Integrative Care: What the Research Shows

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Because the majority of patients with mental illness are treated by generalist physicians, primary care has been described as the “de facto” mental health system [1]. Unfortunately, outcomes for patients with common mental illnesses treated in primary care settings are often poor. Fewer than half of patients with depression recover within 6 months of starting treatment, and outcomes are worse for minority and low-income patients [2, 3]. Studies show multiple problems with the quality of care, including underdiagnosis, inadequate dosage and duration of treatment when psychotropic medication is prescribed, and infrequent follow-up [4, 5]. Early attempts to improve patient outcomes focused on improving care for depression through clinician education and depression screening, but these efforts largely failed. However, important lessons were learned, and it was hypothesized that outcomes could be improved by integrating mental health care with primary care and delivering that integrated care in a primary care setting.

Over the past 2 decades, integrated care has been evaluated in a series of randomized controlled trials (the strongest design for testing a new treatment intervention). In the initial studies, including a 1995 study by Wayne Katon and colleagues [2], adult patients with depression were cared for jointly by a mental health professional and a primary care physician at the same location; often the patients alternated visits with the two providers. These studies showed improved outcomes with this approach; however, it was thought to be too expensive and to strain an already limited supply of mental health professionals. The model evolved into a team approach that incorporates specially trained nurses, pharmacists, or health coaches and makes greater use of telephone follow-up to increase the frequency of contact at reasonable cost. These integrated approaches also borrow from Edward Wagner’s chronic care model [6], empowering and preparing patients to manage their own health and health care. More systematic follow-up, stepped-care treatment algorithms, disease registries and decision support have been introduced. Decision support often takes the form of having a mental health professional supervise the nurse, pharmacist, or health coach. Various permutations of this integrated care model for depression have now been evaluated in more than 40 trials, some of which have included up to 2 years of follow-up.

High-quality systematic reviews [7, 8] have shown that, compared with primary care treatment alone, integrated care for depression doubles the rate of medication adherence and significantly improves symptoms of depression, functional status, and patient satisfaction. In one large trial involving 1,801 older adults, treatment lasting 1 year was shown to have positive effects that were still present at 2-year follow-up, including decreased pain scores in the subset of depressed patients who also had arthritis [9-11]. The results for patients from ethnic minority groups and those with low incomes were as good as or better than those for the group as a whole.

More recent trials have shown that these positive effects extend to depressed patients who have a concurrent condition, such as a chronic medical illness (diabetes mellitus or coronary artery disease, for instance), generalized anxiety disorder, or panic disorder. Integrated care that focuses on mental health outcomes does not have a halo effect that improves general medical outcomes [12]. However, when integrated care uses similar methods for both depression and chronic medical conditions, increasing follow-up and measurement-based care for both, outcomes for both (including measures of disease control such as glycated hemoglobin and serum cholesterol levels) are improved [13, 14]. Integrated, collaborative care of this sort has been shown to be highly cost-effective, and in some subgroups of patients, it has actually produced cost savings [15, 16].

What are the key ingredients of integrated care? An analysis that sought to identify the components of integrated care that have been consistently associated with greater impact on symptoms of depression [17] concluded that the most important features are active care by the primary care physician, collaboration with a mental health professional, adherence monitoring, treatment response assessment using a symptom scale, active support for patient self-management skills, and integrated treatment lasting at least 16 weeks.

How can integrated care for depression be promoted in North Carolina? The state’s primary care physicians support integrated care, and the approach described here is consistent with the “medical home” team-based medical care delivery model. However, given current...
Institutional and system-level interventions are necessary to promote integration in primary care. These interventions include the following: 1. Developing and implementing comprehensive care models for depression care delivery, which have been shown to improve patient outcomes and health care efficiency. 2. Creating new payment models that incentivize collaboration between specialists and primary care providers. 3. Incorporating behavioral health services into primary care practices through the implementation of interdisciplinary care teams. 4. Leveraging electronic health record systems to facilitate communication and coordination between providers. 5. Conducting ongoing quality improvement initiatives to assess and improve the integration of mental health services within primary care settings.

By focusing on these strategies, primary care providers can better address the mental health needs of their patients, leading to improved mental health outcomes and overall patient well-being. Further research in this area is needed to understand the impact of these interventions and to guide future developments in integrated care models.