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La prise en charge intégrée des soins pour les personnes vivant avec un trouble psychique sévère

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Table des matières

Introduction

Les personnes vivant avec des troubles psychiques sévères souffrent plus fréquemment de maladies chroniques somatiques, telles que le diabète et les troubles cardiovasculaires. Leur espérance de vie est réduite en moyenne de quinze ans avec une mortalité prématurée, avant l'âge de 65 ans, quadruplée par rapport à la population générale.[1] Si les causes de ces comorbidités et de cette surmortalité sont multifactorielles, ces constats suggèrent une inadéquation des prises en charge existantes : en effet, la plupart des pays se caractérisent par une fragmentation des soins de santé mentale et physique, qui sont souvent financés et délivrés séparément. Cette situation ne favorise pas un bon accès aux soins, notamment en termes de prévention[2], ni une bonne coordination entre les professionnels de santé.

Réalisée dans le cadre du projet européen EU-Mind (https://eumind.eu/), financé par l'initiative Transforming Health and Care Systems (THCS), dont l'objectif est d'identifier les modèles de soins intégrés les plus efficaces et les plus adaptés aux personnes vivant avec des troubles psychiques sévères, cette bibliographie rassemble de la littérature scientifique identifiée à partir de l'interrogation des bases de données et portails suivants : Medline, Irdes, Cairn, Science direct, Web of science, Googlescholar.

Les aspects principalement documentés sont : les définitions et les concepts fondamentaux liés aux soins intégrés ; l'articulation entre soins somatiques et soins psychiatriques dans le cadre des soins primaires ; ainsi que le développement des soins intégrés inversés, principalement mis en œuvre au sein de structures spécialisées en santé mentale.

Les soins intégrés : définitions, concept

La notion de soins intégrés est un concept large, utilisée pour décrire un ensemble de changements cliniques, organisationnels et politiques visant à améliorer l'efficacité des services, l'expérience des patients, les résultats de santé et le coût des services.

Leutz (1999)[3] propose une typologie des modèles d'intégration qui distingue trois niveaux d'intégration :

- **Liaison** : Les organisations collaborent ponctuellement via des procédures souples pour échanger des informations sur les patients. Chaque structure connaît le rôle des autres, notamment en matière de financement et d'éligibilité.
- **Coordination** : Des mécanismes sont mis en place pour réduire la fragmentation entre les structures, favoriser la continuité des soins et le partage d'informations.

[1] Coldefy M. et Gandré C. (2018). " Personnes suivies pour des troubles psychiques sévères : une espérance de vie fortement réduite et une mortalité prématurée quadruplée". *Questions d'économie de la santé,* n° 237
[2] Coldefy M. et Gandré C. (2020). "Moins de soins de prévention, de recours aux spécialistes et plus d'hospitalisations évitables chez les personnes suivies pour un trouble psychique sévère. "*Questions d'économie de la santé, n° 250*
Gandré C., et al. (2023). Obstacles, ressources et contrastes dans les parcours de soins complexes : le cas du cancer chez les personnes vivant avec un trouble psychique sévère. *Questions d'économie de la santé, n° 281*
[3] Leutz W.N. (1999). Five Laws for Integrity Acute and long-term Care. *Milbank Quarterly* 1999 ; 77.

- **Intégration complète** : Une seule entité gère l'ensemble des services, avec des ressources, financements et systèmes d'information unifiés. Les équipes multidisciplinaires assurent la gestion de cas selon des procédures standardisées.

Ces modèles répondent à différents degrés de complexité des besoins des personnes.[4] Cependant d'autres catégorisations ont été proposées dans la littérature au cours du temps.
En 2016, l'intégration a été définie l'OMS comme « la gestion et la délivrance de services de santé qui permettent aux usagers de recevoir un continuum de soins préventifs et curatifs, en adéquation avec leurs besoins au cours du temps et à différents niveaux du système de santé.
Godwin et al.[5] insiste sur une approche centrée sur la personne, visant à coordonner les services de santé et sociaux pour répondre aux besoins complexes des individus, en particulier ceux atteints de maladies chroniques ou en situation de vulnérabilité.

ETUDES FRANÇAISES

(2016). "Parcours de soins, parcours santé, parcours de vie : Pour une prise en charge adaptée des patients et usagers. Lexique de A à Z". Paris, Ministère chargé de la Santé
http://social-sante.gouv.fr/IMG/pdf/2016-01-11_lexique_vf.pdf

> Les parcours se définissent comme la prise en charge globale du patient et de l'usager dans un territoire donné au plus près de son lieu de vie, avec une meilleure attention portée à l'individu et à ses choix, nécessitant l'action coordonnée des acteurs de la prévention, de la promotion de la santé, du sanitaire, du médico-social, du social, et intégrant les facteurs déterminants de la santé que sont l'hygiène, le mode de vie, l'éducation, le milieu professionnel et l'environnement. Les parcours ont une dimension temporelle qui est d'organiser une prise en charge du patient et de l'usager coordonnée dans le temps, et spatiale dans un territoire et la proximité de leur domicile. Leur réussite repose sur la participation et l'implication des patients et des usagers, sur l'intervention efficace et coordonnée des acteurs du système de soins, des services et établissements médico-sociaux et sociaux, des collectivités locales, des autres services de l'Etat et des organismes de protection sociale. Ce lexique de A à Z propose la définition des concepts les plus fréquemment évoqués dans les parcours. [résumé d'auteur]

Brunn, M. et Chevreul, K. (2013). "Prise en charge des patients atteints de maladies chroniques. Concepts, évaluations et enseignements internationaux." Sante publique **25**(1): 87-94, fig.
https://www.cairn.info/revue-sante-publique-2013-1-page-87.htm

> [BDSP. Notice produite par EHESP 9R0xsCI9. Diffusion soumise à autorisation]. Le nombre croissant de personnes atteintes de maladies chroniques représente un défi majeur pour les systèmes de santé en termes de morbidité, de mortalité, de qualité de la prise en charge et d'impact financier. Afin de répondre à ce défi, plusieurs concepts organisationnels pour une prise en charge structurée des maladies chroniques ont été développés, notamment dans certains pays étrangers tels que les USA, le Royaume-Uni et l'Allemagne. Les auteurs ont

[4] Adapté de : (2016). "Parcours de soins, parcours santé, parcours de vie : Pour une prise en charge adaptée des patients et usagers. Lexique de A à Z". Paris, Ministère chargé de la Santé
http://social-sante.gouv.fr/IMG/pdf/2016-01-11_lexique_vf.pdf

[5] Goodwin, N., Stein, V., Amelung, V. (2021). What is Integrated Care?. In: Amelung, V., Stein, V., Suter, E., Goodwin, N., Nolte, E., Balicer, R. (eds) Handbook Integrated Care. Springer

mené une revue de la littérature afin d'identifier les concepts-clés, les résultats et les facteurs de succès potentiels des dispositifs mis en place. Quatre concepts principaux, tous rattachés au concept plus large des soins intégrés, ont été identifiés : le "case management", le "disease management", le "chronic care model" et le "population management". Les travaux d'évaluation disponibles indiquent que les résultats escomptés en termes de gains de santé et de réduction des coûts ne sont que partiellement atteints mais qu'il existe bien une amélioration de la prise en charge.

Chambaud, L. (2016). "Le système de santé français à l'épreuve des transitions." Socio : la nouvelle revue des sciences sociales(6): 157-170.
https://socio.revues.org/2300

Cet article s'intéresse au concept d'integrated care, traduit par la notion d' « intégration des soins et des services » qui tend à s'imposer dans la littérature des études sur la santé, la maladie, les soins. Ce concept, qui peut être rapproché de la notion de parcours de soins actuellement prôné en France, aide à dépasser le clivage habituel entre le cure et le care, entre le soin et l'accompagnement. Sa mise en œuvre s'appuie sur un changement paradigmatique en cours à partir d'un phénomène de transition combinant cinq domaines : transition épidémiologique – avec la chronicisation de la plupart des maladies graves ; transition démographique, qui promeut la notion de service à la personne, préventif/curatif, accompagnement ; transition professionnelle, qui passe par les jeunes professionnels de santé ; transition technologique, non spécifique au monde de la santé mais qui la réalise, ne serait-ce qu'avec les technologies qui bousculent les prises en charge, ou le dépistage ; transition démocratique, dont on retrouve la trace dans le droit des malades des années 2000 et lors de l'émergence de concepts nouveaux comme le malade-expert ou l'éducation thérapeutique. Les enjeux actuels et les obstacles à cette évolution de notre système de santé sont discutés.

Contandriopoulos, A. p., Denis, J. l., Touati, N., et al. (2001). "Intégration des soins : dimensions et mise en oeuvre." Ruptures : revue transdisciplinaire en sante **8**(2): 38-52,
https://www.researchgate.net/publication/251783304_Integration_des_soins_Dimensions_et_mise_en_oeuvre

Le texte montre en quoi l'intégration des soins représente une solution potentielle aux dysfonctionnements des systèmes de santé. Définie sommairement, l'intégration consiste à organiser une cohérence durable dans le temps entre un système de valeurs, une gouverne et un système clinique de façon à créer un espace dans lequel des acteurs (des organisations) interdépendants trouvent du sens et un avantage à coordonner leurs pratiques dans un contexte particulier. La cohérence recherchée par l'intégration résulte de la mise en œuvre de façon durable dans le temps des cinq dimensions du processus d'intégration : l'intégration des soins, l'intégration de l'équipe clinique, l'intégration fonctionnelle, l'intégration normative, l'intégration systémique. Le processus de changement qui peut prendre naissance à n'importe quel niveau d'intégration représente une transformation radicale dont la mise en œuvre est exigeante.

Glaser, C., Canceil, O. et Gozlan, G. (2016). "Case management en psychiatrie : vers des pratiques professionnelles intégrées." L'information psychiatrique **92**(7): 539-545.
https://www.cairn.info/revue-l-information-psychiatrique-2016-7-page-539.htm

Le case management propose un cadre de référence à la prise en charge ambulatoire des personnes atteintes de pathologies chroniques. La philosophie de l'intervention vise à

favoriser un accompagnement progressif vers le rétablissement dans le milieu de vie ordinaire, en collaboration avec les proches et l'entourage immédiat. Dans cette perspective le concept de case management permet d'envisager un métier d'opérateur en santé mentale dont le champ de compétences transdisciplinaires pourrait trouver son application dans l'organisation du secteur. La globalité des réponses proposées aux besoins des usagers par le case management ne doit pas être une entrave à leur prise en charge mais contribuer à démontrer, par l'innovation, l'importance de l'approche-métier en psychiatrie (et a fortiori par le secteur) pour des soins efficaces et efficients.

Sebai, J. (2016). "Une analyse théorique de la coordination dans le domaine des soins : application aux systèmes de soins coordonnés." Sante publique **28**(2): 223-234.
https://www.cairn.info/revue-sante-publique-2016-2-page-223.htm

Différents enjeux d'ordre organisationnel, fonctionnel ou structurel ont été à l'origine de la remise en question des fondements de l'ancien système de soin basé sur une segmentation traditionnelle du marché entre médecine de ville et médecine hospitalière, entre secteur sanitaire et secteur social et marqué par une concurrence entre le secteur privé et le secteur public. La reconfiguration actuelle du système de soins se démarque par de « nouveaux » leviers expliqués par le développement d'une nouvelle reconfiguration organisationnelle du modèle sanitaire de premiers recours. C'est dans ce contexte que les structures de soin coordonné (SSC) se sont développées faisant de la coordination la pierre angulaire des relations entre professionnels pour une prise en charge globale, continue et de qualité. Notre contribution se propose de souligner les apports de différentes approches théoriques ainsi que leur contribution dans la compréhension du concept de la coordination dans l'analyse de la spécificité actuelle du domaine de santé.

Somme, D., Trouve, H., Passadori, Y., et al. (2013). "Prise de position de la Société Française de Gériatrie et Gérontologie sur le concept d'intégration." Gérontologie et société(145): 201-212.
https://shs.cairn.info/revue-gerontologie-et-societe1-2013-2-page-201

[BDSP. Notice produite par FNG R0xBDBq8. Diffusion soumise à autorisation]. Le concept d'intégration des soins et des services, bien que datant des années 90, n'est que récemment apparu dans les politiques publiques en France. Ce concept doit s'articuler avec celui de "coordination" qui a prévalu dans la conduite de la majorité des politiques publiques touchant le champ gérontologique depuis les années 60 en France. Afin de clarifier le concept et son adaptation à la réalité du système de soins et de services français, la Société française de gériatrie et de gérontologie a mandaté un groupe de travail interdisciplinaire. Les travaux de ce groupe sont synthétisés dans cet article. (R.A.).

A L'ÉTRANGER

Ahgren, B. et Axelsson, R. (2005). "Evaluating integrated health care: a model for measurement." Int J Integr Care. 5:e0

Purpose: In the development of integrated care, there is an increasing need for knowledge about the actual degree of integration between different providers of health services. The purpose of this article is to describe the conceptualisation and validation of a practical model for measurement, which can be used by managers to implement and sustain integrated care. Theory: The model is based on a continuum of integration, extending from full segregation through intermediate forms of linkage, coordination and cooperation to full integration.

Methods: The continuum was operationalised into a ratio scale of functional clinical integration. This scale was used in an explorative study of a local health authority in Sweden. Data on integration were collected in self-assessment forms together with estimated ranks of optimum integration between the different units of the health authority. The data were processed with statistical methods and the results were discussed with the managers concerned. Results: Judging from this explorative study, it seems that the model of measurement collects reliable and valid data of functional clinical integration in local health care. The model was also regarded as a useful instrument for managers of integrated care. Discussion: One of the main advantages with the model is that it includes optimum ranks of integration beside actual ranks. The optimum integration rank between two units is depending on the needs of both differentiation and integration.

Atun, R. a., Benett, S. et Duran, A. (2008). "When do vertical (stand-alone) programmes have a place in health systems?". Copenhague O.M.S. Bureau régional de l'Europe) http://www.euro.who.int/document/hsm/5_hsc08_ePB_8.pdf

The terms vertical and integrated are widely used in health service delivery, but each describes a range of phenomena. In practice, the dichotomy between them is not rigid, and the extent of verticality or integration varies between programmes ? including : a vertically funded, managed, delivered and monitored programme ; one with integrated funding, organization and management but separate delivery; and a fully integrated approach comprising comprehensive primary health care services. Most health services combine vertical and integrated elements, but the balance between programmes in these elements varies considerably. Hence, when vertical and horizontal and programme design are being discussed, clarity is needed on the programme element being referred to governance arrangements, organization, funding and service delivery.

Burns, L. R., Nembhard, I. M. et Shortell, S. M. (2022). "Integrating network theory into the study of integrated healthcare." Soc Sci Med **296**: 114664.

Healthcare policy in the United States (U.S.) has focused on promoting integrated healthcare to combat fragmentation (e.g., 1993 Health Security Act, 2010 Affordable Care Act). Researchers have responded by studying coordination and developing typologies of integration. Yet, after three decades, research evidence for the benefits of coordination and integration are lacking. We argue that research efforts need to refocus in three ways: (1) use social networks to study relational coordination and integrated healthcare, (2) analyze integrated healthcare at three levels of analysis (micro, meso, macro), and (3) focus on clinical integration as the most proximate impact on patient outcomes. We use examples to illustrate the utility of such refocusing and present avenues for future research.

Busetto, L., Luijkx, K. et Vrijhoef, H. J. M. (2017). "Advancing integrated care and its evaluation by means of a universal typology." Int J Care Coord **20**(1-2): 41-44.

Health systems around the globe implement integrated care interventions to address the Triple Aim of simultaneously improving population health, patient experiences and cost-efficiency. However, the underlying definitions and conceptualisations of integrated care often differ considerably, which makes uniform measurement and comparison difficult. Rather than agreeing on one definition of integrated care, we argue that a universal typology of integrated care interventions should be developed to enable the comparison of interventions that are based on different understandings of integrated care. This universal typology should combine rankable and intangible components with unrankable and tangible

sub-components, and be conceptually sound and flexible. The content of the typology should be developed by an international consortium of relevant stakeholders.

Druss, B. G. et Goldman, H. H. (2018). "Integrating Health and Mental Health Services: A Past and Future History." Am J Psychiatry **175**(12): 1199-1204.

