Integration of Medical and Psychological Treatment within the Primary Health Care Setting

Cristine E. Hine, MSW
Heather B. Howell, MSW
Kimberly A. Yonkers, MD

ABSTRACT. Integrated care entails the provision of behavioral health services within the primary care setting and emphasizes a collaborative approach between mental health professionals and primary care providers (Kenkel, Deleon, Orabona Mantell, Steep, 2005). Research was collected to highlight the history, development, and implementation of integrated care within primary care facilities. The authors performed a comprehensive literature review of collaborative care and summarized the program design of the site where they work. It is hypothesized that integration will improve patient access to health care, increase the rate of evidence based practice, improve patient health and satisfaction, and reduce long-term costs.

KEYWORDS. Integrated care, mental health treatment, health service delivery, Primary care

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Cristine E. Hine is a Research Assistant, Heather B. Howell is a Research Social Worker, and Kimberly A. Yonkers is an Associate Professor in the Department of Psychiatry, Yale University School of Medicine, New Haven, Connecticut.

Address correspondence to: Kimberly A. Yonkers, MD, Department of Psychiatry, Yale University School of Medicine, 142 Temple St., Suite 301, New Haven, CT 06510 (E-mail: Kimberly.Yonkers@yale.edu).

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INTRODUCTION

The boundaries that once distinguished general medical from mental health facilities have been modified over time. Physicians managing general medical conditions are now willing to address the care of patients with symptoms of mood and anxiety disorders. Also, practitioners in general medical settings are allowing and encouraging collaboration with a wide array of behavioral health care professionals.

A number of factors have lead to these changes. First, many medical caregivers are adopting the approach that mind and body are not two entities, but rather one existing whole. Therefore, if mind and body are in constant collaboration and are reliant on one another, the well-being of the mind enhances that of the body and vice versa. Second, clinicians realize that sending patients to multiple treatment sites for their clinical care increases the burden of care and decreases the likelihood of following through with all health care appointments. Research indicates that of the presenting problems demonstrated in primary care facilities, 18% are due to somatization, 14% to depression, and 14% to anxiety. Data suggest that even when diseases have a known physical cause, management of medical symptoms requires concurrent behavioral health care (O'Donohue, Byrd, Cummings, & Henderson, 2005). Additionally, by providing patients with more inclusive psychological treatment, not only will mental health issues be addressed, but they will also utilize less physical health resources as well; estimated cost savings of integrative care range from 20–40% (O'Donohue et al., 2005).

BACKGROUND AND RATIONALE

Integrated care is a progressive approach for twenty-first-century health care; it offers behavioral health services within the primary care setting and emphasizes a collaborative approach between mental health professionals and primary care providers (Kenkel et al., 2005). Patients receive optimal services through a single location therefore minimizing reliance upon external resources.

Integrated care differs from more traditionally practiced behavioral medicine in that it requires collaboration at the logistic and theoretical levels, which exceeds that required for the practice of behavioral medicine alone (O'Donohue et al., 2005). Integrated care has been shown most effective when services are co-located, that is, when mental health counselors

work in the same offices as primary care physicians (Bowling- Aitken & Curtis, 2004). This is especially effective for patients because many physical ailments can be worsened by stress, unhealthy lifestyles, or other mental health needs.

Smith and colleagues demonstrated the need for integrated care by conducting a screening for and detection of depression, panic disorder, and post-traumatic stress disorder (PTSD) among pregnant women receiving prenatal care in public-sector obstetric clinics (Smith et al., 2004). Results suggest that depressed women remain undiagnosed and untreated at their primary care clinic; a mere 2 percent of women who screened positive with depression, none of the women who screened positive with PTSD, and 11 percent of the women who screened positive for panic disorder had their behavioral health diagnosis detected by their health care professional at their prenatal visit (Smith et al., 2004). Additionally, the study found that women referred to a behavioral health care provider located at the same site as their prenatal visit or postpartum visits were more than three times more likely to attend a behavioral care treatment visit than women who were referred to an offsite location (Smith et al., 2004). This study suggests the importance of same site, integrated care.

