No Health without Mental Health
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July 1, 2026

The Honorable Robert F. Kennedy, Jr.
Secretary
United States Department of Health and Human Services
200 Independence Avenue, S.W.
Washington, D.C. 20201

Re: **Public Comment Submittal on Chronic Diseases of Addiction and Mental Illness - Effective Integrated Medical-Behavioral Interventions, and Approaches Targeting Specific Subpopulations,**
91 FR 35221

Dear Secretary Kennedy,

This letter is submitted by NHMH – No Health without Mental Health, a patient advocacy nonprofit dedicated since 2007 to making evidence-based integrated physical and behavioral healthcare widely accessible to all Americans and joined in by the undersigned organizations. We appreciate the opportunity to comment specifically on current research findings and areas requiring future research on: (1) integration interventions with rigorous, empirical evidence of effectiveness in improving MH/SUD, and (2) integration approaches likely to work best for specific, targeted patient subpopulations.

PART ONE: INTEGRATION INTERVENTIONS WITH RIGOROUS, EMPIRICAL EVIDENCE OF OUTCOMES:

General:
A wide range of approaches to the behavioral health treatment of integration behavioral health and primary care have been documented in the scientific literature. Research has consistently reported positive patient health outcomes, persisting across patient, practice, and environmental characteristics.

Broadly, future research should focus on standardization of terminology and categorization of integration approaches in order to assess them for each component's contribution to the outcome of effective integration. Additional areas needing further research include validation of measurements of integration, particularly related to making them more patient-centered. More study is also need to reveal the additive effect and determine at what point more integration does not produce better outcomes, professional roles in integration, workflows, and training needs specific to integrating behavioral health and primary care.

Studies Comparing Effective Approaches to BH Integration and Primary Care:
The following studies varied in terms of settings and with depression the most common condition treated, though some of the interventions were broader including a wide range of conditions.

Interestingly, across these studies it was consistently shown that the more complex or integrated the model, or, the model that added components, those were the models resulting in better outcomes. The more complex the integration model, the better the outcomes. Integration strategies with multiple components and more complex models outperformed more basic approaches. (Strategies for integrating Behavioral Health and Primary Care: A Hybrid Review, AHRQ October 2023).

1) Centrally Assisted Collaborative Telecare (CACT) – includes stepped psychosocial management, use of a symptom registry, expansion of care manager activities and centralized telepsychiatry/psychology and telecare manager. Findings: intervention had greater decrease in PTSD and depression scores, more participants had 50% improvement in symptoms. (Belsher BE et al, Mental Health Utilization Patterns, *Medical Care*, 2016;54(7): 706-13; Engel, CC et al, Centrally Assisted Collaborative Telecare, *JAMA Intern Med*. 2016;176(7):948-56).

2) Collaborative Care Model – adults with depression, depression symptoms (PHQ-9) change from baseline to 12 week follow-up. Findings: Larger reduction for CoCM v. for colocation. (Blackmore MA, et al, Comparison of Collaborative Care and Colocation Treatment, *Psychiatric Services*, 2018:69(11):1184-7).

3) Blended Model, PCBH with addition of care manager for depression – includes monitoring symptoms, assessing medication compliance and use of coping strategies. Findings: Rate of remission improved 110% with PCBH, and another 67% with Blended, and reduction in symptoms. (Landis, SE, et al, Effects of Different Models of Integrated Collaborative Care in Family Medicine Residency Program, Fam Syst Health, 2013;31(3):264-73).

4) Integrated Model, Psychologists and PCPs working in varying levels of integrated practices (providers were study subjects). Findings: Both types of providers in the integrated setting were more satisfied with their collaborations than provider in the other models. (Kaitz, JE, et al, Psychologist and Physician Inter-Professional Collaborative Experiences in Primary Care Integration, *J Clin Psychol Med Settings*, 2021;28(3):436-46).

5) Pediatric Behavioral Health Integrated Program - added pediatric psychologists and psychiatrist and psychiatrist consultants. Findings: Referral rates were higher, all satisfaction scores significantly higher, competency higher for next steps after patients screen positive and in managing ADHD. (German, M, et al, Comparing Two Models of Integrated Behavioral Health Programs in Pediatric Primary Care. *Child Adolesc Psychiatr Clin N Am*, 2017:26(4):815-28).

6) Homeless Patient Aligned Care Team (HPACT), integrated care customized for homeless patients, varied by location, each VA added services to address SDOH in addition to mental health and addiction services to the medical home model. Findings: PC visit more likely and ED visit less likely. (Jones, AL et al, Patient Predictors and Utilization of Health Services within Medical Home for Homeless Persons, *Subst Abus*, 2018;39(3):354-60).