The authors trace the modern history, current landscape, and future prospects for integration between mental health and general medical care in the United States. Research and new treatment models developed in the 1980s and early 1990s helped inform federal legislation, including the 2008 Mental Health Parity and Addiction Equity Act and the 2010 Affordable Care Act, which in turn are creating new opportunities to further integrate services. Future efforts should build on this foundation to develop clinical, service-level, and public health approaches that more fully integrate mental, medical, substance use, and social services. [AJP AT 175: Remembering Our Past As We Envision Our Future July 1928: A President Takes Stock Adolf Meyer: "I sometimes feel that Einstein, concerned with the relativity in astronomy, has to deal with very simple facts as compared to the complex and erratic and multicontingent performances of the human microcosmos, the health, happiness and efficiency of which we psychiatrists are concerned with." (Am J Psychiatry 1928; 85(1):1-31)].

Evans, J. M., Baker, R. G., Berta, W., et al. (2014). "The Evolution Of Integrated Health Care Strategies". In: [Annual Review of Health Care Management: Revisiting The Evolution of Health Systems Organization], Emerald Group Publishing Limited. **15:** 125-161. https://doi.org/10.1108/S1474-8231(2013)0000015011

Purpose To examine the evolution of health care integration strategies and associated conceptualization and practice through a review and synthesis of over 25 years of international academic research and literature. Methods A search of the health sciences literature was conducted using PubMed and EMBASE. A total of 114 articles were identified for inclusion and thematically analyzed using a strategy content model for systems-level integration. Findings Six major, inter-related shifts in integration strategies were identified: (1) from a focus on horizontal integration to an emphasis on vertical integration; (2) from acute care and institution-centered models of integration to a broader focus on community-based health and social services; (3) from economic arguments for integration to an emphasis on improving quality of care and creating value; (4) from evaluations of integration using an organizational perspective to an emerging interest in patient-centered measures; (5) from a focus on modifying organizational and environmental structures to an emphasis on changing ways of working and influencing underlying cultural attitudes and norms; and (6) from integration for all patients within defined regions to a strategic focus on integrating care for specific populations. We propose that underlying many of these shifts is a growing recognition of the value of understanding health care delivery and integration as processes situated in Complex-Adaptive Systems (CAS). Originality/value This review builds a descriptive framework against which to assess, compare, and track integration strategies over time.

Garattini, L., Badinella Martini, M. et Mannucci, P. M. (2022). "Integrated care: easy in theory, harder in practice?" Intern Emerg Med **17**(1): 3-6.

Integrated care (IC) is a term now commonly adopted across the world, which implies a positive attitude towards addressing fragmentation of service provision inside health systems. While the principles of IC are simple, their implementation is more controversial.

The ever growing number of IC definitions is related to the increasing domains of applications, which reflect the increasing demand induced by ageing multi-morbid patients. An exhaustive definition of IC should now enclose the coordination of health and social services useful to deliver seamless care across organizational boundaries. The current debate on IC is largely fueled by the modern mismatch between the growing burden of health needs for chronic conditions from the demand side and the design of health systems still largely centered on acute care from the supply side. The major reasons of persisting IC weakness in Western European nations stem from arguable choices of health policy taken in a quite recent past. The political creed in 'market competition' is likely to be the most emblematic. All initiatives encouraging healthcare providers to compete with each other are likely to discourage IC. Another historically rooted reason of IC weakness is the occupational status of European general practitioners (GPs). While single large-scale organizations have become a pressing priority for a modern primary care, most GPs are still selfemployed professionals working in their own cabinets. It is time to reconsider the anachronistic status of GPs so as to enhance IC in the future.

Garattini, L., Badinella Martini, M. et Nobili, A. (2022). "Integrated care in Western Europe: a wise solution for the future?" Expert Rev Pharmacoecon Outcomes Res **22**(5): 717-721.

INTRODUCTION: IC is a term commonly adopted across the world underpinning a positive attitude against fragmentation of healthcare service provision. While the principles supporting IC are simple, their implementation is more controversial. AREAS COVERED: The growing number of IC definitions is related to the increasing domains of applications, which reflect the increasing demand induced by aging multi-morbid patients. A comprehensive definition of IC should now include the coordination of health and social services useful to deliver continuous care across organizational boundaries. The recent debate on IC is largely influenced by the mismatch between the increasing burden of health and social needs for chronic conditions from the demand side, and the design of health-care systems still focused on acute care from the supply side. EXPERT OPINION: The major reasons of persisting IC weakness in European countries stem from arguable choices of health policy taken in the recent past. The political creed in 'market competition' is probably the most emblematic. All initiatives encouraging health-care providers to compete with each other are likely to discourage IC. Since most European GPs are still self-employed professionals working in their own cabinets, the anachronistic professional status of GPs is another historically rooted reason of IC weakness.

Garattini, L., Barbato, A., D'Avanzo, B., et al. (2023). "Including mental health care in a model of European health system." Epidemiol Psychiatr Sci **32**: e12.

The management of a health system is a matter of economics and business administration because of the costs induced by goods and services delivered. Economics teaches us that the positive effects induced by competition in free markets cannot be expected in health care, which is a classic example of market failure from both demand and supply sides. The most sensible key concepts to refer for managing a health system are funding and provision. While the logical solution for the first variable is universal coverage through general taxation, the second one requires a deeper understanding. Integrated care is the modern approach that better supports the choice in favour of the public sector also for service provision. A major threat against this approach is dual practice legally allowed for health professionals, which inevitably raises financial conflicts of interest. An exclusive contract of employment for civil servants should be the sine qua non for providing public services effectively and efficiently. Integrated care is particularly important for long-term chronic illnesses associated with high

levels of disability, such as neurodegenerative diseases and mental disorders, where the mix of health and social services needed can be very complex. Nowadays the growing number of community-dwelling patients with multiple physical and mental health needs is the major challenge for the European health systems. This happens also in public health systems, which should provide universal health coverage in principle, and the case of mental disorders is striking. In the light of this theoretical exercise, we strongly believe that a public National Health and Social Service should be the most indicated model for both funding and providing health and social care in modern societies. The big challenge of the common model of European health system here envisaged would be to limit the negative influences of politics and bureaucracy.

Goodwin, N., Stein, V., Amelung, V. (2021). What is Integrated Care?. In: [Amelung, V., Stein, V., Suter, E., Goodwin, N., Nolte, E., Balicer, R. (eds) Handbook Integrated Care.] Springer, Cham. https://doi.org/10.1007/978-3-030-69262-9_1

Hughes, G., Shaw, S. E. et Greenhalgh, T. (2020). "Rethinking Integrated Care: A Systematic Hermeneutic Review of the Literature on Integrated Care Strategies and Concepts." Milbank Q **98**(2): 446-492.

Policy Points Integrated care is best understood as an emergent set of practices intrinsically shaped by contextual factors, and not as a single intervention to achieve predetermined outcomes. Policies to integrate care that facilitate person-centered, relationship-based care can potentially contribute to (but not determine) improved patient experiences. There can be an association between improved patient experiences and system benefits, but these outcomes of integrated care are of different orders and do not necessarily align. Policymakers should critically evaluate integrated care programs to identify and manage conflicts and tensions between a program's aims and the context in which it is being introduced. CONTEXT: Integrated care is a broad concept, used to describe a connected set of clinical, organizational, and policy changes aimed at improving service efficiency, patient experience, and outcomes. Despite examples of successful integrated care systems, evidence for consistent and reproducible benefits remains elusive. We sought to inform policy and practice by conducting a systematic hermeneutic review of literature covering integrated care strategies and concepts. METHODS: We used an emergent search strategy to identify 71 sources that considered what integrated care means and/or tested models of integrated care. Our analysis entailed (1) comparison of strategies and concepts of integrated care, (2) tracing common story lines across multiple sources, (3) developing a taxonomy of literature, and (4) generating a novel interpretation of the heterogeneous strategies and concepts of integrated care. FINDINGS: We identified four perspectives on integrated care: patients' perspectives, organizational strategies and policies, conceptual models, and theoretical and critical analysis. We subdivided the strategies into four framings of how integrated care manifests and is understood to effect change. Common across empirical and conceptual work was a concern with unity in the face of fragmentation as well as the development and application of similar methods to achieve this unity. However, integrated care programs did not necessarily lead to the changes intended in experiences and outcomes. We attribute this gap between expectations and results, in part, to significant misalignment between the aspiration for unity underpinning conceptual models on the one hand and the multiplicity of practical application of strategies to integrate care on the other. CONCLUSIONS: Those looking for universal answers to narrow questions about whether integrated care "works" are likely to remain disappointed. Models of integrated care need to be valued for their heuristic

rather than predictive powers, and integration understood as emerging from particular as well as common contexts.

Joseph, R., Kester, R., O'Brien, C., et al. (2017). "The Evolving Practice of Psychiatry in the Era of Integrated Care." Psychosomatics **58**(5): 466-473.

BACKGROUND: Integrating behavioral health care into the primary care setting is increasingly recognized as an effective way to manage mental illness and substance use disorders on a population level in the United States. The term "integrated care," however, is used in many ways and encompasses several different models. OBJECTIVES: The aim of this article is to provide a conceptual framework to understand the landscape of models of integrated care and to use this framework to contrast the roles of behavioral health providers in integrated settings with those in traditional behavioral health delivery models. We will also review some of the advantages and limitations of integrated care for health care delivery systems, patients, and primary care providers.

Kee, K., Nies, H., van Wieringen, M., et al. (2023). "From Integrated Care to Integrating Care: A Conceptual Framework of Behavioural Processes Underlying Effective Collaboration in Care." Int J Integr Care **23**(4): 4.

INTRODUCTION: At all levels, effective collaboration between actors with different backgrounds lies at the heart of integrated care. Much attention has been given to the structural features underlying integrated care, but even under structurally similar circumstances, the effectiveness of collaboration varies largely. THEORY AND METHODS: Social and organizational psychological research shows that the extent to which collaboration is effective depends on actors' behaviours. We leverage insights from these two research fields and build a conceptual framework that helps untangle the behavioural processes underlying effective collaboration. RESULTS: We delineate that effective collaboration can be realized when actors (1) speak up about their interests, values, and perspectives (voice behaviour), (2) listen to the information that is shared by others, and (3) thoroughly process this information. We describe these behaviours and explain the motivations and conditions driving these. In doing so, we offer a conceptual framework that can be used to explain what makes actors collaborate effectively and how collaboration can be enhanced. DISCUSSION AND CONCLUSION: Fostering effective collaboration takes time and adequate conditions, fitting the particular context. As this context continuously changes, the processes and conditions require continuous attention. Integrated care, therefore, actually requires a carefully designed process of integrating care.

Kerrissey, M. (2022). "Commentary on "Integrating network theory into the study of integrated healthcare"." Soc Sci Med **305**: 115035.

As medicine continues to advance, fragmentation problems in care delivery - and the promise of care integration to solve them - will remain central. But focused research over the past thirty years has yet to uncover the key factors that enable integrated care. In their paper, Burns and colleagues offer a path to new discovery in this well-trodden area: drawing on network theory to better understand the social processes through which integrated care is produced. Social processes are a vital and understudied aspect of integration, and applying network theory may help to refocus integration in a more comprehensive way. However, to transform our understanding of integrated care - and to enable impact in practice - will require expansion beyond the usual network approaches to also capture the communication

and work processes that occur among entities. This is no small endeavor. It will take considerable humility, open-mindedness, and focus.

Kodner, D. L. (2009). "All together now: a conceptual exploration of integrated care." Healthc Q **13 Spec No**: 6-15.

Integrated care is a key strategy in reforming health systems around the world. Despite its importance, the concept's polymorphous nature and lack of specificity and clarity significantly hamper systematic understanding, successful application and meaningful evaluation. This article explores the many definitions, concepts, logics and methods found in health system and service integration. In addition to framing this evolving, albeit imprecise field, the article summarizes the main elements or building blocks of integrated care and suggests a way to address its various complexities and unknowns in a real-world sense.

Lambert, A. s., Op de beeck, S., (2022). "Vers des soins plus intégrés en Belgique : synthèse". Bruxelles, K.C.E. (KCE Report 359B)
https://kce.fgov.be/fr/publications/tous-les-rapports/vers-des-soins-plus-integres-en-belgique

Le système actuel de soins de santé en Belgique est essentiellement basé sur une approche par maladie et financé par prestation, ce qui n'est pas optimal pour faire face aux défis du vieillissement et de la multiplication des maladies chroniques. C'est pourquoi il est souhaitable d'évoluer vers un système de « soins intégrés », c'est-à-dire des soins plus adaptés aux besoins multidimensionnels des patients atteints de maladies chroniques, tout au long de leur vie et à travers les différentes lignes de soins. Différentes initiatives en ce sens sont déjà en cours en Belgique, tant au niveau fédéral que des entités fédérées, mais les acteurs de terrain ont l'impression que celles-ci ne sont pas encore assez coordonnées. Le nouveau Plan interfédéral sur les Soins intégrés, prévu pour début 2024, devrait pouvoir y remédier. Le Centre fédéral d'Expertise des Soins de Santé (KCE) a été chargé de faire le point sur l'état des lieux des soins intégrés en Belgique et d'identifier les points d'action pour mener à bien pour une transition vers davantage d'intégration des soins. Après une large consultation des acteurs de terrain, trois priorités ont été dégagées : un accord politique clair, une définition des territoires, une réforme du financement des soins.

Leutz, W. N. (1999). "Five laws for integrating medical and social services: lessons from the United States and the United Kingdom." Milbank Q 77(1): 77-110, iv-v.

Because persons with disabilities (PWDs) use health and social services extensively, both the United States and the United Kingdom have begun to integrate care across systems. Initiatives in these two countries are examined within the context of the reality that personal needs and use of systems differ by age and by type and severity of disability. The lessons derived from this scrutiny are presented in the form of five "laws" of integration. These laws identify three levels of integration, point to alternative roles for physicians, outline resource requirements, highlight friction from differing medical and social paradigms, and urge policy makers and administrators to consider carefully who would be most appropriately selected to design, oversee, and administer integration initiatives. Both users and caregivers must be involved in planning to ensure that all three levels of integration are attended to and that the borders between medical and other systems are clarified.

Nolte, E., Knai, C. etSaltman, R. B (2014). " Assessing chronic disease management in European health systems: Concepts and approaches. Copenhagen (Denmark), European Observatory on Health Systems and Policies

> The rising burden of chronic illness, in particular the rapid increase in the number of people with multiple health problems, is a challenge to health systems globally. Associated premature mortality and reduced physical functioning, along with higher use of health services and related costs, are among the key concerns faced by policy-makers and practitioners. There is a clear need to redesign delivery systems in order to better meet the needs created by chronic conditions, moving from the traditional, acute and episodic model of care to one that better coordinates professionals and institutions and actively engages service users and their carers. Many countries have begun this process but it has been difficult to reach conclusions about the best approach to take: care models are highly context-dependent and scientifically rigorous evaluations have been lacking. Assessing chronic disease management in European health systems explores some of the key issues, ranging from interpreting the evidence base to assessing the policy context for, and approaches to, chronic disease management across Europe. Drawing on 12 detailed country reports (available in a second, online volume), the study provides insights into the range of care models and the people involved in delivering these; payment mechanisms and service user access; and challenges faced by countries in the implementation and evaluation of these novel approaches. This book builds on the findings of the DISMEVAL project (Developing and validating DISease Management EVALuation methods for European health care systems), led by RAND Europe and funded under the European Union's (EU) Seventh Framework Programme (FP7) (Agreement

Peek, C. J. (2019). "What Is Integrated Behavioral Health?". In: [Integrated Behavioral Health in Primary Care: Your Patients Are Waiting]. Gold, S. B. etGreen, L. A. Cham, Springer International Publishing**:** 11-32.

> This chapter defines integrated care using as its foundation a carefully vetted, published definition that is widely sanctioned. More importantly, it explains this official definition and translates it into compatible language both for use within your practice and also for audiences beyond your practice who will have different needs to know what you are doing. The chapter connects this definition to different models of integrated care. It culminates with providing a worksheet to determine how your local approach to integrating behavioral health sustains the essential features of integrated care while customizing it to what your patients need and what can be done under your circumstances.

Peek, C. (2013). "Lexicon for behavioral health and primary care integration: Concepts and definitions developed by expert consensus". Rockville, MD: Agency for Healthcare Research and Quality. https://integrationacademy.ahrq.gov/sites/default/files/2020-06/Lexicon.pdf https://integrationacademy.ahrq.gov/products/ibh-lexicon(version web actualisée)

> This lexicon is a set of concepts and definitions developed by expert consensus for what we mean by behavioral health and primary care integration—a functional definition—what things look like in practice. A consensus lexicon enables effective communication and concerted action among clinicians, care systems, health plans, payers, researchers, policymakers, business modelers and patients working for effective, widespread implementation on a meaningful scale.