It is estimated that of patients waiting to see primary care physicians, 60–70% need mental health services (Bowling-Aitkin & Curtis, 2004); evidence also suggests that 50–90% of clients with mental health needs rely solely on primary care physicians for services (Broody, Khaliq, & Thompson, 1997). Somatic complaints are prevalent in primary care; nearly three quarters of presenting symptoms (e.g., pain, fatigue, dizziness) are of uncertain etiology and are likely psychosocial or behavioral in origin. Therefore, it is both clinically effective and cost effective to make behavioral health providers part of an overarching integrated health care facility (Kenkel et al., 2005).

METHODS

The authors performed a comprehensive literature review of documented programs and summarized the program design of the site where they work. Research was collected to highlight the history, development, progressions, and implementation of integrated care within primary care facilities. The following databases were searched from January 2007 through April 2007: Medline, PsycLIT, Global Health, PsycINFO,

PubMed, PreMEDLINE, HealthSTAR, Health and Medicine, Social Work in Health Care, Social Work Research, Social Work, Ebsco, ERIC, and PsycARTICLES.

DISCUSSION

Goals and Benefits of Integrated Care

The goals of integrated care are to (a) improve recognition of behavioral health needs in general medical settings, (b) provide care that addresses psychosocial issues in primary care, (c) minimize referrals to specialty mental health clinics, (d) improve the fit between treatment patients seek in primary care and the services delivered, and (e) prevent more serious behavioral and physical health problems through early recognition and intervention (O'Donohue et al., 2005). By diagnosing and treating both physiological and psychological illnesses, integrated care considers co-morbidity and its effects on the individual as a whole. Unlike traditional specialty health care models, integrated health care recognizes that behavioral issues play a significant role in the development, detection, and successful treatment and management of primary medical disorders (O'Donohue et al., 2005). The hope in developing this type of environment is that the services provided by mental health practitioners will become fully integrated into the primary care unit.

UNIFICATION/SYMBIOSIS OF MIND AND BODY

There has been an overall movement toward appreciating the amalgamation of mind and body; therefore, it is logical that the facilities that care for the whole being should do so in a comprehensive and unified way. It has been well documented that individuals with mental health diagnoses present more often in general medical settings than in specialty mental health settings and that mental disorders continue to go undetected and untreated in general medical settings (Hoge & Flaherty, 2001). In addition, mental health issues that do not meet diagnostic criteria for a DSM-IV disorder (such as subthreshold depression or anxiety symptoms or casual illicit drug use) are more apt to be identified in the medical setting, which leads to increased opportunity for secondary prevention rather than future need for intervention. Collaborative approaches to care

that involve psychiatry in primary care settings can produce increased adherence to medication, increased patient satisfaction, and improved short-term clinical outcomes (Katon et al., 1996).

ECONOMIC CONSIDERATIONS

Integration of care also provides profound financial and economic advantages. Integrated care provides a means for accessing populations who could benefit from behavioral health care but would not otherwise afford treatment. Moreover, care is more efficient. Resources are often drained from primary care settings when a clinician prescribes unnecessary tests for a condition that is behavioral and not somatic in nature (for example, an expensive cardiac work-up for a patient with panic disorder) (Pruitt, Klapow, Epping-Jordan, & Dresselhaus, 1998).

Treatment non-compliance and difficulties adhering to good health habits may be driven or worsened by a psychological condition. If a provider is able to successfully identify and address the psychological illness that complicates a general medical condition, a clinician may be able to improve the outcome of both illnesses. Identifying and dealing with mental health issues as an initial and primary task reduces repeated visits and health care costs (Kenkel et al., 2005).

Patients who have known psychological disorders use approximately 50% more physical health care services each year than patients who are not experiencing psychological distress (O'Donohue et al., 2005). If health care providers are able to administer more comprehensive psychological treatment, a substantial decrease in psychological symptoms and a notably significant decrease in physical health resources will result. Cost savings have been approximated at between 20–40% (O'Donohue et al., 2005).

ERADICATION OF STIGMA

The stigma attached to accessing and engaging in mental health treatment often prompts patients to not pursue care. The primary care setting may be a preferred facility for the delivery of behavioral health care services because it does not carry the stigma so often associated with mental health care (O'Donohue et al., 2005). As stated, 60–70% of clients being seen by primary care physicians could benefit from mental health services. Furthermore, of the 40% who receive a referral to a mental

health practitioner, only 10% follow up with appointments (Bowling-Aitken & Curtis, 2004).

