Research Shows There is No “One Size Fits All” Model for Effective Integration of Behavioral Services in Primary Care

*Evidence and practice illustrate value of multiple approaches*

Integrated primary care, in which teams of primary care and mental and behavioral health clinicians work together with patients and their families, is increasingly seen as a way of improving patient outcomes and satisfaction with care, and of reducing overall treatment costs. Achieving this is not easy. Integrating behavioral health treatment into primary care typically requires changes to primary care practices’ physical offices, information technology systems, management procedures, clinical staffing and policies, health records and data tracking practices, and provider education and training.

With these challenges, and given differences in patient populations and the goals of the integration effort, there is no “one size fits all” approach to effective integrated primary care. As stated in a recent review, “[t]here are several models and differing levels of integration described in the literature, suggesting that approaches to integration should be responsive to the needs and context of the community” (Vogel et al., 2017, p. 81).

**Integrated primary care encompasses a broad continuum of models**

At the least intensive end of the spectrum, primary care providers and behavioral health providers (such as psychologists, psychiatrists, social workers, and counselors) collaborate in physically separate locations or even different clinical systems. At the other end of the spectrum, behavioral health consultants and primary care providers work in the same physical location as members of the same clinical team. A host of different mental and behavioral health providers currently work in primary care and serve in various roles.

In the Primary Care Behavioral Health (PCBH) model, primary care providers, behavioral health consultants, and care managers are co-located, or readily available via telehealth, sharing the same health record systems, administrative support staff, and waiting areas, collaborating as a team in monitoring and managing patient progress. From the patient’s perspective, behavioral health services are seamlessly interwoven with medical care, and the behavioral health consultant (BHC) is understood to be a core member of the primary care team routinely involved in treatment, helping to mitigate the stigma often associated with behavioral health services.
In this model, BHCs provide consultations to patients and their families, and to primary care clinicians (with or without the patient present), virtually or in person. Rather than functioning as therapists, BHCs use brief, focused visits with a large percentage of the clinic population, including both patients with mental health or substance use disorders and patients with other health conditions influenced by biopsychosocial factors. Generally, the BHC strives to see patients on the same day the primary care provider (PCP) requests help, ideally through a “warm hand-off,” and works with the PCP to implement clinical pathways for treatment of depression and other targeted conditions. However, the focus of the PCBH model is on improving primary care services for all of the clinic’s patients, instead of replicating a specialty mental health service inside a primary care clinic (Reiter et al., 2018).

Studies of PCBH model programs have documented their effectiveness in treating depression, anxiety, and PTSD; in smoking cessation; and in reducing specialty mental health referrals. The Primary Care Behavioral Health (PCBH) model of integrated care is also present in settings including pediatric primary care centers such as the Texas Child study center at Dell Children’s Hospital, Cherokee Health, and the Department of Defense (Robinson & Reiter, 2016).

The Veterans Health Administration (VHA) began implementing Primary Care-Mental Health Integration (PC-MHI) treatment at its facilities in 2007, and it is now the country’s most widely used model. VA policies require PC-MHI services to use a blended model that includes:
- Co-located collaborative care (CCC), in which one or more mental health professionals are integral components of the primary care team, providing assessment and psychosocial treatment as needed for a variety of mental health problems; and
- Care management (CM) services, based on evidence-based strategies such as the Translating Initiatives for Depression into Effective Solutions (TIDES) model, which include monitoring of treatment adherence, outcomes and medication side effects; patient education and activation; and referral to specialty mental health care programs when needed.

In roughly two-thirds of PC-MHI programs, all PC-MHI staff are co-located within primary care clinics, and patients receive services from a psychologist more often than from other types of providers (Wray et al. 2012). Research on the implementation of PC-MHI finds that it has increased access to mental health services, and increased rates of diagnosis of depression, anxiety, post-traumatic stress disorder, and alcohol abuse (Johnson-Lawrence et al., 2012; Leung et al., 2018; Zivin et al., 2010).