Peterson, K., Anderson, J., Bourne, D., et al. (2019). "Health Care Coordination Theoretical Frameworks: a Systematic Scoping Review to Increase Their Understanding and Use in Practice." J Gen Intern Med **34**(Suppl 1): 90-98.

BACKGROUND: Care coordination is crucial to avoid potential risks of care fragmentation in people with complex care needs. While there are many empirical and conceptual approaches to measuring and improving care coordination, use of theory is limited by its complexity and the wide variability of available frameworks. We systematically identified and categorized existing care coordination theoretical frameworks in new ways to make the theory-to-practice link more accessible. METHODS: To identify relevant frameworks, we searched MEDLINE®, Cochrane, CINAHL, PsycINFO, and SocINDEX from 2010 to May 2018, and various other nonbibliographic sources. We summarized framework characteristics and organized them using categories from the Sustainable intEgrated chronic care modeLs for multi-morbidity: delivery, FInancing, and performancE (SELFIE) framework. Based on expert input, we then categorized available frameworks on consideration of whether they addressed contextual factors, what locus they addressed, and their design elements. We used predefined criteria for study selection and data abstraction. RESULTS: Among 4389 citations, we identified 37 widely diverse frameworks, including 16 recent frameworks unidentified by previous reviews. Few led to development of measures (39%) or initiatives (6%). We identified 5 that are most relevant to primary care. The 2018 framework by Weaver et al., describing relationships between a wide range of primary care-specific domains, may be the most useful to those investigating the effectiveness of primary care coordination approaches. We also identified 3 frameworks focused on locus and design features of implementation that could prove especially useful to those responsible for implementing care coordination. DISCUSSION: This review identified the most comprehensive frameworks and their main emphases for several general practice-relevant applications. Greater application of these frameworks in the design and evaluation of coordination approaches may increase their consistent implementation and measurement. Future research should emphasize implementation-focused frameworks that better identify factors and mechanisms through which an initiative achieves impact.

Piquer-Martinez, C., Urionagüena, A., Benrimoj, S. I., et al. (2024). "Theories, models and frameworks for health systems integration. A scoping review." Health Policy **141**: 104997.

Plochg, T., Ilinca, S. et Noordegraaf, M. (2017). "Beyond integrated care." J Health Serv Res Policy **22**(3): 195-197.

Integrated care tops the health care agenda. But more integration alone will not remedy the crisis in health care, and there is a danger in the increasingly prevalent conceptualization of care integration as a goal in itself rather than as an instrument for improving performance. Operating integrated care systems, staffed by an overly specialized medical workforce, is unsustainable in terms of human and financial resources and is likely to produce little benefit for patients with multi-morbidity. An alternative approach involves health care leaders going beyond integrated care and nurturing transformative change from within the medical workforce instead. To be fit for purpose, the doctors must be encouraged and facilitated to customize their expertise to current and expected future burdens of disease. This would lead to more adaptive doctors who could actively support people in healing and managing their own health. Integrated care should be conceptualized as one possible lever for transformative change rather than its endpoint.

Rajan, D. et Rouleau, K. (2024). "Implementing the Primary Health Care Approach: a Primer". Copenhague, O.M.S. Bureau régional de l'Europe
https://eurohealthobservatory.who.int/publications/i/implementing-the-primary-health-care-approach-a-primer

> Primary health care (PHC) has values – around treating people close to home, continuity and coordination. It stands as the principal interface between the health system and communities – the locus where the formalized system meshes with people's lives. More than that, primary health care can shape and reshape health systems to make them more accessible, more integrated and more sustainable. The Primer is organized in three parts: Part I explains the PHC approach, its history, core concepts and rationale, and draws out lessons for transformation. Part II addresses the 'operational levers of PHC' or dimensions that need to be addressed to make PHC work. It covers the operational and strategic levers of governance, financing and human resources for health, medicines, health technology, infrastructure and digital health, and their role in implementing change.Part III concludes by taking a cross-cutting view of the impacts of PHC on the health system and wider goals of efficiency, quality of care, equity, access, financial protection and health systems resilience, including in the face of climate change.

Reid, R., Haggerty, J. et Mckendry, R. (2002). "Dissiper la confusion : concepts et mesures de la continuité des soins". Ottawa, Canadian Health Services Research Foundation

> Quand un patient reçoit des soins de diverses sources, il devient de plus en plus difficile de relier ces soins dans une trajectoire harmonieuse. Dans le monde entier, les rapports de politiques demandent un effort concerté pour éviter la fragmentation et améliorer la continuité des soins. Mais les efforts pour décrire le problème ou proposer des solutions sont entravés parce que la continuité a été définie et mesurée de maintes façons différentes. Ce rapport examinera comment la continuité a été utilisée et mesurée afin d'établir une notion commune du concept et de recommander des mesures pour la surveillance du système de santé. Les auteurs ont procédé à une enquête systématique sur la façon dont l'expression « continuité des soins » a été utilisée dans la documentation.

Show, S., Rosen, R. et Rumbold, B. (2011). "Integrated care summary: What is it? Does it work? What does it mean for the NHS?". Londres, Nuffield Trust
https://papers.ssrn.com/sol3/papers.cfm?abstract_id=2501338

> 'Integrated care' is a term that reflects a concern to improve patient experience and achieve greater efficiency and value from health delivery systems. The aim is to address fragmentation in patient services, and enable better coordinated and more continuous care, frequently for an ageing population which has increasing incidence of chronic disease. The search for ways to integrate care more effectively is a pressing policy concern. But what do we actually mean by 'integrated care'? This research report examines what is meant by 'integrated care'. It explores integrated care from an NHS perspective, identifies the concepts that underpin integrated care, suggests how these can be used to inform practical integration efforts both within and beyond the NHS, and sets out how integration might be measured.

Strandberg-Larsen, M. (2011). "Measuring integrated care." Dan Med Bull **58**(2): B4245.

> The positive outcomes of coordination of healthcare services are to an increasing extent becoming clear. However the complexity of the field is an inhibiting factor for vigorously designed trial studies. Conceptual clarity and a consistent theoretical frame-work are thus needed. While researchers respond to these needs, patients and providers face the multiple challenges of today's healthcare environment. Decision makers, planners and managers need evidence based policy options and information on the scope of the integrated care challenges they are facing. The US managed care organization Kaiser Permanente has been

put forward as an example for European healthcare systems to follow, although the evidence base is far from conclusive.

Uijen, A. A., Schers, H. J., Schellevis, F. G., et al. (2012). "How unique is continuity of care? A review of continuity and related concepts." Fam Pract **29**(3): 264-271.

BACKGROUND: The concept of 'continuity of care' has changed over time and seems to be entangled with other care concepts, for example coordination and integration of care. These concepts may overlap, and differences between them often remain unclear. OBJECTIVE: In order to clarify the confusion of tongues and to identify core values of these patient-centred concepts, we provide a historical overview of continuity of care and four related concepts: coordination of care, integration of care, patient-centred care and case management. METHODS: We identified and reviewed articles including a definition of one of these concepts by performing an extensive literature search in PubMed. In addition, we checked the definition of these concepts in the Oxford English Dictionary. RESULTS: Definitions of continuity, coordination, integration, patient-centred care and case management vary over time. These concepts show both great entanglement and also demonstrate differences. Three major common themes could be identified within these concepts: personal relationship between patient and care provider, communication between providers and cooperation between providers. Most definitions of the concepts are formulated from the patient's perspective. CONCLUSIONS: The identified themes appear to be core elements of care to patients. Thus, it may be valuable to develop an instrument to measure these three common themes universally. In the patient-centred medical home, such an instrument might turn out to be an important quality measure, which will enable researchers and policy makers to compare care settings and practices and to evaluate new care interventions from the patient perspective.

Valentijn, P. P., Boesveld, I. C., van der Klauw, D. M., et al. (2015). "Towards a taxonomy for integrated care: a mixed-methods study." Int J Integr Care **15**: e003.

INTRODUCTION: Building integrated services in a primary care setting is considered an essential important strategy for establishing a high-quality and affordable health care system. The theoretical foundations of such integrated service models are described by the Rainbow Model of Integrated Care, which distinguishes six integration dimensions (clinical, professional, organisational, system, functional and normative integration). The aim of the present study is to refine the Rainbow Model of Integrated Care by developing a taxonomy that specifies the underlying key features of the six dimensions. METHODS: First, a literature review was conducted to identify features for achieving integrated service delivery. Second, a thematic analysis method was used to develop a taxonomy of key features organised into the dimensions of the Rainbow Model of Integrated Care. Finally, the appropriateness of the key features was tested in a Delphi study among Dutch experts. RESULTS: The taxonomy consists of 59 key features distributed across the six integration dimensions of the Rainbow Model of Integrated Care. Key features associated with the clinical, professional, organisational and normative dimensions were considered appropriate by the experts. Key features linked to the functional and system dimensions were considered less appropriate. DISCUSSION: This study contributes to the ongoing debate of defining the concept and typology of integrated care. This taxonomy provides a development agenda for establishing an accepted scientific framework of integrated care from an end-user, professional, managerial and policy perspective.

Wankah, P., Gordon, D., Shahid, S., et al. (2023). "Equity Promoting Integrated Care: Definition and Future Development." Int J Integr Care **23**.

Warwick-Giles, L. et Checkland, K. (2018). "Integrated care." J Health Organ Manag **32**(1): 85-100.

> Purpose The purpose of this paper is to try and understand how several organisations in one area in England are working together to develop an integrated care programme. Weick's (1995) concept of sensemaking is used as a lens to examine how the organisations are working collaboratively and maintaining the programme. Design/methodology/approach Qualitative methods included: non-participant observations of meetings, interviews with key stakeholders and the collection of documents relating to the programme. These provided wider contextual information about the programme. Comprehensive field notes were taken during observations and analysed alongside interview transcriptions using NVIVO software. Findings This paper illustrates the importance of the construction of a shared identity across all organisations involved in the programme. Furthermore, the wider policy discourse impacted on how the programme developed and influenced how organisations worked together. Originality/value The role of leaders from all organisations involved in the programme was of significance to the overall development of the programme and the sustained momentum behind the programme. Leaders were able to generate a "narrative of success" to drive the programme forward. This is of particular relevance to evaluators, highlighting the importance of using multiple methods to allow researchers to probe beneath the surface of programmes to ensure that evidence moves beyond this public narrative.

Zonneveld, N., Driessen, N., Stüssgen, R. A. J., et al. (2018). "Values of Integrated Care: A Systematic Review." Int J Integr Care 18(4): 9.

> INTRODUCTION: Although substantial generic knowledge about integrated care has been developed, better understanding of the factors that drive behaviour, decision-making, collaboration and governance processes in integrated care networks is needed to take integrated care forward. To gain more insight into these topics and to understand integrated care in more depth, a set of underlying values of integrated care has been developed and defined in this study. THEORY AND METHODS: A systematic literature review was conducted to identify the underlying values of integrated care. Values theory was used as a theoretical framework for the analysis. RESULTS: This study identified 23 values in the current body of knowledge. The most frequently identified values are 'collaborative', 'co-ordinated', 'transparent', 'empowering', 'comprehensive', 'co-produced' and 'shared responsibility and accountability'. DISCUSSION AND CONCLUSION: The set of values is presented as a potential basis for a values-driven approach to integrated care. This approach enables better understanding of the behaviours and collaboration in integrated care and may also be used to develop guidance or governance in this area. The practical application of the values and their use at multiple levels is discussed. The consequences of different stakeholder perceptions on the values is explored and an agenda for future research is proposed.

Les modèles intégrant santé mentale et santé somatique : de multiples dispositifs existants

ETUDES FRANÇAISES

ANAP. (2015). "Les parcours des personnes en psychiatrie et santé mentale - Première approche". Paris, A.N.A.P.
http://www.anap.fr/publications-et-outils/publications/detail/actualites/les-parcours-des-personnes-en-psychiatrie-et-sante-mentale-premiere-approche/

La notion de « parcours en psychiatrie et santé mentale » est récente et elle est peu encore usitée. L'ANAP a voulu mettre en exergue cette dimension du « prendre soin », qui implique aussi bien les patients eux-mêmes, les familles, les aidants, les soignants du sanitaire et du médico-social et les acteurs de l'environnement social. Ce travail a pu se faire en identifiant 5 portes d'entrée dans le parcours, qui impliquent et interrogent l'ensemble des acteurs : L'accès au diagnostic et aux soins psychiatriques ; Les hospitalisations inadéquates ; L'accès aux accompagnements sociaux et médico-sociaux ; L'accès aux soins somatiques ; La prévention et la gestion des situations de crise. Partant de cette approche, plusieurs constats ont été réalisés, dont par exemple : La régulation séparée des secteurs sanitaire, médico-social et social est une entrave à la visibilité des parcours ; La non-demande de nombreux patients ; Le handicap psychique est une réalité encore méconnue des professionnels du sanitaire et médico-social ; La faiblesse des outils de mesure fait obstacle à une objectivation du service rendu. Des propositions ont été élaborées qui permettent aussi bien de tenir compte de la complexité des problématiques, que d'aider au questionnement concret des acteurs. Ce document est complété par les outils créés lors de l'accompagnement des ARS pilotes (résumé de l'éditeur).

A.N.A.P (2021). "Le nouvel ambulatoire en santé mentale : pour une vie debout !". Paris, A.N.A.P.
https://www.anap.fr/s/article/parcours-publication-2831

Améliorer le parcours des personnes vivant avec des troubles psychiques est un enjeu fort des projets territoriaux de santé mentale. Il appartient aux acteurs du territoire de s'organiser pour améliorer, fluidifier et sécuriser le parcours des personnes concernées. Cela implique d'aller vers ces personnes, leur apporter une réponse globale visant leur rétablissement sans négliger leur accès aux soins somatiques. Ces acteurs disposent également d'outils numériques qui peuvent faciliter leur mise en lien avec les autres professionnels du territoire et avec les personnes concernées. Ce livret s'appuie sur des retours d'expérience d'acteurs qui ont mis en place des dispositifs originaux, au-delà des établissements et des structures. Il est étayé par la contribution de trois groupes de réflexion composés d'experts et d'équipes pionnières représentant une vingtaine d'établissements et de personnes concernées.

Anastasi, A. (2021). "Psychiatrie et soins somatiques «Ce n'est pas le tout d'y dire, faut aussi y faire» 1." L'information psychiatrique **97**(6): 465-475.

Les patients psychiatriques ont une espérance de vie réduite du fait d'une morbi-mortalité somatique augmentée. Les difficultés d'accès aux soins en sont les causes essentielles malgré une évolution de la prise en compte de ces problématiques au cours des dernières années. La prise en charge des patients psychiatriques doit être globale et s'appuyer sur des dispositifs allant du droit commun à des structures hospitalières spécialisées comme les unités médico-psychiatriques, en capacité d'appréhender simultanément des situations somato-psychiatriques complexes. L'unité de médecine du centre hospitalier Le Vinatier illustre ce type de prises en charge. La temporalité nécessaire au soin de ces patients est un paramètre incontournable de ce type de situations complexes. Les unités médico-psychiatriques sont complémentaires dans le parcours de soins global pensé autour du sujet psychiatrique et

restent concurrentielles au vu du service médical rendu à une population de patients vulnérables.

Aubriet, S. et Fau, L. (2021). "Santé mentale et santé globale: pour une vision commune, une approche de la complexité." L'information psychiatrique **97**(6): 491-496.

Bensoussan, M. et Prébois, S. (2021). "Dispositif de soins partagés en psychiatrie de la Haute-Garonne." L'information psychiatrique **98**(8): 684-690.
https://www.cairn.info/revue-l-information-psychiatrique-2021-8-page-684.htm

Le dispositif de soins partagés en psychiatrie naît en Haute-Garonne d'une initiative médicale unissant médecins généralistes et psychiatres conscients de devoir engager une action prioritaire pour améliorer leurs pratiques professionnelles. La clinique quotidienne et la littérature médicale dégagent un fort consensus sur les difficultés d'adressage et de coopération entre la médecine générale et la psychiatrie. L'offre de soins spécialisés comme les aspects démographiques n'expliquent pas les difficultés d'accès aux soins psychiatriques, voire d'obtention d'un avis spécialisé, rencontrées sur l'ensemble du territoire de ce département, qu'il s'agisse des zones à forte densité de population et médicale, telles que l'agglomération toulousaine, ou de celles à faible densité. L'expérience d'un autre DSP (dispositif de soins partagés) a montré l'importance de structurer un dispositif apprenant basé sur le partage du soin et l'amélioration des collaborations. Les premiers résultats sont aussi spectaculaires qu'ils précisent les écueils à dépasser.