PART TWO: INTEGRATION APPROACHES LIKELY TO WORK BEST FOR PARTICULAR SUBPOPULATIONS:

While current research on the integration of behavioral health and primary care has consistently shown positive patient health outcomes, integrating care between both domains is a complex process and implementation across the nation has been uneven. This has led to efforts to adapt integration models for specific subpopulations such as people with serious mental illness, people at the extremes of life, OB/GYN patients, children and adolescents, and people with substance use disorders. (Ramanuj, P., Pincus, H. et al, Evolving Models of Integrated Behavioral Health and Primary Care, *Current Psychiatry Reports*, 2019, 21:4).

Proven models of integrated care are now being tailored to specific patient populations. Policy initiatives need to be developed to encourage adoption in particular settings. To date wholly novel approaches to behavioral health integration are significantly less common. The research reflects growing consensus that future efforts to integrate care should allow for flexibility and innovation around implementation, payment models that support delivery of high-quality care, and the development of outcome measures that among other things incentivize collaborative working practices.

1) Perinatal Mental Health Project – South Africa – adapts a collaborative care model utilizing peer support workers and non-specialist health workers. The target population is expectant and new mothers in first postnatal year in low-resources settings. Services included increased screening for psychological distress in expectant mothers and psychological counseling to promote positive birth experiences, successful bonding with the newborn, and enhance maternal caregiving capacity.
There is also a very strong community support linkage. Mental health training is given to general health workers in maternity units and non-specialist health workers receive training as counselors. Women are screened for psychological distress during their first routine visit to the prenatal clinic. Those with distress are referred for individual counseling by an on-site counselor.
(The Perinatal Health Project, *The Perinatal Mental Health Mid-Year Report: January-June 2013.* Cape Town, SA; 2013).

2) Massachusetts Child Psychiatry Access Program – involving a State-wide improved expert consultation and provider training initiative. The target population is children with behavioral health needs and their families in Massachusetts with the aim to improve access to treatment by making child psychiatry services accessible to primary care providers across Massachusetts. A system of regional children's behavioral health consultation teams is deployed to help PCPs and their practices to promote an manage the behavioral health of their pediatric patients as a fundamental component of overall health and wellness. (Sarvet, B. et al, Improving Access to Mental Health Care for Children, *Pediatrics,* 2010:126:1191-200).

3) Commissioning for Quality and Innovation, England and Wales – a policy initiative to pay for performance for monitoring of physical health disorders across England and Wales with target

population people with serious mental illness admitted to psychiatric facilities. This model focused specifically on improving cardiometabolic risk assessments in the target population and onward referral when necessary. Findings were that increased screening and intervention for cardiometabolic disorders improved communication and collaboration between behavioral health and primary care providers ((Ramanuj, P., Pincus, H. et al, Carrots and Sticks on Opposite Sides of the Atlantic: Integration Incentives for People with Serious Mental Illness in England., *Psychiatric Serv*., 2017;68:430-2).

4) SUMMIT – Integrated Care for Alcohol and SUD in Primary Care – involving an adapted SBIRT (Short Brief Intervention Referral to Treatment) Approach. People with opioid or alcohol use disorders in two federally qualified community health centers. A system-level intervention was designed to increase the delivery of either a 6-session brief psychotherapy treatment and/or medication-assisted treatment (Watkins, KE, et al, Collaborative Care for Opioid and Alcohol Use Disorders in Primary Care: SUMMIT RCT*, JAMA Intern Med*, 2017;177-1480-8).

PART THREE: CONCLUSION: We are in a time of great transition in healthcare delivery, payment and policy and meeting the needs of the complex, high-risk, high-cost patient population requires change in both practice and policy. Targets of interest for integrated care have become broader and more comprehensive than the original collaborative care and primary care behavioral health models. New approaches have been adopted for a range of targeted populations in primary care, primarily individuals with chronic medical conditions and mental illness and those with serious mental illness. Research attention has also focused on changing needs across the life cycle with maternal, child and adolescent, young adult, and older adult health targeted for more coordinated approaches to care.
Importantly, evidence and implementation experience are evolving beyond the clinic four walls since health-related social needs have been found to play a critical role in healthcare and health outcomes. Future advances in integrated care rests upon the ability to apply new approaches and technologies, giving particular consideration to the need for flexibility and innovation in implementation. The continuum of care is critical: integration should start early in the life cycle and be expanded applied, as needed, across the different settings of medical care, e.g. schools, workplace, home-based care, geriatric settings. Policy and funding approaches must stay abreast and match these care opportunities, enabled in many cases by new innovations in health workforce planning and technology for scaled implementation.

Finally, new structures, processes and outcomes measures reflecting integration models should support new payment models and ensure future evolutions of healthcare delivery are informed by a meaningful and balanced evidence base. Crucially, this will require investment by practices and health systems in data collection and HIT capabilities to manage the patient data necessary for quality and efficiency measurement and reporting.

Thank you for the opportunity to submit these comments. For questions or further information, please contact Florence Fee at florencefee@nhmh.org.

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