care across the life span, PCPs also treat child behavior problems (e.g., ADHD) in addition to the problems of adults and older adults. Of course, they must do all of this while also tending to the medical needs of their patients. A PCP must truly be a generalist! For all of these reasons, PC has earned the label of the country’s “de facto mental health-care system” (Regier et al., 1993).

Thus, one reason to integrate MH services into PC is to help meet the demand for care there. Another reason lies with the 59% of people who seek no care. An interesting point is that approximately 80% of adult Americans will visit PC in the course of a year (National Center for Health Statistics 2012b). Among American children, the number is about 93% (National Center for Health Statistics 2012c). Thus, many if not most of these undiagnosed people will most certainly enter the PC system. They might only seek help for a sore throat or a work physical, rather than for psychiatric or substance abuse problems. However, the point is that they do enter PC.

Most of the time, these patients pass in and out of the clinic without the psychiatric problem being detected. For example, patients with alcohol dependence receive appropriate assessment and referral in PC only about 10% of the time (McGlynn et al., 2003), and depression goes undetected 30–50% of the time (Simon, Von Korff, & Barlow, 1995). However, a PC clinic with good screening protocols, behaviorally savvy clinicians, and a robust behavioral health staff might be able to detect and treat problems that may otherwise go unnoticed. Thus, a second reason to integrate is to increase a clinic’s ability to identify and provide MH care to patients who would otherwise slip through the cracks of a broken system.

Takeaway: Integration must improve identification of undiagnosed problems.