Blanchard, P., Eslous, L., Yeni, I., et al. (2014). "Evaluation de la coordination d'appui aux soins". Paris, I.G.A.S. (Rapport IGAS 2014-010R)
https://igas.gouv.fr/Evaluation-de-la-coordination-d-appui-aux-soins

A la demande de la ministre en charge de la santé, l'IGAS a été chargée de « procéder à un inventaire et à une analyse de l'ensemble des coordinations d'appui aujourd'hui déployées ». Cette mission a été envisagée dans le cadre de la Stratégie nationale de santé (SNS). Après un diagnostic de la situation, le rapport propose une nouvelle organisation de la coordination d'appui aux soins, reposant sur l'initiative des médecins. La coordination d'appui aux soins proposée est ainsi destinée à éviter toute rupture dans la prise en charge globale des patients grâce à la mobilisation de l'ensemble des professionnels qui peuvent y concourir. Concrètement, la mission propose que ce soit le médecin de premier recours, et lui seul, qui puisse la déclencher en concertation avec le patient. Le médecin de premier recours pourrait ainsi choisir de recourir à différentes modalités en fonction de sa pratique et de ses habitudes.

Bloch, M. a., Henaut, L., Sardas, J. c., et al. (2011). "La coordination dans le champ sanitaire et médico-social : enjeux organisationnels et dynamiques professionnelles". Paris, Fondation de l'Avenir
http://www.fondationdelavenir.org/portail/wp-content/uploads/etude_coordination_cgs_fpb_-fev2011_.pdf

Cette étude scientifique réalisée par le Centre de Gestion Scientifique de Mines-ParisTech pour le compte de la Fondation Paul Bennetot propose un état des connaissances internationales sur le sujet, une analyse inédite de la structuration de la coordination en France, et des solutions qui mériteraient d'être développées en termes de dispositifs et de compétences professionnelles.

Bornes, C. (2022). "La médecine de liaison en psychiatrie, pour une synergie des compétences au bénéfice des patients." Santé Publique **34**(5): 653-661.

Denis, F., Meunier-Beillard, N., Costa, M., et al. (2022). "Propositions des professionnels pour réduire le risque cardiovasculaire des patients psychiatriques." Santé Publique **34**(5): 621-632. https://www.cairn.info/revue-sante-publique-2022-5-page-621.htm

Introduction : Les maladies cardio-vasculaires représentent une des causes majeures de mortalité en France. Elles sont la cause principale de surmortalité des personnes souffrant de troubles psychiques au long cours (TPLC) en dehors des causes liées au suicide. But de l'étude : Cet article vise à identifier, selon le point de vue de professionnels de soins primaires et de la psychiatrie, leurs attentes et leurs besoins pour apporter aux usagers de la psychiatrie une meilleur prise en charge médicale et paramédicale du risque cardiovasculaire (RCV).Méthode : Il s'agit d'une étude qualitative prospective et multicentrique réalisée en deux temps : une phase exploratoire, par entretiens individuels en début d'étude afin de permettre la création des grilles d'entretiens collectifs ad hoc, suivie d'une étude qualitative proprement dite, qui s'inscrit dans la lignée de l'anthropologie médicale et de la sociologie des systèmes de santé. Résultats : Les 30 professionnels de la psychiatrie interrogés s'accordent sur la nécessité d'une meilleure coordination avec les soignants en extra hospitalier. Même si une ouverture est prônée, on observe un rappel des spécificités de la psychiatrie et l'importance d'une prise en compte générale de ces spécificités. Les 26 professionnels de soins primaires témoignent d'une volonté de mieux connaître les troubles, pathologies et traitements psychiatriques pour faciliter la prise en charge de ces patients à besoins spécifiques. Conclusion : Le croisement de ces résultats permettra de proposer une intervention appropriée en vue d'induire des effets probants sur la réduction du RCV chez les personnes souffrant de TPLC.

Fau, L., Ample, B. G. et Meunier, F. P. (2017). "Psychiatrie et médecine générale: un futur commun?" L'Information psychiatrique(2): 107-110.

Funk , M., Benradia , I. et Roelandt , J.-L. (2014). "Santé mentale et soins de santé primaires: une perspective globale." L'Information psychiatrique(5): 331-339.

Gallais, J. L. (2020). "Médecine générale, psychiatrie et soins primaires : regard de généraliste." Medecine : De La Médecine Factuelle à Nos Pratiques **16**(2): 77-83.

Au travers de l'analyse qualitative et quantitative du dispositif de médecine générale est éclairée la position d'interface médicale et sociale spécifique et celle d'acteur de santé mentale du médecin généraliste traitant. Parmi les constats négatifs beaucoup sont reliés aux faiblesses des choix de santé publics et aux défauts structurels d'organisation et de régulation du système de santé français. Dans les reformes en cours, le développement du dispositif du médecin traitant et des parcours de soins coordonnés est décrit comme levier essentiel pour des améliorations nécessaires.

Gandré, C. et Coldefy, M. (2020). "Disparities in the Use of General Somatic Care among Individuals Treated for Severe Mental Disorders and the General Population in France." Int J Environ Res Public Health **17**(10).

Individuals with severe mental illnesses (SMI) face a striking excess and premature mortality which has been demonstrated in several national contexts. This phenomenon, which constitutes a red-flag indicator of public health inequities, can be hypothesized to result from healthcare access issues which have been insufficiently documented so far. In this context,

our objective was to explore patterns of general somatic healthcare use of individuals treated for SMI in comparison to those of the general population in France using national health administrative data and a matched case-control study. Differences in the use of general and specific somatic preventive care services, primary care, routine specialized somatic care and admissions to non-psychiatric hospital departments for somatic causes were described between cases and controls after adjustment on differing clinical needs, socio-economic status, and living environment. Our results show a lower use of general preventive care services and of routine specialized somatic care in the SMI population, despite more frequent comorbidities, and a higher occurrence of avoidable hospitalizations, despite higher contacts with primary care physicians. These findings suggest that the health system fails to address the specific needs of this vulnerable population and support the development of measures aimed at reducing this gap.

Haute Autorité de santé(2018). "Coordination entre le médecin généraliste et les différents acteurs de soins dans la prise en charge des patients adultes souffrant de troubles mentaux : État des lieux, repères et outils pour une amélioration. Guide". Saint-Denis La Plaine, Has
https://has-sante.fr/jcms/c_2876272/fr/guide-coordination-entre-medecin-generaliste-et-acteurs-de-la-psychiatrie

Le médecin généraliste est un acteur majeur de la prise en charge des troubles mentaux. Il participe à la détection et au traitement des troubles et accompagne les patients dans le cadre d'une prise en charge globale. On constate en France une coordination insuffisamment développée entre le médecin généraliste et les professionnels spécialisés en psychiatrie et santé mentale notamment. Cette situation peut aboutir à des ruptures de soins, susceptibles d'avoir des conséquences importantes pour le patient, tant sur le plan psychiatrique que somatique. Pour répondre à ces enjeux, la HAS propose un guide pour aider les professionnels à développer et renforcer la coordination interprofessionnelle dans la prise en charge des patients adultes souffrant de troubles mentaux. Il présente des expériences d'amélioration conduites en France et à l'étranger ainsi que des repères et outils mobilisables de façon isolée ou combinée et en fonction des besoins, des ressources et des contraintes des professionnels.

Jean, A. et Ecole des hautes études en santé, p. (2018). "L'articulation entre soins somatiques et soins psychiatriques à l'heure des GHT" Rennes : Ehesp
https://documentation.ehesp.fr/memoires/2018/edh/Am%C3%A9lie%20JEAN.pdf

La prise en charge des pathologies mentales occupe une place à part entière dans le système de soins français, alimentant la dichotomie entre les soins psychiatriques et soins somatiques. Pourtant, la question de l'articulation entre ces deux modes de prise en charge constitue un véritable enjeu de santé publique. Compte-tenu des écarts d'espérance de vie entre personnes souffrant de pathologies mentales ou non, les études épidémiologiques font deux constats majeurs : d'une part, l'existence de plus grandes comorbidités et effets iatrogènes liés aux traitements des personnes atteintes de pathologies mentales ; d'autre part, le constat d'une plus grande inégalité d'accès aux soins somatiques pour ces personnes souffrant d'un handicap psychique. Ces patients doivent donc faire l'objet d'une attention particulière, notamment en ce qui concerne le dépistage, la surveillance et le suivi médical. Face à ces difficultés de prise en charge et au constat d'un inégal accès aux soins, plusieurs initiatives locales ont permis la mise en place de structures ou organisations de soins transversales dédiées. La réforme des GHT peut en ce sens constituer une opportunité de repenser l'organisation des soins psychiatriques et somatiques, et les modalités de leur articulation sur un territoire donné. Dans ce cadre, la pertinence de la mise en place de GHT

spécialisés en santé mentale peut être saisie afin de proposer une offre de soins adaptée au profil spécifique de ces patients, ou reste à interroger.

Malâtre-Lansac, A. (2020). "Santé mentale: faire face à la crise". Paris : Institut Montaigne

Les impacts psychiatriques de la pandémie du Covid-19 vont sans aucun doute constituer l'un des grands défis sanitaires et sociaux des prochaines années. Alors qu'un Français sur cinq est touché chaque année par un trouble psychiatrique, l'accès aux soins est extrêmement difficile. à peine la moitié des personnes souffrant de troubles psychiques est aujourd'hui prise en charge, avec une qualité de soins très inégale. Plusieurs raisons à cela : des ressources mal réparties sur le territoire, des délais d'attente très longs, des barrières financières, mais aussi des cloisonnements forts entre médecine somatique, psychiatrie et médico-social, ainsi qu'une forte stigmatisation. Pour répondre à ces défis, cette étude propose de reconnaître le rôle essentiel des médecins généralistes et des pédiatres dans la prise en charge des troubles fréquents et leur donner des moyens à la hauteur des enjeux, en favorisant notamment les collaborations entre professionnels et le partage d'information grâce au digital. En initiant une prise en charge innovante et collaborative des troubles les plus fréquents, elle ouvre la voie à une approche centrée sur les patients, à moins de stigmatisation et à un meilleur accès aux soins. Cette étude s'appuie sur les travaux scientifiques menés depuis plus de vingt ans sur ce sujet et sur de nombreux échanges de terrain avec des médecins de premiers recours, des patients, des psychiatres et des psychologues en France comme aux Etats-Unis.

Messer, N. (2024). "Prise en charge somatique des patients souffrant de troubles psychiatriques". In: [La santé mentale en France]. Bordeaux : LEH Editions**:** 219-230.

Beaucoup de facteurs retardent ou limitent l'accès à des soins somatiques adaptés pour les personnes souffrant de troubles mentaux . Ces facteurs diminuent de façon importante l'espérance de vie des personnes concernées et compliquent la prise en charge de leur santé mentale et somatiques. Ce chapitre aborde successivement les aspects épidémiologiques, la complexité de la clinique, les difficultés d'accès aux soins somatiques. Il conclue sur la nécessité de coordonner les soins psychiatriques et somatiques dans une optique pluridiciplinaire.

Saravane, D. et Fond-Harmant, L. (2022). "La santé pour tous : soins somatiques et troubles psychiatriques." Santé Publique **34**(5): 609-611.
https://www.cairn.info/revue-sante-publique-2022-5-page-609.htm

Sur le plan de la littérature internationale, il faut mentionner que les premières études épidémiologiques sur la santé physique des personnes atteintes de pathologies psychiatriques sont peu nombreuses et difficilement comparables. Les travaux les plus marquants de Hall RC et al [1] portent sur une étude prospective de 100 patients atteints de troubles et hospitalisés en psychiatrie : 90 % présentent des anomalies physiques, et pour 80 % d'entre eux, il est nécessaire de mettre en place un traitement thérapeutique somatique. Notons que pour 46 % d'entre eux la maladie n'était pas connue auparavant. Depuis, de nombreux travaux ont pu mettre en évidence des troubles somatiques associés à la pathologie mentale.

Sicot, R. (2025). La psychiatrie de liaison : Vers une conception moderne du soin intégré.Gestions Hospitalières 644: 175-178

La prise en charge des troubles psychiques et somatiques a reposé longtemps sur une séparation rigide, freinant une approche globale et cohérente du soin. La psychiatrie de liaison, qui vise à intégrer l'expertise psychiatrique aux services de soins somatiques, constitue une réponse essentielle à cette dichotomie historique. Pourtant, malgré des besoins croissants et une prévalence élevée des comorbidités psychiatriques chez les patients hospitalisés, son développement en France reste limité. L'auteur explore ici les freins historiques, organisationnels et financiers qui entravent l'essor de cette discipline et propose des pistes pour renforcer son ancrage au sein des établissements hospitaliers, au bénéfice des patients et des soignants.

Souweine, G. et al., e. (2021). "Psychiatrie et médecine générale à la moulinette du terrain : positions respectives et attentes réciproques." L'information psychiatrique **98**(8): 671-676.
https://www.cairn.info/revue-l-information-psychiatrique-2021-8-page-671.htm

Le dialogue qui suit a été élaboré à partir d'entretiens auxquels ont participé un psychiatre et un pédopsychiatre, tous deux de secteur, exerçant à Lyon et ses environs et deux médecins généralistes lyonnais. Les échanges ont permis de montrer que dans le contexte de tension d'accès aux soins psychiatriques que nous subissons, les relations entre médecins généralistes et psychiatres sont marqués par des stratégies récurrentes. Il s'agit pour les omnipraticiens de faire accéder leurs patients aux soins institutionnels et pour les psychiatres de réguler des structures saturées. Ces stratégies reposent à la fois sur les limites et les failles des institutions mais également sur un usage détourné de la clinique qui ne sert plus à soulager mais à fermer la porte d'un dispositif. Nous proposons de rechercher des modalités de coopération qui permettent de penser des solutions réalistes et adaptées pour le soin des patients.

A L'ETRANGER

(2017). "Partnership working in mental health : : joining up the dots, not picking up the pieces". London :, Grant Thornton
http://www.grantthornton.co.uk/en/insights/partnership-working-in-mental-health/

This paper draws together examples of successful collaboration between public services and feedback from a West Midlands round table discussion – the West Midlands Combined Authority having set up a mental health commission – to look at how different services have overcome some of the traditional barriers and demarcation lines between organisations

Aquin, J. P., El-Gabalawy, R., Sala, T., et al. (2017). "Anxiety Disorders and General Medical Conditions: Current Research and Future Directions." Focus (Am Psychiatr Publ) **15**(2): 173-181.

Evidence that anxiety disorders are associated with general medical conditions is growing. While it is known that medical and mental conditions are often comorbid, research demonstrates that there may be underlying causal mechanisms. Furthermore, comorbid anxiety and general medical conditions are associated with poorer patient outcomes than either condition alone. Comorbid general medical and mental disorders not only affect individual patient health but also strain existing medical systems. Growing health care expenditures and increasing time pressures on clinicians create a challenging environment for intensive therapy in traditional settings. Effective screening, diagnosis, and treatment of individuals with comorbid conditions require health systems that are based on

interprofessional collaboration, including integrative and collaborative care services. These models encourage the provision of patient care within a network of health care professionals, working together and sharing expertise for more efficient and holistic care. Research on the design and implementation of these systems within the context of anxiety disorders and comorbid general medical conditions is in its infancy. Given the staggeringly high rates of anxiety disorders within the general population and the continued rise of many chronic medical conditions coinciding with the increasing lifespan, mental health and primary care providers should consider how they might implement integrative care methods within their own practice.

Azrin, S. T. (2014). "Integrated care: High-impact mental health-primary care research for patients with multiple comorbidities." Psychiatr Serv **65**(4): 406-409.

Patients with multiple psychiatric and medical comorbidities are common in primary care practices (PCPs), and recent health care reforms will likely lead to an increase in their numbers. PCPs need flexible, integrated mental health-primary care interventions that are applicable to these complex patients and compatible with the PCP setting. Generating practice-ready solutions for rapid uptake in typical PCPs requires a new direction for mental health-primary care research. This column describes an approach that embraces both real-world relevance and methodological rigor to stimulate such research. The approach emphasizes generating knowledge that decision makers need, using practice-based evidence and efficient methods, and planning for sustainability and broad uptake from the outset.

Bellamy, C. D., E, H. F., Costa, M., et al. (2016). "Barriers and Facilitators of Healthcare for People with Mental Illness: Why Integrated Patient Centered Healthcare Is Necessary." Issues in Mental Health Nursing **37**(1096-4673 (Electronic)): 421-428.

