to prioritize access to ancillary services to individuals who are linked to a mental health home. This illustrates how the mental health home model can act to leverage precious other services that individuals with serious mental illness typically access with great difficulty.

Integration of primary and preventive care

The public mental health system has increasingly recognized the importance of physical health and wellness in an individual's recovery. Recent research indicates that individuals with serious mental illness in the public mental health system do not receive medical care consistent with their needs and have a 20% reduction in expected life span compared with the general population, with early morbidity and mortality resulting from highly prevalent medical illnesses, such as cardiovascular and lung disease, diabetes, and cancer (30). Moreover, psychotropic medications may contribute to rates of obesity, insulin sensitivity and diabetes, and other risk factors for cardiovascular disease (31). To improve care, the mental health home assists in engagement with and actively collaborates with a primary health care practitioner while also focusing the individual's attention on wellness and primary care. The mental health home incorporates wellness and primary care issues into the individual's treatment

plan. Education regarding diet, healthy living (including smoking cessation and physical activity), and risk factors for cardiovascular disease are essential elements of care in the mental health home.

Integration of mental health and primary care will be a challenge for clinicians caring for individuals with serious mental illness. Over 30 randomized clinical trials of integrated medical care have been published in the past ten years, yet none focused on populations of individuals with serious mental illness (32). There is, however, a growing body of literature to guide mental health clinicians in medical disease management and disability care coordination strategies for these individuals (33,34).

Use of evidence-based practices and continuous quality improvement

The mental health home team actively embraces new knowledge and accepts that treatments can become outdated. The mental health home has a dynamic continuous quality improvement team that engages staff and recipients of care in ongoing efforts to identify and adopt new practices and ensures that existing practices are used in a manner true to their proven methods. One of the biggest gaps in mental health care pertains to how few people actually receive evidence-based practices (35). Continuous quality improvement teams identify where practices do not meet the evidence base and develop initiatives to close those gaps.

Adoption of recovery principles

The mental health home is a platform for clinicians to provide a recovery-oriented approach to care. This means partnership and full participation of the recipient in all decision making; an unrelenting search for opportunities for self-determination, choice, and personal growth (4); and an emphasis on coordination of services so that individuals with serious mental illness have choices and opportunities. A single clinical care entity for recovery-related activities greatly reduces complexity as well as the stigma and confusion often experienced by recipients in navigating health care services.

Family and community outreach

The mental health home extends current notions of family and support system outreach by engaging communities and families beyond individual treatment plans. Focus groups and surveys identify needs, health and wellness initiatives target the local community, and crisis intervention services are easily accessible. The mental health home establishes an identity aligned with the community's prevailing cultures. The mental health home model adopts a "customer is always right," consumer-friendly ethos. This involves shared decision making, in which individuals and families are equal partners with clinicians in health care and treatment decisions.

Contrasting the mental health home with existing models

There are notable differences between a medical home and the description offered here of a mental health home. For example, in the medical home the physician coordinates a team of clinicians. Individuals with serious mental illness often have their primary treatment alliance with a nonphysician clinician, and behavioral health teams are frequently led by nonphysician clinicians, with the psychiatrist serving as the expert consultant. This enhanced role of nonphysicians in a mental health home is consistent with the key principles of the model.

Another notable distinction is that psychiatry is not a primary care discipline. Mental health home clinicians would actively educate and support individuals about health and wellness, especially given the high rates of smoking, obesity, and metabolic conditions among individuals with serious mental illness. However, a mental health home psychiatrist would not serve as a primary care physician. The psychiatrist would interface with the primary care physician and actively monitor basic health indicators (such as body mass index, blood pressure, and smoking status) as well as critical lifestyle matters, including nutrition and physical activity. The recent Clinical Antipsychotic Trials of Intervention Effectiveness (CATIE) study (36), which examined antipsychotic

medication effectiveness for individuals with serious mental illness, reported that 30% of individuals meeting diagnostic criteria for diabetes were receiving no treatment with a glucose-lowering agent, 88% of those with elevated cholesterol were not receiving a lipid-lowering agent, and 62% of those meeting criteria for hypertension were not receiving antihypertensive medications (37). The role of the mental health home psychiatrist would be to actively monitor these and other primary care indicators, educate recipients regarding health and wellness, and ensure coordination with primary care providers so that medical conditions can be appropriately managed.