The Collaborative Care Model (CoCM) is based on a treatment team that includes a primary care provider and a care manager working together, along with a psychiatric consultant (who typically does not see patients and is off-site). Research on this model has shown that it is effective in treating patients with depression and anxiety but has not demonstrated that the psychiatric consultant must be a prescribing provider, such as a psychiatrist, for programs to be successful. The primary research articles cited as evidence of the effectiveness of CoCM included programs in which psychologists and other non-psychiatrist providers functioned as psychiatric consultants.

- A major review by Archer et al. (2012) evaluated the effectiveness of collaborative care for treating depression and anxiety, and defined collaborative care as including four key criteria:
  1. A multi-professional approach to patient care, including a primary care provider and “at least one other health professional (e.g. nurse, psychologist, psychiatrist, or pharmacist) or paraprofessional involved with patient care” (p. 4);
2. A structured management plan, including management of “either or both pharmacological (e.g. antidepressant medication) and non-pharmacological interventions (e.g. patient and provider education, counseling, or cognitive behavior therapy (CBT)” (p. 4);

3. Scheduled patient follow-ups to facilitate treatment adherence and monitor symptoms; and

4. Enhanced inter-professional communication.

Psychologists and psychiatrists were both considered appropriate for filling the role of mental health consultant in collaborative care programs, as a second prescribing provider in addition to the primary care provider was not considered essential.

Models usually used teams with three distinct roles (primary care providers, care managers, and mental health specialists), while in some cases care was provided through providers serving in two roles (primary care providers and case managers, who were typically mental health specialists). The review found significant variation in collaborative care programs across all four criteria, concluding that “[c]ollaborative care is a complex intervention which is difficult to define precisely” (p. 24).

Importantly, the Archer review concluded that “the benefits of collaborative care are similar to other treatments (such as CBT [cognitive behavioral therapy] and other psychological therapies) when delivered in primary care settings” (p. 26).

- A systematic review published in the American Journal of Preventive Medicine by Thota et al. (2012) also studied the effectiveness of collaborative care for treating depression, defined as a model in which care is provided by a team consisting of a primary care provider, a case manager, and a mental health specialist, and found that psychiatrists and psychologists most frequently served as the mental health specialist. The study found modest differences in effect estimates related to the type of healthcare professional serving in the role of case manager, but did not uncover differences in effect estimates for collaborative care programs based on whether the mental health specialist position was filled by a psychologist or psychiatrist.

- Coventry et al. (2014) carried out a systematic review of 74 RCTs of collaborative care programs to determine the characteristics contributing to their effectiveness in the treatment of depression. The study used the same four key criteria for defining collaborative care programs as in the Archer study, and again noted the significant variation in the exact nature of the intervention and staff involved.

The Coventry review’s primary conclusion was that access to psychological services was a key determinant of successful treatment in collaborative care programs:

Our findings show that structured management plans that included psychological interventions either as a standalone therapy or in combination with antidepressant medication predicted reductions in depressive symptoms more so than collaborative care that only offered patients anti-depressant medication. (p. 12)

Other research on intervention factors for collaborative care model programs has failed to show any particular component or factor to be statistically associated with its effectiveness (Miller et al., 2013).
Flexibility and Blending of Models

Jurgen Unutzer, M.D., the psychiatrist head of the AIMS Center and a leading researcher on collaborative care generally and on the CoCM model, has called for the adoption of a flexible, blended approach including levels of care in which primary care providers are supported by on-site behavioral health consultants as in the PCBH model; receive consultation for patients with more significant mental health or substance use disorders from an off-site behavioral health expert “such as a psychologist or psychiatrist”; and are able to refer patients as needed to specialty mental health providers. behavioral health care managers and consultants who is usually off-site” (Unutzer, 2016).

Because the various integrated primary care models complement each other’s limitations, PCPs should have the option to develop programs tailored to the treatment needs of their patient population, and enable broad access to services.

References