Understanding barriers and facilitators of healthcare for people with mental illness is essential for healthcare and mental healthcare organizations moving towards patient centered care. This paper presents findings of a measure on barriers and facilitators of healthcare completed by 204 patients being served at a co-located wellness center (primary healthcare clinic) located in an urban mental health center. The top 10 results show important findings for planning healthcare services that are responsive to the needs of people with mental illness. Basic structural issues as a result of poverty are extremely important (transportation, housing, payment) as well as difficulty with public healthcare that often involves long wait-times for appointments and at the doctor's office and hours that might not be convenient. Healthcare services that want to meet the needs of people with mental illness need to address these issues. What facilitates healthcare is not just removing the barriers to receiving healthcare services but instead involves more interpersonal aspects of healthcare such as liking your provider, being able to talk with your provider, feeling your provider cares about you and listens to you. Structural supports such as also being in mental health services, having systems for remembering appointments, and/or having appointment times that are convenient also facilitate seeking healthcare. Facilitating healthcare seeking also seems to involve a sense of agency-looking forward to taking charge of your health and feeling capable of following healthcare provider instructions. Healthcare systems for people with mental illness need to support these facilitators to give care-seekers the support they need. Key points are provided on how organizations and staff can work more effectively in implementing patient centered care. FAU - Bellamy, Chyrell D

Belson, C., Sheitman, B. et Steiner, B. (2020). "The Effects of an Enhanced Primary Care Model for Patients with Serious Mental Illness on Emergency Department Utilization." Community Ment Health J **56**(7): 1311-1317.

Patients with Serious Mental Illness (SMI) have high rates of emergency department visits and high premature mortality rates, often due to poor primary care. A model of enhanced primary care services integrated in a behavioral health location is being implemented and studied at the UNC WakeBrook Primary Care Center (UNCWPC). This research was conducted as a retrospective cohort study. ED Visit Utilization before and after establishing care at UNCWPC were calculated for a cohort and a subset of patients. There was a decrease in ED utilization after years 3-4 of enrollment for physical health complaints for the overall cohort (n = 101), from 3.23 to 1.83 visits/person/year, and for patients with multiple physical comorbidities (n = 50), from 4.04 to 2.48 visits/person/year. This study indicated that an enhanced model of primary care can help decrease ED utilization for primary care conditions. The decline was not seen until the patients were well-established.

Byng, R., Creanor, S., Jones, B., et al. (2023). "The effectiveness of a primary care-based collaborative care model to improve quality of life in people with severe mental illness: PARTNERS2 cluster randomised controlled trial." Br J Psychiatry **222**(6): 246-256.

BACKGROUND: Individuals living with severe mental illness can have significant emotional, physical and social challenges. Collaborative care combines clinical and organisational components. AIMS: We tested whether a primary care-based collaborative care model (PARTNERS) would improve quality of life for people with diagnoses of schizophrenia, bipolar disorder or other psychoses, compared with usual care. METHOD: We conducted a general practice-based, cluster randomised controlled superiority trial. Practices were recruited from four English regions and allocated (1:1) to intervention or control. Individuals receiving limited input in secondary care or who were under primary care only were eligible. The 12-month PARTNERS intervention incorporated person-centred coaching support and liaison work. The primary outcome was quality of life as measured by the Manchester Short Assessment of Quality of Life (MANSA). RESULTS: We allocated 39 general practices, with 198 participants, to the PARTNERS intervention (20 practices, 116 participants) or control (19 practices, 82 participants). Primary outcome data were available for 99 (85.3%) intervention and 71 (86.6%) control participants. Mean change in overall MANSA score did not differ between the groups (intervention: 0.25, s.d. 0.73; control: 0.21, s.d. 0.86; estimated fully adjusted between-group difference 0.03, 95% CI -0.25 to 0.31; P = 0.819). Acute mental health episodes (safety outcome) included three crises in the intervention group and four in the control group. CONCLUSIONS: There was no evidence of a difference in quality of life, as measured with the MANSA, between those receiving the PARTNERS intervention and usual care. Shifting care to primary care was not associated with increased adverse outcomes.

Cerimele, J. M., Katon, W. J., Sharma, V., et al. (2012). "Delivering psychiatric services in primary-care setting." Mt Sinai J Med **79**(4): 481-489.

Psychiatric disorders, particularly depression and anxiety disorders, are common in primary-care settings, though often overlooked or untreated. Depression and anxiety disorders are associated with a poorer course for and complications from common chronic diseases such as diabetes mellitus and coronary heart disease. Integrating psychiatric services into primary-care settings can improve recognition and treatment of psychiatric disorders for large populations of patients. Numerous research studies demonstrate associations between improved recognition and treatment of psychiatric disorders and improved courses of

psychiatric disorders, but also with improvements in other chronic diseases such as diabetes. The evidence bases supporting the use of 2 models of integrated care, colocation of psychiatric care and collaborative care, are reviewed. These models' uses in specific populations are also discussed.

Chwastiak, L. A., Jackson, S. L., Russo, J., et al. (2017). "A collaborative care team to integrate behavioral health care and treatment of poorly-controlled type 2 diabetes in an urban safety net primary care clinic." Gen Hosp Psychiatry **44**: 10-15.

OBJECTIVE: Demonstrate the feasibility of implementing a collaborative care program for poorly-controlled type 2 diabetes and complex behavioral health disorders in an urban academically-affiliated safety net primary care clinic. METHODS: This retrospective cohort study evaluates multidisciplinary team care approach to diabetes in a safety net clinic, and included 634 primary care clinic patients with hemoglobin A1c (HbA1c)>9%. HbA1c, blood pressure, and depression severity were assessed at the initial visit and at the end of treatment, and compared to those of patients who were not referred to the team. RESULTS: The 151 patients referred to the program between March 2013 and November 2014 had a higher initial mean HbA1c: 10.6% vs. 9.4%, and were more likely to have depression (p=0.006), anxiety (p=0.04), and bipolar disorder (p=0.03), compared to the 483 patients who were not referred. During the 18-month study period, there was a mean decrease in HbA1c of 0.9 (10.6 to 9.4) among those referred to the team, compared to a mean decrease of 0.2 (9.4 to 9.2) among those not referred. This was a significantly greater percent change in HbA1c (p=0.008). CONCLUSION: The integration of behavioral healthcare into chronic care management of patients with diabetes is a promising strategy to improve outcomes among the high risk population in safety net settings.

Duncan, M. H., Erickson, J. M., Chang, D., et al. (2022). "Psychiatry's Expanded Integration into Primary Care." Psychiatr Clin North Am **45**(1): 71-80.

Integrated behavioral care, and in particular, the collaborative care model, has been working to improve access and treatment for people with mental health disorders. Integrated care allows for adaptable, scalable, and sustainable practice that addresses the mental health needs of the public. During the pandemic several challenges emerged to delivering integrated care. This disruption happened at a systems level, team-based care level, scope of care level, and patient access level. This article looks through the lens of those various levels to identify and some of the lessons learned to help build a more resilient and flexible integrated care program.

Dunn, P., Fraser, C., Williamson, S., et al. (2022). "Integrated care systems : what do they look like?". London :, Health Foundation (Long read)
https://www.health.org.uk/publications/long-reads/integrated-care-systems-what-do-they-look-like
https://www.health.org.uk/publications/long-reads/

Integrated care systems (ICSs) are the centrepiece of the biggest legislative overhaul of the NHS in a decade. From July 2022, England will be formally divided into 42 area-based ICSs, covering populations of around 500,000 to 3 million people. ICSs face a mammoth task. Staffing shortages in the NHS are chronic, health and care services are under extreme strain, and health inequalities are wide and growing. This long read presents analysis of publicly available data on some of the characteristics of ICSs and policy context in each area. We outline some of the challenges facing ICSs and reflect on the implications for national policy. The task facing ICSs is not equal. Pressures on services and the health of the population vary

widely between ICSs – as do the resources available to address them. ICSs also look very different in their size, complexity and other characteristics that will shape how they function and their ability to collaborate to improve services. National policy on ICSs must acknowledge this variation and be realistic about what different areas can achieve. Differences in local context should be reflected in how ICS performance is assessed and reported. Policymakers must target support for ICSs with different needs, and some areas will likely require additional resources to help deliver national policy objectives

Ellis H, Alexander V. (2016). Eradicating Barriers to Mental Health Care Through Integrated Service Models: Contemporary Perspectives for Psychiatric-Mental Health Nurses Service Models: Contemporary Perspectives for Psychiatric-Mental Health Nurses." Arch Psychiatr Nurs **30**(3): 432-438.

There has been renewed, global interest in developing new and transformative models of facilitating access to high-quality, cost-effective, and individually-centered health care for severe mentally-ill (SMI) persons of diverse racial/ethnic, cultural and socioeconomic backgrounds. However, in our present-day health-service delivery systems, scholars have identified layers of barriers to widespread dispersal of well-needed mental health care both nationally and internationally. It is crucial that contemporary models directed at eradicating barriers to mental health services are interdisciplinary in context, design, scope, sequence, and best-practice standards. Contextually, nurses are well-positioned to influence the incorporation and integration of new concepts into operationally interdisciplinary, evidence-based care models with measurable outcomes. The aim of this concept paper is to use the available evidence to contextually explicate how the blended roles of psychiatric mental health (PMH) nursing can be influential in eradicating barriers to care and services for SMI persons through the integrated principles of collaboration, integration and service expansion across health, socioeconomic, and community systems. A large body of literature proposes that any best-practice standards aimed at eliminating barriers to the health care needs of SMI persons require systematic, well-coordinated interdisciplinary partnerships through evidence-based, high-quality, person-centered, and outcome-driven processes. Transforming the conceptual models of collaboration, integration and service expansion could be revolutionary in how care and services are coordinated and dispersed to populations across disadvantaged communities. Building on their longstanding commitment to individual and community care approaches, and their pivotal roles in research, education, leadership, practice, and legislative processes; PMH nurses are well-positioned to be both influential and instrumental in the development of innovative, revolutionary, and transformative paradigmatic models aimed at eradicating treatment barriers, promoting well-being, and reducing preventable mortalities and morbidities among SMI persons.

Flanagan EH, Wyatt JP, Pavlo AJ. (2024). "Care integration goes Beyond Co-Location: Creating a Medical Home". Adm Policy Ment Health. 2024 Jan;**51**(1):123-133

How to successfully integrate mental health and primary care remains a critically important question given the continued morbidity and early mortality of people with serious mental illness. This study investigated integration in a community mental health center (MHC) primarily treating people with SMI in a large, urban northeastern city where an on-site primary care center (PCC) was opened resulting in co-located mental health and primary care services being provided. Using focus groups and online surveys this study asked participants about their thoughts and interactions with the on-site PCC. Participants included staff from clinical, non-clinical, and leadership roles in the mental health center (MHC; PCC staff; and MHC clients who did not use the on-site PCC). MHC staff also offered their thoughts about

and experiences with the on-site PCC one year and two years after the on-site PCC opened through an on-line survey. In both methods, staff reported limited awareness and expectations of the PCC in the first year. Staff indicated that successful care integration goes beyond co-location and peer health navigation can enhance integration. Finally, staff discussed desires for enhancing care integration and co-located services into a medical home that included communicating across medical records and providers at different agencies. Our results suggest that, in addition to the previously researched three C's of care integration (consultation, coordination, and collaboration), two more C's were essential to successful care integration: co-location and communication. Communication across medical records and providers at different agencies was an essential component of care integration, and co-location added increased ability to communicate across providers.

Fleury, M.-J. (2011). "Application des réseaux intégrés de services en santé mentale au Québec: contexte d'implantation, état de la mise en œuvre et opinions des omnipraticiens." Santé Publique **23**(HS): 155-159.

Cet article présente le contexte d'émergence des réseaux intégrés de services (RIS), les fondements des RIS et certaines conditions de succès de leur mise en œuvre. La réforme en santé mentale au Québec permet d'illustrer l'état d'implantation de l'intégration du dispositif de soins. Dans les transformations en cours, la consolidation des soins primaires et le déploiement de modèles de soins partagés ou de collaboration sont surtout visés. En raison de leur complexité d'implantation, les RIS soutenant une restructuration systémique, n'ont encore été que peu développés. Les omnipraticiens sont au cœur des transformations, et sont des acteurs incontournables du succès de l'implantation des modèles d'intégration de services dont les RIS.

Funderburk, J. S., Sugarman, D. E., Labbe, A. K., et al. (2011). "Behavioral health interventions being implemented in a VA primary care system." J Clin Psychol Med Settings **18**(1): 22-29.

The integration of behavioral health and primary care has received much attention in the literature. Behavioral health providers (BHPs) in integrated settings are faced with different treatment constraints than those who work in specialty mental health. The existing literature focuses on what BHPs should do in primary care settings; however, little research exists specifying what BHPs are actually doing. This study provides a glimpse into what types of interventions BHPs are using, and what types of patients they are seeing, in primary care. A chart review was conducted of patients (N = 180) seen by BHPs in five Veterans Affairs primary care clinics. Depression was the most common diagnosis, while less common presenting problems included substance abuse/dependence, psychosis, and bipolar disorder. Common interventions used were medical management, psycho-education, elements of cognitive-behavioral therapy (CBT), and supportive psychotherapy. Future research should examine the efficacy of brief interventions in primary care settings.

Geist, R., Versloot, J., Mansfield, E., et al. (2020). "The Collaborative Care Model for Patients With Both Mental Health and Medical Conditions Implemented in Hospital Outpatient Care Settings." J Ambul Care Manage **43**(3): 230-236.

With the increased concern regarding the negative impact that care in silos has on patients and the health care system, there is growing interest in integrated models of care especially for individuals with co-occurring physical and mental health conditions. Although generally applied in a community setting, we adapted and implemented an evidence-based integrated model of care, the collaborative care model (CCM) in an adult and a pediatric hospital-based

outpatient clinic. Enrolment was criteria based and management was measurement driven. The model is team based and consists of new roles for its members including the patient, the care manager, the primary care clinician, and the psychiatric consultant. A key role was that of the care manager who worked with the patient and engaged primary care. The care manager also organized team-based treatment planning in systematic case reviews that contributed to the care plan. Support for training of the new and changes in roles is underscored. In this communication we comment on our initial experience of applying the CCM to the hospital outpatient setting.

Goodrich, D. E., Kilbourne, A. M., Nord, K. M., et al. (2013). "Mental health collaborative care and its role in primary care settings." Curr Psychiatry Rep **15**(8): 383.

Collaborative care models (CCMs) provide a pragmatic strategy to deliver integrated mental health and medical care for persons with mental health conditions served in primary care settings. CCMs are team-based intervention to enact system-level redesign by improving patient care through organizational leadership support, provider decision support, and clinical information systems, as well as engaging patients in their care through self-management support and linkages to community resources. The model is also a cost-efficient strategy for primary care practices to improve outcomes for a range of mental health conditions across populations and settings. CCMs can help achieve integrated care aims underhealth care reform yet organizational and financial issues may affect adoption into routine primary care. Notably, successful implementation of CCMs in routine care will require alignment of financial incentives to support systems redesign investments, reimbursements for mental health providers, and adaptation across different practice settings and infrastructure to offer all CCM components.

Grazier, K. L., Smiley, M. L. et Bondalapati, K. S. (2016). "Overcoming Barriers to Integrating Behavioral Health and Primary Care Services." J Prim Care Community Health **7**(4): 242-248.

OBJECTIVE: Despite barriers, organizations with varying characteristics have achieved full integration of primary care services with providers and services that identify, treat, and manage those with mental health and substance use disorders. What are the key factors and common themes in stories of this success? METHODS: A systematic literature review and snowball sampling technique was used to identify organizations. Site visits and key informant interviews were conducted with 6 organizations that had over time integrated behavioral health and primary care services. Case studies of each organization were independently coded to identify traits common to multiple organizations. RESULTS: Common characteristics include prioritized vulnerable populations, extensive community collaboration, team approaches that included the patient and family, diversified funding streams, and data-driven approaches and practices. CONCLUSIONS: While significant barriers to integrating behavioral health and primary care services exist, case studies of organizations that have successfully overcome these barriers share certain common factors.

Guerrero, E. G., Heslin, K. C., Chang, E., et al. (2015). "Organizational correlates of implementation of colocation of mental health and primary care in the Veterans Health Administration." Adm Policy Ment Health **42**(4): 420-428.