DECREASE BURDEN FOR PRIMARY CARE PHYSICIANS

As described, integration of care within the primary care setting decreases treatment costs, ameliorates stigma, and promotes symbiotic mental and medical health care treatment. However, with these numerous changes, physicians may fear that their burden may increase. Primary care physicians (PCPs) already spend an average of 12.1 hours per week providing direct treatment for psychiatric conditions. The pressure for primary care physicians to manage more patients and an expanding spectrum of patient problems has led to unjust expectations and demands for the physician and insufficient care for the patient (Pruitt et al., 1998).

One of the many beneficial aims of integration is to lessen the responsibility for PCPs so they no longer maintain the expectation of providing physiological and psychological treatment to patients. Multidisciplinary integrated care has the capacity to employ multiple professionals from various backgrounds such as psychology, social work, psychiatry, nursing, case management, and so forth. In order for integrated care to progress into modern day health care facilities, mental health practitioners must find ways to network and initiate integration with physicians (Bowling-Aitken & Curtis, 2004). Integration widens the range of the mental health vocation and provides further job opportunities to mental health care professionals within a variety of health care settings.

REDUCTION IN REFERRALS

Along with significantly decreasing cost and stigma associated with mental health treatment, integrated care may decrease the number of outside referrals made by primary care physicians. In nonintegrated care facilities, primary care physicians may miss 50% or more of mental health problems in their patients. Moreover, as stated, even when the physician accurately determines that the patient needs to see a mental health professional and makes an appropriate referral, only 10% of those patients actually follow up with an appointment (Bowling-Aitken & Curtis, 2004). The aforementioned case is more concerning for patients dual-diagnosed with mental illness and substance abuse. When substance abuse treatment

facilities refer dually diagnosed patients to other agencies for needed services, patients must negotiate separate systems of care when they themselves are most significantly compromised. This fragmentation of service delivery has been found to be detrimental in terms of treatment retention, patient outcomes, and long-term cost effectiveness (Ducharme Knudsen, & Roman, 2006).

LIMITATIONS OF INTEGRATION

There is a need for integration of care within primary care facilities; however, a number of limitations impede integration. First, adopting an integrated model necessitates role changes for clinicians. For each member of a multidisciplinary team, being integrated demands a sufficient comprehension about disciplines and trainings of one's colleagues in order to design collaborative interventions that will most appropriately meet patients' needs (O'Donohue et al., 2005). In addition, although the conceptualization of integrated and wrap-around service delivery presents as an ideal, this level of care necessitates the capacity and resources for managing medical needs after-hours and having timely access to specialist consultation (O'Toole et al., 2005). Another impediment for the implementation of integration is misconceptions both within the psychological and physiological health care professions. Physicians tend to focus on biomedical explanations of illness (Pruitt et al., 1998). Conversely, mental health practitioners' misperceptions of medical care may also be a hindrance to implementation of integration. Without a thorough comprehension of medical concepts and the physician culture, psychologists may fail to make an impact on primary care (Pruitt et al., 1998).

Another issue that limits integration is the need for mental health counselors to obtain licensure and get instated on insurance panels. Mental health counselors who can receive third party insurance reimbursement are more likely to be employed by PCPs because of potential for generating revenue (Bowling-Aitken & Curtis, 2004). If integrated care is to be successful, mental health practitioners will need to gain licensure, obtain adequate skills and training in assessment for accurate diagnosing, familiarize themselves with administering brief standardized screening instruments, and maintain confidence in leading time-limited structured groups. Integrated care demands that mental health counselors become comfortable in working in the biopsychosocial model of care, including the role of medication and pharmacological treatment. (Bowling-Aitken & Curtis, 2004).

MODELS OF IMPLEMENTED INTEGRATED CARE

Models of Integrated Care and Depression

A number of facilities throughout the country have successfully implemented models of integrative care that can be replicated in numerous health care environments. In particular, many models have highlighted the progress and adaptability of integrated care with specific DSM-IV diagnoses, and most commonly depression (Lin et al., 2006).