Many aspects of the mental health home resemble characteristics of the community mental health centers (CMHCs) introduced in 1963. CMHCs emphasized the provision of support and coordinated services to individuals in the community, consistent with medical and mental health home approaches. CMHC program funding, however, supported outpatient centers serving defined population areas and a wide range of individuals, including children, seniors, and those with substance use disorders (38). The mental health home targets a more limited population of individuals with serious mental illness and emphasizes a focused, chronic care-disease management model that integrates medical and psychiatric care. This is a population that was underserved by CMHCs because of the program's broad service mandate and lack of supporting resources and funding. With appropriate attention to funding issues (see below), the mental health home could succeed where the CMHC movement failed by providing a stable locus of care for the neediest recipients.

Next steps

Community-based public mental health services are well positioned to adopt a mental health home approach. Based on 30 years of experience with medical home models in primary care, the following guidelines may be useful in the systemic development and dissemination of a mental health home approach.

Communicating key concepts to stakeholders

The medical home (and mental health home) develops strong and lasting relationships with individuals receiving services. As providers implement mental health home principles and practices, they will need to educate individuals and their families. Most important will be helping individuals understand their treatment team (clinic) as a mental health home where all service needs will be coordinated. Families, the local community, and other members of the individual's support system need to be recruited as members of a team that engages in shared decision making.

Training clinical staff in the mental health home model

Culture change means ensuring that clinical staff is educated and fully engaged in this new model of care. A range of training strategies have been effective in implementing medical home programs (16,39,40). First, a sense of urgency and a core of knowledge regarding basic principles of the mental health home must be imparted to clinical and administrative staff, with enhanced training for specific disciplines (including preventive care approaches for physicians and nursing professionals). Second, technical manuals, training curricula, and continuing education courses can be developed. Distance learning programs permit widespread and affordable knowledge dissemination throughout the public mental health care system. Finally, learning collaboratives and other proven quality improvement tools—where participants from different settings review data, relate specific successes and failures, and problem solve regarding best practices—need to be widely implemented (40).

Piloting initiatives with innovative providers

Medical home programs implemented in primary care focus on how to best coordinate care, for example by establishing referral agreements with specific providers or utilizing "e-referrals" over the Internet for rapid consultation and communication with specialty clinicians (29). Another ex-

ample of how physician relationships with patients can be strengthened involves a “teamlet” approach where staff coaches meet with an individual immediately before and after physician appointments to optimize use of their brief time together (41). These strategies can be adapted for mental health settings. Other areas where novel initiatives could be piloted involve the use of peer specialists, Web-based psychoeducation technologies, and methods for enhancing shared decision making (42).

Exploring and testing reimbursement strategies

As with medical homes, implementation of the mental health home will require innovative reimbursement approaches. The Agency for Healthcare Research and Quality (32), the Substance Abuse and Mental Health Services Administration (43), and policy experts (44) have described substantial financial barriers to integrated, coordinated care within current state and national health care systems. These include Medicaid limitations on same-day billing and insufficient or disincentives for care coordination built into many fee-for-service, carve-out, and capitation plans. There is a growing consensus among public health administrators that insurance reform needs to create incentives for less intensive, community-based preventive and disease management approaches (21). For example, Medicaid financing for medical (including mental health) services in the state of New York will soon involve procedure code payments that will vary by complexity of visit and type of provider, offering greater reimbursement for some care coordination activities.

A range of care management reimbursement models exist in fee-for-service, capitation, risk-based, and hybrid models (45). Pay-for-performance approaches could be well adapted to mental health home initiatives. Over the past 15 years the medical home movement has progressed from small-scale studies of innovative reimbursement approaches to system redesign sponsored by state agencies or payers and finally to legislative efforts mandating reimbursement re-

form. State public mental health leaders should pursue similar paths of innovation to support mental health home initiatives.