This study explored the role of organizational factors in the ability of Veterans Health Administration (VHA) clinics to implement colocated mental health care in primary care settings (PC-MH). The study used data from the VHA Clinical Practice Organizational Survey

collected in 2007 from 225 clinic administrators across the United States. Clinic degree of implementation of PC-MH was the dependent variable, whereas independent variables included policies and procedures, organizational context, and leaders' perceptions of barriers to change. Pearson bivariate correlations and multivariable linear regression were used to test hypotheses. Results show that depression care training for primary care providers and clinics' flexibility and participation were both positively correlated with implementation of PC-MH. However, after accounting for other factors, regressions show that only training primary care providers in depression care was marginally associated with degree of implementation of PC-MH (p = 0.051). Given the importance of this topic for implementing integrated care as part of health care reform, these null findings underscore the need to improve theory and testing of more proximal measures of colocation in future work.

Gunn, R., Davis, M. M., Hall, J., et al. (2015). "Designing Clinical Space for the Delivery of Integrated Behavioral Health and Primary Care." J Am Board Fam Med **28 Suppl 1**(Suppl 1): S52-62.

PURPOSE: This study sought to describe features of the physical space in which practices integrating primary care and behavioral health care work and to identify the arrangements that enable integration of care. METHODS: We conducted an observational study of 19 diverse practices located across the United States. Practice-level data included field notes from 2-4-day site visits, transcripts from semi structured interviews with clinicians and clinical staff, online implementation diary posts, and facility photographs. A multidisciplinary team used a 4-stage, systematic approach to analyze data and identify how physical layout enabled the work of integrated care teams. RESULTS: Two dominant spatial layouts emerged across practices: type-1 layouts were characterized by having primary care clinicians (PCCs) and behavioral health clinicians (BHCs) located in separate work areas, and type-2 layouts had BHCs and PCCs sharing work space. We describe these layouts and the influence they have on situational awareness, interprofessional "bumpability," and opportunities for on-the-fly communication. We observed BHCs and PCCs engaging in more face-to-face methods for coordinating integrated care for patients in type 2 layouts (41.5% of observed encounters vs 11.7%; P < .05). We show that practices needed to strike a balance between professional proximity and private work areas to accomplish job tasks. Private workspace was needed for focused work, to see patients, and for consults between clinicians and clinical staff. We describe the ways practices modified and built new space and provide 2 recommended layouts for practices integrating care based on study findings. CONCLUSION: Physical layout and positioning of professionals' workspace is an important consideration in practices implementing integrated care. Clinicians, researchers, and health-care administrators are encouraged to consider the role of professional proximity and private working space when creating new facilities or redesigning existing space to foster delivery of integrated behavioral health and primary care.

Hammer, J. H., Perrin, P. B. et Spiker, D. A. (2021). "Impact of integrated care and co-location of care on mental help-seeking perceptions".

BACKGROUND: Integrated care may offer a solution to subpar mental health referral adherence, but people’s openness to receiving psychological treatment in this setting is understudied. AIMS: The present study examined the influence of the integrated care context and co-location of care on people’s help-seeking perceptions. METHOD: This study (N = 397) used an experimental vignette design to compare the impact of treatment type (integrated care vs. traditional psychotherapy) and distance (close vs. far) on help-seeking perceptions. RESULTS: The integrated care environment (significant effect on perceived behavioral control) and closer proximity of the psychologist (significant effect on intention,

attitudes, perceived effectiveness of treatment, self-stigma) only improved help-seeking perceptions among those with prior experience with mental health treatment. In the overall sample, treatment type and distance only demonstrated an effect among women, but not men. CONCLUSIONS: Pending replication with samples from diverse populations, these findings provide a cautionary tale about lay perceptions of integrated care's anticipated utility. However, co-location and, to a lesser degree, the common attributes of the integrated care format (e.g. team approach, flexible scheduling) may represent a potential pathway for reducing resistance to help seeking that can accompany traditional psychotherapy referrals among those with past exposure to behavioral healthcare. [Abstract]

Happell, B., Platania-Phung, C., Scott, D., et al. (2014). "Communication with colleagues: frequency of collaboration regarding physical health of consumers with mental illness." Perspect Psychiatr Care **50**(1): 33-43.

PURPOSE: To identify how frequently nurses in mental health services communicate about physical health of consumers with other healthcare professionals, and whether such collaboration is associated with physical care actions with consumers. DESIGN AND METHODS: An online national Australian survey of nurses in mental health services. FINDINGS: Nurses discuss physical health frequently with general practitioners, psychiatrists, and case managers, and less frequently with occupational therapists, social workers, and nurse practitioners. Interprofessional attention was positively associated with direct physical health care such as clinical screening and health education. PRACTICE IMPLICATIONS: Interprofessional communication may support nurses in direct physical healthcare actions with consumers. Increasing collaborations with nurse practitioners, social workers, and occupational therapists need to be explored as part of clinical teamwork development.

Heddaeus, D., Dirmaier, J., Brettschneider, C., et al. (2019). "Study protocol for the COMET study: a cluster-randomised, prospective, parallel-group, superiority trial to compare the effectiveness of a collaborative and stepped care model versus treatment as usual in patients with mental disorders in primary care." BMJ Open **9**(11): e032408.

INTRODUCTION: Mental healthcare is one of the biggest challenges for healthcare systems. Comorbidities between different mental disorders are common, and patients suffer from a high burden of disease. While the effectiveness of collaborative and stepped care models has been shown for single disorders, comorbid mental disorders have rarely been addressed in such care models. The aim of the present study is to evaluate the effectiveness of a collaborative and stepped care model for depressive, anxiety, somatoform and alcohol use disorders within a multiprofessional network compared with treatment as usual. METHODS AND ANALYSIS: In a cluster-randomised, prospective, parallel-group superiority trial, n=570 patients will be recruited from primary care practices (n=19 practices per group). The intervention is a newly developed collaborative and stepped care model in which patients will be treated using treatment options of various intensities within an integrated network of outpatient general practitioners, psychiatrists, psychotherapists and inpatient institutions. It will be compared with treatment as usual with regard to effectiveness, cost-effectiveness and feasibility, with the primary outcome being a change in mental health-related quality of life from baseline to 6 months. Patients in both groups will undergo an assessment at baseline, 3, 6 and 12 months after study inclusion. ETHICS AND DISSEMINATION: The study has been approved by the ethics committee of the Hamburg Medical Association (No. PV5595) and will be carried out in accordance with the principles of the Declaration of Helsinki. For dissemination, the results will be published in peer-reviewed journals and presented at conferences. Within the superordinate research project Hamburg Network for

Health Services Research, the results will be communicated to relevant stakeholders in mental healthcare. TRIAL REGISTRATION NUMBER: NCT03226743.

House, A., Guthrie, E., Walker, A., et al. (2018). "A programme theory for liaison mental health services in England".
https://bmchealthservres.biomedcentral.com/articles/10.1186/s12913-018-3539-2

BACKGROUND: Mechanisms by which liaison mental health services (LMHS) may bring about improved patient and organisational outcomes are poorly understood. A small number of logic models have been developed, but they fail to capture the complexity of clinical practice. METHOD: We synthesised data from a variety of sources including a large national survey, 73 in-depth interviews with acute and liaison staff working in hospitals with different types of liaison mental health services, and relevant local, national and international literature. We generated logic models for two common performance indicators used to assess organisational outcomes for LMHS: response times in the emergency department and hospital length of stay for people with mental health problems. RESULTS: We identified eight areas of complexity that influence performance, and 6 trade-offs which drove the models in different directions depending upon the balance of the trade-off. The logic models we developed could only be captured by consideration of more than one pass through the system, the complexity in which they operated, and the trade-offs that occurred. CONCLUSIONS: Our findings are important for commissioners of liaison services. Reliance on simple target setting may result in services that are unbalanced and not patient-centred. Targets need to be reviewed on a regular basis, together with other data that reflect the wider impact of the service, and any external changes in the system that affect the performance of LMHS, which are beyond their control.

Hudon, C., Aubrey-Bassler, K., Chouinard, M. C., et al. (2022). "Better understanding care transitions of adults with complex health and social care needs: a study protocol." BMC Health Serv Res **22**(1): 206.

BACKGROUND: Adults with chronic conditions who also suffer from mental health comorbidities and/or social vulnerability require services from many providers across different sectors. They may have complex health and social care needs and experience poorer health indicators and high mortality rates while generating considerable costs to the health and social services system. In response, the literature has stressed the need for a collaborative approach amongst providers to facilitate the care transition process. A better understanding of care transitions is the next step towards the improvement of integrated care models. The aim of the study is to better understand care transitions of adults with complex health and social care needs across community, primary care, and hospital settings, combining the experiences of patients and their families, providers, and health managers. METHODS/DESIGN: We will conduct a two-phase mixed methods multiple case study (quantitative and qualitative). We will work with six cases in three Canadian provinces, each case being the actual care transitions across community, primary care, and hospital settings. Adult patients with complex needs will be identified by having visited the emergency department at least three times over the previous 12 months. To ensure they have complex needs, they will be invited to complete INTERMED Self-Assessment and invited to enroll if positive. For the quantitative phase, data will be obtained through questionnaires and multi-level regression analyses will be conducted. For the qualitative phase, semi-structured interviews and focus groups will be conducted with patients, family members, care providers, and managers, and thematic analysis will be performed. Quantitative and qualitative results will be compared and then merged. DISCUSSION: This study is one of the first to examine care transitions of adults with complex needs by adopting a comprehensive vision of care transitions and bringing together the experiences of patients and family members, providers,

and health managers. By using an integrated knowledge translation approach with key knowledge users, the study's findings have the potential to inform the optimization of integrated care, to positively impact the health of adults with complex needs, and reduce the economic burden to the health and social care systems.

Hunt, C. M., Spence, M. et McBride, A. (2016). "The role of boundary spanners in delivering collaborative care: a process evaluation." BMC Fam Pract **17**: 96.

BACKGROUND: On average, people with schizophrenia and psychosis die 13-30 years sooner than the general population (World Psychiatry 10 (1):52-77, 2011). Mental and physical health care is often provided by different organisations, different practitioners and in different settings which makes collaborative care difficult. Research is needed to understand and map the impact of new collaborative ways of working at the primary/secondary care interface (PloS One 7 (5); e36468). The evaluation presented in this paper was designed to explore the potential of a Community and Physical Health Co-ordinator role (CPHC) (CPHCs were previously Care Co-ordinators within the Community Mental Health Team, Community in the title CPHC refers to Community Mental Health) and Multi-Disciplinary Team (MDT) meetings across primary and community care, with the aim of improving collaboration of mental and physical health care for service users with Severe Mental Illness (SMI). METHODS: Data collection took place across five general practices (GPs) and a Community Mental Health Team (CMHT) in the Northwest of England, as part of a process evaluation. Semi-structured interviews were conducted with a purposive sample of GP staff (n= 18) and CMHT staff (n=4), a focus group with CMHT staff (n=8) and a survey completed by 13 CMHT staff, alongside cardiovascular risk data and MDT actions. Framework analysis was used to manage and interpret data. RESULTS: The results from the evaluation demonstrate that a CPHC role and MDT meetings are effective mechanisms for improving the collaboration and co-ordination of physical health care for SMI service users. The findings highlight the importance of embedding and supporting the CPHC role, with an emphasis on protected time and continuing professional roles and integrating multiple perspectives through MDT meetings. Considering the importance of physical health care for SMI service users and the complex environment, these are important findings for practitioners, researchers and policy makers in the field of primary care and mental health. CONCLUSION: There is an increasing focus on integration and collaborative working to ensure the delivery of quality care across the whole patient pathway, with a growing need for professionals to work together across service and professional boundaries. The introduction of a two pronged approach to collaboration has shown some important improvements in the management of physical health care for service users with SMI.

Irwin, K. E., Callaway, C. A., Corveleyn, A. E., et al. (2022). "Study protocol for a randomized trial of bridge: Person-centered collaborative care for serious mental illness and cancer." Contemp Clin Trials **123**: 106975.

BACKGROUND: Individuals with serious mental illness (SMI) experience inequities in cancer care that contribute to increased cancer mortality. Involving mental health at the time of cancer diagnosis may improve cancer care delivery for patients with SMI yet access to care remains challenging. Collaborative care is a promising approach to integrate mental health and cancer care that has not yet been studied in this marginalized population. METHODS/DESIGN: We describe a 24-week, two-arm, single-site randomized trial of person-centered collaborative care (Bridge) for patients with SMI (schizophrenia, bipolar disorder, or major depression with psychiatric hospitalization) and their caregivers. 120 patients are

randomized 1:1 to Bridge or Enhanced Usual Care (EUC) along with their caregivers. Researchers proactively identify individuals with SMI and a new breast, lung, gastrointestinal, or head and neck cancer that can be treated with curative intent. EUC includes informing oncologists about the patient's psychiatric diagnosis, notifying patients about available psychosocial services, and tracking patient and caregiver outcomes. Bridge includes a proactive assessment by psychiatry and social work, a person-centered, team approach including collaboration between mental health and oncology, and increased access to evidence-based psycho-oncology care. The primary outcome is cancer care disruptions evaluated by a blinded panel of oncologists. Secondary outcomes include patient and caregiver-reported outcomes and healthcare utilization. Barriers to Bridge implementation and dissemination are assessed using mixed methods. DISCUSSION: This trial will inform efforts to systematically identify individuals with SMI and cancer and generate the first experimental evidence for the impact of person-centered collaborative care on cancer care for this underserved population.

Janich, N. A.-O. et Vazquez-Arreola, E. (2022). "Patient Service Utilization Among Individuals with Co-occurring Disorders: A Comparison of Two Models of Care Coordination." Community Mental Health Journal **58**(1573-2789 (Electronic)): 1168-1178.

Healthcare systems have increasingly adopted integrated care models with demonstrated effectiveness. However, few studies examine integrated care for individuals with co-morbid mental illness and medical conditions. This quasi-experimental study compared service use for two integrated care models for patients with co-occurring conditions. We used hierarchical negative binomial and logistic regressions with random effects to test the relationship between integration and service use. Patients treated at co-located agencies had significantly higher odds of inpatient hospitalization compared to those in fully integrated settings. Additionally, some comorbidities had significantly different levels of service use. Patients at co-located agencies had more outpatient and emergency visits, but was not statistically significant. Our findings provide evidence that the model of care may impact service use for patients experiencing co-occurring conditions, however, variations in service use for specific co-morbid conditions highlight the need to examine the specific needs and characteristics of this population.

Janich, N. et Vazquez Arreola, E. (2020). "Staff and Organizational Capacity in the Implementation of Coordinated Care: an Examination of 10 Behavioral Health Agencies in Rural Communities." J Behav Health Serv Res **47**(4): 476-492.

Providing primary care services in behavioral health settings has become more common and necessary given the needs of individuals with serious mental illness (SMI). In this exploratory study, we developed a survey to assess agency and professional staff and practitioner capacity for coordinated care. The survey provides a feedback mechanism for agencies to target staff and organizational needs related to building capacity to provide coordinated care. Logistic regressions compared differences in 24 dimensions of coordinated care specifically comparing capacity based on professional role (behavioral health and medical), model of coordination (co-located and fully integrated), and time of model adoption (early and late adopters). Findings indicated that all three were significant predictors of capacity in multiple dimensions suggesting the need for training and planning around inter-professional and inter-agency coordination.

Karlin, B. E. et Karel, M. J. (2014). "National Integration of Mental Health Providers in VA Home-Based Primary Care: An Innovative Model for Mental Health Care Delivery With Older Adults." The Gerontologist **54**(5): 868-879.

> PURPOSE OF THE STUDY: To promote mental health (MH) service access and quality for veterans with complex and chronic medical, social, and behavioral conditions, the U.S. Department of Veterans Affairs (VA) has integrated a full-time MH provider into each VA home-based primary care (HBPC) team. The goal of the current evaluation is to examine the nature and extent to which MH care processes and practices have been integrated into HBPC nationally. DESIGN AND METHODS: Separate surveys assessing the integration of a wide range of MH care practices and HBPC team processes were sent to MH providers and program directors in each HBPC program in 2010. RESULTS: A total of 132 MH providers representing 119 HBPC programs, and 112 program directors completed the surveys. The most common clinical issues addressed by MH providers were depression, coping with illness and disability, anxiety, caregiver/family stress, and cognitive evaluation. Other team members typically conducted initial MH screenings, with MH providers' time focusing on cases with identified needs. Approximately 40% of MH providers' time was devoted to direct clinical care. Significant time was also spent on team activities, driving, and charting. IMPLICATIONS: Integration of MH services into HBPC is feasible and facilitates service access for a vulnerable population. Mental health care delivery in HPBC generally involves a high degree of interdisciplinary practice. Mental health integration into HBPC may serve as a model for other systems interested in promoting MH care delivery among homebound and other older individuals

Kates, N. (2024). "Commentary: Reducing the Mortality Gap for the Mentally Ill - Rethinking How and Where We Provide Care." Healthc Policy **20**(1): 29-33.