Lin and colleagues analyzed arthritis pain and disability and patients' response to collaborative depression care. The model incorporated older adults who met criteria for major depression or dysthymia (Lin et al., 2006). Intervention participants in primary care settings received antidepressant pharmacotherapy and problem-solving treatment. Control patients received care as usual. Over a twelve-month period, collaborative depression management was associated with significant reductions in arthritis pain among the intervention patients relative to usual care patients (Lin et al., 2006). This integrated approach may provide older adult patients who suffer from depression and arthritis with optimal pain and depression management. Additionally, the model helped researchers to observe that even if total resolution of pain does not ensue, functional improvements for both arthritis and depression should be considered achievable goals of this intervention.

A similar model based on collaborative care management of late-life depression in the primary care setting was assessed by Unutzer, Katon, and their team of colleagues. One thousand, eight hundred and one elderly patients were assigned to either receive the collaborative intervention model, which was referred to as Improving Mood-Promoting Access to Collaborative Treatment (IMPACT), or care as usual (Unutzer et al., 2002). After 12 months, their program affected an impressive 50% decrease in depressive symptoms in 45% of IMPACT enrollees, but in only 19% of controls (Unutzer et al., 2002). IMPACT patients also reported statistically significant improved depression treatment, more satisfaction with depression care, lower depression severity, less functional impairment, and greater quality of life than patients who received care as usual within primary care facilities (Unutzer et al., 2002). The model demonstrated a range of benefits from onsite depression treatment in a primary care setting (Unutzer et al., 2002).

Levine and colleagues assessed another model of integrative care in order to assess physician's satisfaction with a collaborative disease

management program for late-life depression in primary care (Levine et al., 2005). Prior to intervention of collaborative care, 53.6% of physicians surveyed reported satisfaction with resources available for treatment of depression within their primary care facility. When participants were surveyed post collaborative care intervention, more than 90% reported the intervention as helpful in treating patients with depression and 82% felt that collaborative care improved patients' clinical outcomes (Levine et al., 2005). In addition, two-thirds of physicians stated that implementation of integrative care would influence their diagnostic and treatment behavior (Levine et al., 2005).

Overall, models implemented to assess collaborative care and its affects on adherence to antidepressant medication, satisfaction with care of depression treatment, and reduction of depressive symptoms indicate a number of successes and high level of satisfaction with the integrated care program. Patients who were part of integrated care models were significantly more likely to adhere to antidepressant medication when compared with usual care patients (Katon et al., 1996). Furthermore, a majority of models demonstrated that the intervention of collaborative care was accepted by both patient and primary care physician (Katon et al., 1996). Moreover, program researchers stated that the essential elements of this model were the following: increasing the intensity of care for patients who had not demonstrated improvements, ensuring active follow-up, monitoring the process and outcome of care, and educating and activating patients to become collaborators in illness management (Katon et al., 1996).

Cost-Effective Models of Integrated Care

In addition to examining the recovery benefits of integrative care models on depression within primary care facilities, a number of models of collaborative care have been analyzed in order to assess cost-effectiveness of this type of care. As stated previously, Katon, Unutzer, and colleagues found that collaborative care is associated with long-term benefits that often go well beyond the initial intervention period (Katon & Unutzer, 2006). Results show that increased health care costs during the initial 12 months were offset by cost savings in the 12–28 month follow-up (Katon & Unutzer, 2006). This suggests that health care facilities investing in collaborative care may improve quality of care and health outcomes, while also demonstrating either neutral effects or savings on health care costs over a 2-year period (Katon & Unutzer, 2006).

Katon and colleagues assessed the incremental cost-effectiveness of a collaborative care intervention for panic disorder (Katon et al., 2006). The purpose of this comparison of integrative care versus usual care was to analyze total outpatient costs, anxiety free days, and quality of adjusted life-years (Katon et al., 2006). Data indicated that total incremental ambulatory mental health costs in the intervention group were approximately $473 higher than that of usual care group (Katon et al., 2006). However, when considering total ambulatory and inpatient costs, data suggests a $276 savings with patients who received integrative care versus patients who received care as usual (Katon et al., 2006). In regard to total medical costs, evidence suggests that a cost saving of approximately $240 occurs when implementing integrative care. The savings in inpatient costs were primarily due to significantly increased percentage of usual care patients requiring two or more medical hospitalizations compared to patients who received collaborative care (Katon et al., 2006).