Conclusions

Building on medical home concepts, mental health care providers can create a mental health home for individuals with serious mental illness that provides key service elements shown to enhance access, care coordination, and quality of care. In most states, the public mental health system remains fragmented and complex. A mental health home with clinicians and other resources highly focused on the individual and recovery offers a means of closing existing access and quality gaps. Although there will be great challenges to introducing mental health homes, the successful experiences of pediatrics and primary care with medical homes can guide clinical and financing reforms and help to sustain the determination needed for success. The rewards of doing so will be that individuals with serious mental illness will experience better physical health, mental health, and quality of life and that unnecessary social costs will be reduced.

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References

1. Sederer LI: Moral therapy and the problem of morale. *American Journal of Psychiatry* 134:267–272, 1977
2. Rosenheck R: The delivery of mental health services in the 21st century: bringing the community back in. *Community Mental Health Journal* 36:107–124, 2000
3. Torrey WC, Rapp CA, Van TL, et al: Recovery principles and evidence-based practice: essential ingredients of service improvement. *Community Mental Health Journal* 41:91–100, 2005
4. Farkas M, Gagne C, Anthony W, et al: Implementing recovery oriented evidence based programs: identifying the critical dimensions. *Community Mental Health Journal* 41:141–158, 2005
5. Drake RE, Torrey WC, McHugo GJ: Strategies for implementing evidence-based practices in routine mental health settings. *Evidence-Based Mental Health* 6:6–7, 2003
6. Kessler RC, Berglund PA, Bruce ML, et al: The prevalence and correlates of untreated serious mental illness. *Health Services Research* 36:987–1007, 2001

7. Kessler RC, Berglund PA, Walters EE, et al: A methodology for estimating the 12-month prevalence of serious mental illness, in *Mental Health, United States 1998*. Edited by Manderscheid RW, Henderson MJ. Washington, DC, Substance Abuse and Mental Health Services Administration, Center for Mental Health Services, 1998
8. Wang PS, Demler O, Kessler RC: Adequacy of treatment for serious mental illness in the United States. *American Journal of Public Health* 92:92–98, 2002
9. Velligan DI, Lam YWF, Glahn DC, et al: Defining and assessing adherence to oral antipsychotics: a review of the literature. *Schizophrenia Bulletin* 32:724–742, 2006
10. Dhossche DM, Ghani SO: A study on recidivism in the psychiatric emergency room. *Annals of Clinical Psychiatry* 10:59–67, 1998
11. Ledoux Y, Minner P: Occasional and frequent repeaters in a psychiatric emergency room. *Social Psychiatry and Psychiatric Epidemiology* 41:115–121, 2006
12. Gilmer TP, Dolder CR, Lacro JP, et al: Adherence to treatment with antipsychotic medication and health care costs among Medicaid beneficiaries with schizophrenia. *American Journal of Psychiatry* 161:692–699, 2004
13. Weiden PJ, Kozma C, Grogg A, et al: Partial compliance and risk of rehospitalization among California Medicaid patients with schizophrenia. *Psychiatric Services* 55:886–891, 2004
14. Marcus SC, Olsson M: Outpatient antipsychotic treatment and inpatient costs of schizophrenia. *Schizophrenia Bulletin* 34:173–180, 2008
15. Hogan MF, Gibbs LI, O'Donnell DE, et al: New York State/New York City Mental Health–Criminal Justice Panel Report and Recommendations. New York, New York State Office of Mental Health, 2008
16. Sia C, Tonniges TF, Osterhus E, et al: History of the medical home concept. *Pediatrics* 113:1473–1478, 2004
17. American Academy of Pediatrics Medical Home Initiatives for Children with Special Needs Project Advisory Committee: The medical home. *Pediatrics* 113:1545–1547, 2004
18. Starfield B, Shi L: The medical home, access to care, and insurance: a review of evidence. *Pediatrics* 113:1493–1498, 2004
19. Joint Principles of the Patient-Centered Medical Home. American Academy of Family Physicians, American Academy of Pediatrics, American College of Physicians, American Osteopathic Association, March 2007. Available at www.medicalhome.info.org
20. Rosenthal TC: The medical home: growing evidence to support a new approach to primary care. *Journal of the American Board of Family Medicine* 21:427–440, 2008
21. Davis K, Schoen C: State health system performance and state health reform. *Health Affairs* 26:w664–w666, 2007