> The mortality gap faced by Canadians living with a severe and persistent mental illness is a national scandal. If we are to change this and take advantage of the possibilities that reverse integration presents, we need to rethink the ways our systems of care function and remove barriers to accessing care while tapping the full potential of collaborative partnerships, moving to earlier interventions with this population and integrating poverty reduction into all our work. Above all, we need to be much more effective in bringing these issues into the public discourse.

Kilbourne, A. M., Lai, Z., Bowersox, N., et al. (2011). "Does colocated care improve access to cardiometabolic screening for patients with serious mental illness?" General Hospital Psychiatry 33(6): 634-636.

> Objective Individuals with serious mental illness (SMI; e.g., schizophrenia, bipolar disorder) experience disparities in mortality relative to the general population, mainly because of medical conditions (i.e., cardiometabolic disease).We assessed whether VA patients with SMI and receiving care from VA mental health facilities with colocated medical care were more likely to receive cardiometabolic risk assessments in accordance with clinical practice guidelines than patients from noncolocated facilities. Methods Patients with SMI identified prescribed second-generation antipsychotic medications in fiscal year (FY) 2007 receiving care from VA mental health facilities completing the VA Mental Health Program Survey were included. VA administrative data were ascertained to assess receipt of the following tests every 6 months in FY 2007: body mass index (BMI), blood pressure, lipid profile and fasting glucose. Results Out of 40,600 patients with SMI prescribed second-generation

antipsychotics, 29% received all cardiometabolic tests (lipid, glucose, BMI and blood pressure). While 79% and 76% received blood pressure and BMI assessments, respectively, only 37% received a lipid test. Patients from colocated sites were more likely to receive all cardiometabolic tests (odds ratio=1.26, 95% confidence interval: 1.18–1.35, P<.001). Conclusions Colocated general medical providers in mental health clinics are more likely to provide cardiometabolic assessments for patients with SMI prescribed second-generation antipsychotics.

Kilbourne, A. M., PA., P. et Zong, L. (2011). "Quality of general medical care among patients with serious mental illness: does colocation of services matter?" Psychiatr Serv. **62**(8): 922-928.

OBJECTIVE: This study was conducted to determine whether patients with serious mental illness receiving care in Veterans Affairs (VA) mental health programs with colocated general medical clinics were more likely to receive adequate medical care than patients in programs without colocated clinics based on a nationally representative sample. METHODS: The study included all VA patients with diagnoses of serious mental illness in fiscal year (FY) 2006-2007 who were also part of the VA's External Peer Review Program (EPRP) FY 2007 random sample and who received care from VA facilities (N=107 facilities) with organizational data from the VA Mental Health Program Survey (N=7,514). EPRP included patient-level chart review quality indicators for common processes of care (foot and retinal examinations for diabetes complications; screens for colorectal health, breast cancer, and alcohol misuse; and tobacco counseling) and outcomes (hypertension, diabetes blood sugar, and lipid control). RESULTS: Ten out of 107 (10%) mental health programs had colocated medical clinics. After adjustment for organizational and patient-level factors, analyses showed that patients from colocated clinics compared with those without colocation were more likely to receive foot exams (OR=1.87, p<.05), colorectal cancer screenings (OR=1.54, p<.01), and alcohol misuse screenings (OR=2.92, p<.01). They were also more likely to have good blood pressure control (<140/90 mmHg; OR=1.32, p<.05) but less likely to have glycosylated hemoglobin <9% (OR=.69, p<.05). CONCLUSIONS: Colocation of medical care was associated with better quality of care for four of nine indicators. Additional strategies, particularly those focused on improving diabetes control and other chronic medical outcomes, might be warranted for patients with serious mental illness. FAU - Kilbourne, Amy M

Kroenke, K. et Unutzer, J. (2017). "Closing the False Divide: Sustainable Approaches to Integrating Mental Health Services into Primary Care." J Gen Intern Med **32**(4): 404-410.

Mental disorders account for 25% of all health-related disability worldwide. More patients receive treatment for mental disorders in the primary care sector than in the mental health specialty setting. However, brief visits, inadequate reimbursement, deficits in primary care provider (PCP) training, and competing demands often limit the capacity of the PCP to produce optimal outcomes in patients with common mental disorders. More than 80 randomized trials have shown the benefits of collaborative care (CC) models for improving outcomes of patients with depression and anxiety. Six key components of CC include a population-based approach, measurement-based care, treatment to target strategy, care management, supervision by a mental health professional (MHP), and brief psychological therapies. Multiple trials have also shown that CC for depression is equally or more cost-effective than many of the current treatments for medical disorders. Factors that may facilitate the implementation of CC include a more favorable alignment of medical and mental health services in accountable care organizations and patient-centered medical homes; greater use of telecare as well as automated outcome monitoring; identification of

patients who might benefit most from CC; and systematic training of both PCPs and MHPs in integrated team-based care.

Lawrence, D. et Kisely, S. (2010). "Inequalities in healthcare provision for people with severe mental illness." J Psychopharmacol **24**(4 Suppl): 61-68.

There are many factors that contribute to the poor physical health of people with severe mental illness (SMI), including lifestyle factors and medication side effects. However, there is increasing evidence that disparities in healthcare provision contribute to poor physical health outcomes. These inequalities have been attributed to a combination of factors including systemic issues, such as the separation of mental health services from other medical services, healthcare provider issues including the pervasive stigma associated with mental illness, and consequences of mental illness and side effects of its treatment. A number of solutions have been proposed. To tackle systemic barriers to healthcare provision integrated care models could be employed including co-location of physical and mental health services or the use of case managers or other staff to undertake a co-ordination or liaison role between services. The health care sector could be targeted for programmes aimed at reducing the stigma of mental illness. The cognitive deficits and other consequences of SMI could be addressed through the provision of healthcare skills training to people with SMI or by the use of peer supporters. Population health and health promotion approaches could be developed and targeted at this population, by integrating health promotion activities across domains of interest. To date there have only been small-scale trials to evaluate these ideas suggesting that a range of models may have benefit. More work is needed to build the evidence base in this area.

Lee, S. J., Crowther, E., Keating, C., et al. (2013). "What is needed to deliver collaborative care to address comorbidity more effectively for adults with a severe mental illness?" Aust N Z J Psychiatry **47**(4): 333-346.

OBJECTIVE: Innovative models of care for people with a severe mental illness have been developed across Australia to more effectively address comorbidity and disability by enhancing the collaboration between clinical and non-clinical services. In particular, this review paper focuses on collaboration that has occurred to address comorbidities affecting the following domains: homelessness; substance addiction; physical ill-health; unemployment; and forensic issues. METHOD: The identification of relevant collaborative care models was facilitated by carrying out a review of the published peer-reviewed literature and policy or other published reports available on the Internet. Contact was also made with representatives of the mental health branches of each Australian state and territory health department to assist in identifying examples of innovative collaborative care models established within their jurisdiction. RESULTS: A number of nationally implemented and local examples of collaborative care models were identified that have successfully delivered enhanced integration of care between clinical and non-clinical services. Several key principles for effective collaboration were also identified. Governmental and organisational promotion of and incentives for cross-sector collaboration is needed along with education for staff about comorbidity and the capacity of cross-sector agencies to work in collaboration to support shared clients. Enhanced communication has been achieved through mechanisms such as the co-location of staff from different agencies to enhance sharing of expertise and interagency continuity of care, shared treatment plans and client records, and shared case review meetings. Promoting a 'housing first approach' with cross-sector services collaborating to stabilise housing as the basis for sustained clinical engagement has also been successful. CONCLUSIONS: Cross-sector collaboration is achievable and can result in

significant benefits for mental health consumers and staff of collaborating services. Expanding the availability of collaborative care across Australia is therefore a priority for achieving a more holistic, socially inclusive, and effective mental health care system.

Leung, L. B., Benitez, C. T., Dorsey, C., et al. (2021). "Integrating Mental Health in Safety-net Primary Care: A Five-year Observational Study on Visits in a County Health System." Medical Care **59**(11). https://journals.lww.com/lww-medicalcare/Fulltext/2021/11000/Integrating_Mental_Health_in_Safety_net_Primary.5.aspx

Background: Beginning in 2010, Los Angeles County Departments of Health Services and Mental Health collaborated to increase access to effective mental health care. The Mental Health Integration Program (MHIP) embedded behavioral health specialists in primary care clinics to deliver brief, problem-focused treatments, and psychiatric consultation support for primary care-prescribed psychotropic medications. Objective: The aim was to compare primary care visits associated with psychiatric diagnoses before and after MHIP implementation. Methods: This retrospective cohort study (2009–2014) examined 62,945 patients from 8 safety-net clinics that implemented MHIP in a staggered manner in Los Angeles. Patients' primary care visits (n=695,354) were either associated or not with a previously identified or "new" (defined as having no diagnosis within the prior year) psychiatric diagnosis. Multilevel regression models used MHIP implementation to predict odds of visits being associated with psychiatric diagnoses, controlling for time, clinic, and patient characteristics. Results: 9.4% of visits were associated with psychiatric diagnoses (6.4% depression, 3.1% anxiety, <1% alcohol, and substance use disorders). Odds of visits being associated with psychiatric diagnoses were 9% higher [95% confidence interval (CI)=1.05–1.13; P<0.0001], and 10% higher for diagnoses that were new (CI=1.04–1.16; P=0.002), after MHIP implementation than before. This appeared to be fueled by increased visits for depression post-MHIP (odds ratio=1.11; CI=1.06–1.15; P<0.0001). Conclusions: MHIP implementation was associated with more psychiatric diagnoses coded in safety-net primary care visits. Scaling up this effort will require greater attention to the notable differences across patient populations and languages, as well as the markedly low coding of alcohol and substance use services in primary care.

Malâtre-Lansac, A., Engel, C. C., Xenakis, L., et al. (2020). "Factors Influencing Physician Practices' Adoption of Behavioral Health Integration in the United States: A Qualitative Study." Ann Intern Med **173** 92-99. https://www.ncbi.nlm.nih.gov/pubmed/32479169

BACKGROUND: Behavioral health integration is uncommon among U.S. physician practices despite recent policy changes that may encourage its adoption. OBJECTIVE: To describe factors influencing physician practices' implementation of behavioral health integration. DESIGN: Semi structured interviews with leaders and clinicians from physician practices that adopted behavioral health integration, supplemented by contextual interviews with experts and vendors in behavioral health integration. SETTING: 30 physician practices, sampled for diversity on specialty, size, affiliation with parent organizations, geographic location, and behavioral health integration model (collaborative or co-located). PARTICIPANTS: 47 physician practice leaders and clinicians, 20 experts, and 5 vendors. MEASUREMENTS: Qualitative analysis (cyclical coding) of interview transcripts. RESULTS: Four overarching factors affecting physician practices' implementation of behavioral health integration were identified. First, practices' motivations for integrating behavioral health care included expanding access to behavioral health services, improving other clinicians' abilities to

respond to patients' behavioral health needs, and enhancing practice reputation. Second, practices tailored their implementation of behavioral health integration to local resources, financial incentives, and patient populations. Third, barriers to behavioral health integration included cultural differences and incomplete information flow between behavioral and nonbehavioral health clinicians and billing difficulties. Fourth, practices described the advantages and disadvantages of both fee-for-service and alternative payment models, and few reported positive financial returns. LIMITATION: The practice sample was not nationally representative and excluded practices that did not implement or sustain behavioral health integration, potentially limiting generalizability. CONCLUSION: Practices currently using behavioral health integration face cultural, informational, and financial barriers to implementing and sustaining behavioral health integration. Tailored, context-specific technical support to guide practices' implementation and payment models that improve the business case for practices may enhance the dissemination and long-term sustainability of behavioral health integration. PRIMARY FUNDING SOURCE: American Medical Association and The Commonwealth Fund. FAU - Malâtre-Lansac, Angèle

McCarron, R. M. (2015). "Integrated Care at the Interface of Psychiatry and Primary Care: Prevention of Cardiovascular Disease." Psychiatr Clin North Am **38**(3): 463-474.

Patients with mental illness, particularly serious mental illness, are more likely to suffer from common disorders without optimal treatment. Changes in preventive practice patterns cannot be fully realized on a large scale until clinicians are trained how to routinely provide this care. Psychiatrists may consider using preventive care strategies in the area of cardiovascular health, as cardiovascular disease is the most common cause of death and disproportionately affects patients with mental illness. At minimum, psychiatrists are well positioned to work collaboratively with primary care providers to address psychopathology that may interfere with adherence to the treatment plan.

McCracken, R. K., Fung, L., Stratis, A. K., et al. (2018). "Family doctors providing primary care to patients with mental illness in a tertiary care facility." Can Fam Physician **64**(10): e440-e445.

PROBLEM ADDRESSED: Individuals with severe mental illness have an increased burden of physical comorbidities. Physical concerns of patients admitted to hospital for mental health reasons might be addressed by multiple specialists, leading to fragmented care and high costs to the system, when many of these concerns could be addressed by primary care. OBJECTIVE OF PROGRAM: The Family Doctor Outreach Clinic (FDOC) aims to provide rapid consultations for common concerns, to provide consultations for complex chronic disease and addictions, and to identify gaps in community care that contribute to patients' potential readmission to hospital. The FDOC is a simple and novel collaborative program of care in a tertiary care setting. PROGRAM DESCRIPTION: Members of the Department of Family Medicine at St Paul's Hospital in Vancouver, BC, have been providing consultation services for patients admitted to the 4 mental health wards (total of 108 beds). Using a prospective cohort of consecutive consultations (N = 104) from July to August 2014, the study team collected data on details of current admissions, connections to community primary care, and reasons for consultations. CONCLUSION: Including family physicians in the care of mental health inpatients, as is done at the FDOC, might avert referrals to specialist services and provide a bridge between acute care and community family practice.

McDevitt, J., Braun, S., Noyes, M., et al. (2005). "Integrated primary and mental health care: evaluating a nurse-managed center for clients with serious and persistent mental illness." Nurs Clin North Am **40**(4): 779-790, xii.

Nurse-managed centers have been at the forefront of providing ambulatory care alternatives for underserved populations lacking access to care. Following this model, the Center for Integrated Health Care of the College of Nursing at the University of Illinois in Chicago delivers primary and mental health care services to a population of people with serious and persistent mental illness. The authors' experience illustrates the many rewards and challenges that nurse-managed centers face. This article describes their center's model of integrated care, examines selected performance indicators, and discusses the implications, opportunities, and challenges ahead.

Matthews, E. A.-O., Lushin, V., Macneal, E., et al. (2024). "The Impact of Structural Integration on Clinical Outcomes among Individuals with Serious Mental Illness and Chronic Illness." Community Mental Health Journal **60**(1573-2789 (Electronic)): 1372-1379.

Though considered a best practice, there is substantial variation in how integrated behavioral health (IBH) services are structured. This study examined the impact of IBH structure on health outcomes among individuals with serious mental illness (SMI) and chronic disease receiving care in community health centers (CHCs). Data from the ADVANCE network identified 8,548 individuals with co-occurring SMI diabetes and 16,600 with an SMI and hypertension. Logistic regression tested whether IBH type impacted disease specific health outcomes among these populations. Among those with diabetes or hypertension, colocated care was associated with better health outcomes related to HbA1c, blood pressure control, and BMI compared to less coordinated and unintegrated care, though there was significant variation in this relationship across SMI diagnoses. Results reflect that colocation of primary care and behavioral health may improve outcomes for individuals with bipolar disorder or major depression and chronic disease, but that CHC-based integrated care may not be optimized for individuals with schizophrenia.

Murphy, K. A., Dalcin, A., McGinty, E. E., et al. (2021). "Applying Care Coordination Principles to Reduce Cardiovascular Disease Risk Factors in People With Serious Mental Illness: A Case Study Approach." Frontiers in psychiatry **12**: 742169.

People with serious mental illness (SMI) have a 2-3-fold higher mortality than the general population, much of which is driven by largely preventable cardiovascular disease. One contributory factor is the disconnect between the behavioral and physical health care systems. New care models have sought to integrate physical health care into primary mental health care settings. However, few examples of successful care coordination interventions to improve health outcomes with the SMI population exist. In this paper, we examine challenges faced in coordinating care for people with SMI and explore pragmatic, multi-disciplinary strategies for overcoming these challenges used in a cardiovascular risk reduction intervention shown to be effective in a clinical trial.