Finally, Gilbody assessed the costs and consequences of enhanced collaborative care for depression within the primary care setting; economic evaluations were based on collaborative care models integrated within the U.S. health care system (Gilbody, 2006). Overall models of integrated care demonstrated increased treatment costs associated with delivering the intervention, increased treatment costs when pertaining to primary care visits and increased use of antidepressant medication (Gilbody, 2006). In regard to primary care depression treatment costs, estimates ranged from $13 to $24 per depression-free day (Gilbody, 2006). However, when further assessing cost-effectiveness of integrative care, Gilbody concludes that increased costs associated with the intervention may result in an increase of depression free days, which may lead to reduction in use of outside services (Gilbody, 2006).

Ground-Breaking Models of Integrated Care

A number of primary care clinics have integrated unique models of collaborative care into their facilities. In particular, results have shown that a model program featuring primary care physicians, nurses, and mental health providers working collaboratively significantly improves health outcomes, quality of life, and depression care for adolescents (ages 13–21) (Rosenbaum Asarnow et al., 2005). This study is unique because it is the first to evaluate a collaborative care program for adolescent depression in primary care clinics (Rosenbaum Asarnow et al., 2005). The integrated model suggests that, compared with adolescents who received standard

treatment, patients offered collaborative care were 11% less likely to report severe depression, demonstrated fewer depressive symptoms, superior quality of life, and improved satisfaction with mental health care (Rosenbaum Asarnow et al., 2005).

A second unique model demonstrated the effectiveness of collaborative care when implemented into a public center oncology clinic serving low-income Latina patients with breast or cervical cancer and comorbid depression (Dwight-Johnson, Ell, & Lee, 2005). Dwight-Johnson and colleagues assessed this collaborative care model and found that relative to patients in usual care, patients who received collaborative care were more likely to show > 50% improvement in depressive symptoms (Dwight-Johnson et al., 2005). In addition, women who received collaborative care were increasingly likely to demonstrate improvement in emotional well-being (Dwight-Johnson et al., 2005). Moreover, collaborative care may be associated with improvements in depression and emotional well-being in this substantially vulnerable population (Dwight-Johnson et al., 2005).

Finally, the authors are currently involved in a model of integrated care at two inner-city obstetrical care centers in Connecticut. This program referred to as Psychosocial Research to Improve Drug treatment Evaluation during Pregnancy (PRIDE) provides patients with onsite substance abuse treatment in conjunction with prenatal care integrated into their obstetrical care facility. Once again, the hypothesis is that integrated care models implemented *within* the primary care facility will demonstrate significant benefits to emotional and physical health when compared to non-integrated models of substance abuse care. After data have been collected, PRIDE program researchers will analyze the effectiveness of integrating substance abuse care into primary prenatal care facilities.

CONCLUSION

Implementation of integrated health care has the possibility of providing greater societal benefit. Integrated health care may diminish the stigmatization that so often is associated with mental health care. It may also reduce health care costs by decreasing referrals to outside providers that often yields insufficient results. Finally, integrated care provides physicians some relief for the multiple duties they have come to undertake and for which they may lack sufficient specialty training to provide.

It is hypothesized that the revolutionary concept of integration will improve patient access, increase the rate of evidence based practice, and

improve patient health and satisfaction, in addition to reducing long-term costs (O'Donohue et al., 2005). The majority of the problems presented in primary care clinics cannot adequately be addressed from an exclusive biomedical framework; a more comprehensive approach to care is required and depicted through integration (Pruitt et al., 1998). Integrated care creates a synergy that benefits all involved: Physicians receive the support they need to manage the burgeoning number of primary care clients presenting with mental health issues, mental health counselors are given the opportunity to work in unique settings that reach many people who would normally go untreated and, most importantly, clients receive integrated care that could significantly enhance the quality of their lives (Bowling Aitken & Curtis, 2004). The main beneficiary is the patient who can access comprehensive and coordinated health care: health care that addresses the biological, social, and psychological factors that promote a full and healthy life (Kenkel et al., 2005).

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