22. Standards and Guidelines for Physician Practice Connections: Patient-Centered Medical Home (PPC-PCMH). National Committee for Quality Assurance, 2008. Available at www.ncqa.org/tabid/631/default.aspx
23. Cooley WC, McAllister JW, Sherrieb K, et al: The Medical Home Index: development and validation of a new practice-level measure of implementation of the medical home model. *Ambulatory Pediatrics* 3:173–180, 2003
24. Berenson RA, Hammons T, Gans DN, et al: A house is not a home: keeping patients at the center of practice redesign. *Health Affairs* 27:1219–1230, 2008
25. Keckley PH, Underwood HR: The Medical Home: Disruptive Innovation for a New Primary Care Model. Washington, DC, Deloitte Center for Health Solutions, 2008
26. Sidorov JE: The patient-centered medical home for chronic illness: is it ready for prime time? *Health Affairs* 27:1231–1234, 2008
27. Barr MS: The need to test the patient-centered medical home. *JAMA* 300:834–835, 2008
28. Rittenhouse DR, Casalino LP, Gillies RR, et al: Measuring the medical home infrastructure in large medical groups. *Health Affairs* 27:1246–1258, 2008
29. Bodenheimer T: Coordinating care: a perilous journey through the health care system. *New England Journal of Medicine* 358:1064–1071, 2008
30. Parks J, Svendsen D, Singer P, et al: Morbidity and Mortality in Persons With Severe Mental Illness. Alexandria, Va, National Association of State Mental Health Program Directors Medical Directors Council, 2006
31. Newcomer JW: Metabolic considerations in the use of antipsychotic medications: a review of recent evidence. *Journal of Clinical Psychiatry* 68(suppl 1):20–27, 2007
32. Butler M, Kane RL, McAlpine D, et al: Integration of Mental Health/Substance Abuse and Primary Care, No 173. AHRQ pub no 09-E003. Rockville, Md, Agency for Healthcare Research and Quality, 2008
33. Mastal MF, Reardon ME, English M: Innovations in disability care coordination organizations: integrating primary care and behavioral health clinical systems. *Professional Case Management* 12:27–36, 2007
34. Thielke S, Vannoy S, Unützer J: Integrating mental health and primary care. *Primary Care: Clinics in Office Practice* 34:571–592, 2007
35. Grol R, Grimshaw J: From best evidence to best practice: effective implementation of change in patients' care. *Lancet* 362:1225–1230, 2003
36. Lieberman JA, Stroup TS, McEvoy JP, et al: Effectiveness of antipsychotic drugs in patients with chronic schizophrenia. *New England Journal of Medicine* 353:1209–1223, 2005
37. Nasrallah HA, Meyer JM, Goff DC, et al: Low rates of treatment for hypertension, dyslipidemia and diabetes in schizophrenia: data from the CATIE schizophrenia trial sample at baseline. *Schizophrenia Research* 86:15–22, 2006
38. Frank RG, Glied SA: Mental Health Policy in the United States Since 1950: Better but Not Well. Baltimore, Johns Hopkins University Press, 2006
39. Moore B, Tonniges TF: The "Every Child Deserves a Medical Home" training program: more than a traditional continuing medical education course. *Pediatrics* 113:1479–1484, 2004
40. Future of Family Medicine Project Leadership Committee: The future of family medicine: a collaborative project of the family medicine community. *Annals of Family Medicine* 2(suppl):S3–S32, 2004
41. Bodenheimer T, Laing BY: The teamlet model of primary care. *Annals of Family Medicine* 5:457–461, 2007
42. Adams JR, Drake RE, Wolford GL: Shared decision-making preferences of people with severe mental illness. *Psychiatric Services* 58:1219–1221, 2007
43. Kautz C, Mauch D, Smith SA: Reimbursement of Mental Health Services in Primary Care Settings. HHS pub no SMA-08-4324. Rockville, Md, Substance Abuse and Mental Health Services Administration, Center for Mental Health Services, 2008
44. Issue Brief: Medical Homes and Integration of Mental Health. Washington, DC, Bazelon Center for Mental Health Law, Nov 2008. Available at www.bazelon.org/issues/mentalhealth/healthreform
45. Bachman J, Pincus HA, Houtsinger JK, et al: Funding mechanisms for depression care management: opportunities and challenges. *General Hospital Psychiatry* 28:278–288, 2006