Naylor, C., Bell, A., Baird, B., et al. (2020). "Mental health and primary care networks : understanding the opportunities". London :, The King's Fund, , CMH
https://www.kingsfund.org.uk/publications/mental-health-primary-care-networks

The establishment of primary care networks (PCNs) is one of the most important reforms to primary care in England in recent years. This report explores the opportunities the emergence of these new networks creates for improving the support and treatment provided

to people with mental health needs in primary care, and describes why such improvement is badly needed.

Naylor, C., Taggart, H. et Charles, A. (2017). "Mental health and new models of care : : lessons from the vanguards". London :, The King's Fund
https://www.kingsfund.org.uk/sites/files/kf/field/field_publication_file/MH_new_models_care_Kings_Fund_May_2017_0.pdf
https://www.kingsfund.org.uk/publications/mental-health-new-care-models

This report draws on recent research with vanguard sites in England, conducted in partnership with the Royal College of Psychiatrists. It finds that where new models of care have been used to remove the barriers between mental health and other parts of the health system, local professionals saw this as being highly valuable in improving care for patients and service users. It concludes that there remains much to be done to fully embed mental health into integrated care teams, primary care, urgent and emergency care pathways, and in work on population health

Newton, H., Busch, S. H., Brunette, M. F., et al. (2022). "Innovations in Care Delivery for Patients With Serious Mental Illness Among Accountable Care Organizations." Psychiatric Services **73**: 889-896.

OBJECTIVE: This study examined whether and how organizations participating in accountable care organization (ACO) contracts integrate primary care and treatment for patients with serious mental illness. METHODS: This study used responses to the 2017–2018 National Survey of ACOs (55% response rate) to measure ACO-reported use of three integrated care strategies: care manager to address physical health treatment coordination or nonmedical needs (e.g., job support and housing), patient registries to track physical health conditions, and primary care clinician colocated in a specialty mental health setting. Logistic regression was used to determine associations between ACO characteristics and strategy use. RESULTS: Of 399 respondents who answered questions on integration, 303 (76%) reported using at least one integrated care strategy in at least one location. Use of care managers (defined by the respondent) was most common (N=281, 70%), followed by use of a patient registry (N=146, 37%) and colocation of a primary care clinician in a specialty mental health setting (N=118, 30%). Respondents reporting that their largest Medicaid contract or largest commercial contract included quality measures specific to serious mental illness (e.g., antipsychotic adherence) were more likely to use each integrated care delivery strategy. Self-reported use of three collaborative care strategies (care management, patient registry, or mental health consulting clinician) for treatment of depression or anxiety was associated with use of integrated primary care and treatment for serious mental illness. CONCLUSIONS: In a national survey of ACOs, few respondents reported using either patient registries or primary care colocation to integrate primary care and treatment for serious mental illness. FAU - Newton, Helen

NHS Confederation (2021). "Working together to improve patient care : : how PCNs are working in partnership to support people's mental health". London :, NHS Confederation
https://www.nhsconfed.org/resources/2021/02/mhn-pcn-briefing-working-together-to-improve-patient-care

Mental health disorders are one of the common causes of morbidity in England and primary care plays a key role in supporting patients' mental health and wellbeing, so it has become a priority for many primary care networks (PCNs). This briefing provides examples of three

models of partnership working that are currently under way in primary care to support mental health at place level

NHS Confederation (2013). "Mental health and community services : : a marriage made in heaven?". London :, NHS Confederation (Briefing ;)
http://www.nhsconfed.org/~/media/Confederation/Files/Publications/Documents/Mental-health-community-services.pdf

Nicaise, P., Dubois, V. et Lorant, V. (2014). "Mental health care delivery system reform in Belgium: The challenge of achieving deinstitutionalisation whilst addressing fragmentation of care at the same time." Health Policy **115**(2-3): 120-127.

Most mental health care delivery systems in welfare states currently face two major issues: deinstitutionalisation and fragmentation of care. Belgium is in the process of reforming its mental health care delivery system with the aim of simultaneously strengthening community care and improving integration of care. The new policy model attempts to strike a balance between hospitals and community services, and is based on networks of services. We carried out a content analysis of the policy blueprint for the reform and performed an ex-ante evaluation of its plan of operation, based on the current knowledge of mental health service networks. When we examined the policy's multiple aims, intermediate goals, suggested tools, and their articulation, we found that it was unclear how the new policy could achieve its goals. Indeed, deinstitutionalisation and integration of care require different network structures, and different modes of governance. Furthermore, most of the mechanisms contained within the new policy were not sufficiently detailed. Consequently, three major threats to the effectiveness of the reform were identified. These were: issues concerning the relationship between network structure and purpose, the continued influence of hospitals despite the goal of deinstitutionalisation, and the heterogeneity in the actual implementation of the new policy

Nover, C. H. (2013). "Mental health in primary care: perceptions of augmented care for individuals with serious mental illness." Soc Work Health Care **52**(7): 656-668.

Individuals with serious mental illness are at increased risk of developing secondary physical illnesses because of lifestyle and psychiatric treatment-related factors. Many individuals with mental illness participate in primary care clinics, such as Placer County Community Clinic (PCCC), which provides primary care and medication-only psychiatric services to low-income county residents. This qualitative study describes an augmented care program provided to this population at PCCC and explores participant experiences with that program. The augmented program consisted of a full-time social worker and part-time registered nurse working as a team to coordinate care between providers, and provide psychosocial education and illness management support. Previous studies have demonstrated that similar programs result in improved clinical outcomes for people with mental illness but have largely not included perspectives of participants in these pilot programs. This article includes participant reports about medical service needs, barriers, and beneficial elements of the augmented program. Medical service needs included the need to provide input in treatment and to be personally valued. Barriers ranged from doubts about provider qualifications to concerns about medication. Elements of the augmented care program that participants found beneficial were those involving care coordination, social support, and weight management support.

Nover, C. H. (2014). "Implementing a mental health and primary care partnership program in Placer County, California." Soc Work Health Care **53**(2): 156-182.

Individuals with serious mental illness are at an increased risk for developing co-morbid chronic physical illnesses, such as diabetes and cardiovascular disease. This article is a descriptive piece about an intervention to decrease physical health risks in this population through a partnership effort between a primary care clinic and mental health agency in rural Placer County, California. The project was conducted as a part of the CalMEND Pilot Collaborative to Integrate Primary Care and Mental Health Services, which took place in five California counties in 2010-2011. A description of the program elements, conceptual models, key measures, and the process of program implementation is provided. Benefits were observed in areas of quality assurance, intra- and inter

O'Donnell, A. N., Williams, M. et Kilbourne, A. M. (2013). "Overcoming roadblocks: current and emerging reimbursement strategies for integrated mental health services in primary care." J Gen Intern Med **28**(12): 1667-1672.

The Chronic Care Model (CCM) has been shown to improve medical and psychiatric outcomes for persons with mental disorders in primary care settings, and has been proposed as a model to integrate mental health care in the patient-centered medical home under healthcare reform. However, the CCM has not been widely implemented in primary care settings, primarily because of a lack of a comprehensive reimbursement strategy to compensate providers for day-to-day provision of its core components, including care management and provider decision support. Drawing upon the existing literature and regulatory guidelines, we provide a critical analysis of challenges and opportunities in reimbursing CCM components under the current fee-for-service system, and describe an emerging financial model involving bundled payments to support core CCM components to integrate mental health treatment into primary care settings. Ultimately, for the CCM to be used and sustained over time to integrate physical and mental health care, effective reimbursement models will need to be negotiated across payers and providers. Such payments should provide sufficient support for primary care providers to implement practice redesigns around core CCM components, including care management, measurement-based care, and mental health specialist consultation.

O'Neill, B., Kalia, S., Aliarzadeh, B., et al. (2019). "Agreement between primary care and hospital diagnosis of schizophrenia and bipolar disorder: A cross-sectional, observational study using record linkage." PLoS One **14**(1): e0210214.

People with serious mental illness die 10-25 years sooner than people without these conditions. Multiple challenges to accessing and benefitting from healthcare have been identified amongst this population, including a lack of coordination between mental health services and general health services. It has been identified in other conditions such as diabetes that accurate documentation of diagnosis in the primary care chart is associated with better quality of care. It is suspected that if a patient admitted to the hospital with serious mental illness is then discharged without adequate identification of their diagnosis in the primary care setting, follow up (such as medication management and care coordination) may be more difficult. We identified cohorts of patients with schizophrenia and bipolar disorder who accessed care through the North York Family Health Team (a group of 77 family physicians in Toronto, Canada) and North York General Hospital (a large community hospital) between January 1, 2012 and December 31, 2014. We identified whether labeling for these conditions was concordant between the two settings and explored predictors of concordant

labeling. This was a retrospective cross-sectional study using de-identified data from the Health Databank Collaborative, a linked primary care-hospital database. We identified 168 patients with schizophrenia and 370 patients with bipolar disorder. Overall diagnostic concordance between primary care and hospital records was 23.2% for schizophrenia and 15.7% for bipolar disorder. Concordance was higher for those with multiple (2+) inpatient visits (for schizophrenia: OR 2.42; 95% CI 0.64-9.20 and for bipolar disorder: OR 8.38; 95% CI 3.16-22.22). Capture-recapture modeling estimated that 37.4% of patients with schizophrenia (95% CI 20.7-54.1) and 39.6% with bipolar disorder (95% CI 25.7-53.6) had missing labels in both settings when adjusting for patients' age, sex, income quintiles and co-morbidities. In this sample of patients accessing care at a large family health team and community hospital, concordance of diagnostic information about serious mental illness was low. Interventions should be developed to improve diagnosis and continuity of care across multiple settings.

Patel, V. et Chatterji, S. (2015). "Integrating Mental Health In Care For Noncommunicable Diseases: An Imperative For Person-Centered Care." Health Aff (Millwood) **34**(9): 1498-1505.

Mental disorders such as depression and alcohol use disorders often co-occur with other common noncommunicable diseases such as diabetes and heart disease. Furthermore, noncommunicable diseases are frequently encountered in patients with severe mental disorders such as schizophrenia. The pathways underlying the comorbidity of mental disorders and noncommunicable diseases are complex. For example, mental and physical noncommunicable diseases may have common environmental risk factors such as unhealthy lifestyles, and treatments for one condition may have side effects that increase the risk of another condition. Building on the robust evidence base for effective treatments for a range of mental disorders, there is now a growing evidence base for how such treatments can be integrated into the care of people with noncommunicable diseases. The best-established delivery model is a team approach that features a nonspecialist case manager who coordinates care with primary care physicians and specialists. This approach maximizes efficiencies in person-centered care, which are essential for achieving universal health coverage for both noncommunicable diseases and mental disorders. A number of research gaps remain, but there is sufficient evidence for policy makers to immediately implement measures to integrate mental health and noncommunicable disease care in primary care platforms.

Pirraglia, P. A., Rowland, E., Wu, W. C., et al. (2012). "Benefits of a primary care clinic co-located and integrated in a mental health setting for veterans with serious mental illness." Prev Chronic Dis **9**(1545-1151 (Electronic)): E51.

INTRODUCTION: Efficacy trials have shown that primary care co-located in the mental health setting improves the receipt of high-quality medical care among people with serious mental illness. We tested whether implementation of such a program affected health service use and cardiovascular risk factor control among veterans with serious mental illness who had previously demonstrated limited primary care engagement. METHODS: We performed a cohort study of veterans enrolled in a co-located, integrated primary care clinic in the mental health outpatient unit through targeted chart review. Two successive 6-month periods in the year before and in the year following enrollment in the co-located primary care clinic were examined for primary care and emergency department use and for goal attainment of blood pressure, fasting blood lipids, body mass index (BMI), and, among patients with diabetes, hemoglobin A1c (HbA1c). We used repeated-measures logistic regression to analyze goal

attainment and repeated measures Poisson regression to analyze service use. RESULTS: Compared with the period before enrollment, the 97 veterans enrolled in the clinic had significantly more primary care visits during 6 months and significantly improved goal attainment for blood pressure, low-density lipoprotein cholesterol, triglycerides, and BMI. Changes with regard to goal attainment for high-density lipoprotein cholesterol and HbA1c were not significant. CONCLUSION: Enrollment in a co-located, integrated clinic was associated with increased primary care use and improved attainment of some cardiovascular risk goals among veterans with serious mental illness. Such a clinic can be implemented effectively in the mental health setting.

Plappert, H., Byng, R., Reilly, S. T., et al. (2024). [Collaborative care intervention for individuals with severe mental illness: the PARTNERS2 programme including complex intervention development and cluster RCT. Southampton (UK), National Institute for Health and Care Research

BACKGROUND AND AIMS: Individuals living with severe mental illness such as schizophrenia and bipolar can have significant emotional, cognitive, physical and social challenges. Most people with severe mental illness in the United Kingdom do not receive specialist mental health care. Collaborative care is a system of support that combines clinical and organisational components to provide integrated and person-centred care. It has not been tested for severe mental illness in the United Kingdom. We aimed to develop and evaluate a primary care-based collaborative care model (PARTNERS) designed to improve quality of life for people with diagnoses of schizophrenia, bipolar or other psychoses when compared with usual care. METHODS: Phase 1 included studies to (1) understand context: an observational retrospective study of primary and secondary care medical records and an update of the Cochrane review 'Collaborative care approaches for people with severe mental illness'; (2) develop and formatively evaluate the PARTNERS intervention: a review of literature on collaborative care and recovery, interviews with key leaders in collaborative care and recovery, focus groups with service users and a formative evaluation of a prototype intervention model; and (3) develop trial science work in this area: a core outcome set for bipolar and recruitment methods. In phase 2 we conducted a cluster randomised controlled trial measuring quality of life using the Manchester Short Assessment of Quality of Life and secondary outcomes including time use, recovery and mental well-being; a cost-effectiveness study; and a mixed-methods process evaluation. Public involvement underpinned all of the workstream activity through the study Lived Experience Advisory Panel and the employment of service user researchers in the project team. RESULTS PHASE 1: The study of records showed that care for individuals under secondary care is variable and substantial and that people are seen every 2 weeks on average. The updated Cochrane review showed that collaborative care interventions were highly variable, and no reliable conclusions can be drawn about effectiveness. The PARTNERS model incorporated change at organisational, practitioner and individual levels. Coaching was selected as the main form of support for individuals' personal goals. In the formative evaluation, we showed that more intensive supervision and 'top-up' training were needed to achieve the desired shifts in practice. A core outcome set was developed for bipolar, and measures were selected for the trial. We developed a stepped approach to recruitment including initial approach and appointment. RESULTS PHASE 2: The trial was conducted in four areas. In total, 198 participants were recruited from 39 practices randomised. Participants received either the PARTNERS intervention or usual care. The follow-up rate was 86% at 9–12 months. The mean change in overall Manchester Short Assessment Quality of Life score did not differ between the groups [0.25 (standard deviation 0.73) for intervention vs. 0.21 (standard deviation 0.86) for control]. We also found no difference for any secondary measures. Safety outcomes (e.g.

crises) did not differ between those receiving and those not receiving the intervention. Although the costs of intervention and usual care were similar, there is insufficient evidence to draw conclusions about the overall cost-effectiveness of PARTNERS. The mixed-methods process evaluation demonstrated that a significant proportion of individuals did not receive the full intervention. This was partly due to care partner absence and participant choice. The in-depth realist informed case studies showed that participants generally appreciated the support, with some describing having a 'professional friend' as very important. For some people there was evidence that delivery of the intervention had led to specific personal changes. STRENGTHS AND LIMITATIONS: The phase 1 records study provided insights into usual care that had not been previously documented. The realist informed complex intervention development was both theoretical and pragmatic. The trial continued through the COVID-19 pandemic with high levels of follow-up. The process evaluation had the depth to explore individual changes in participants' response to the intervention. Weaknesses in the trial methodology included suboptimal implementation, outcome measures that may not have been sensitive to changes patients most appreciated and difficulties collecting some outcomes. CONCLUSIONS: While PARTNERS was not shown to be superior to usual care, the change to PARTNERS care was not shown to be unsafe. Full intervention implementation was challenging, but this is to be expected in studies of care that include those with psychosis. Some individuals responded well to the intervention when psychological support in the form of individualised goal setting was flexibly deployed, with evidence that having access to a 'professional friend' was experienced as particularly helpful for some individuals. FUTURE WORK: Key components of the PARTNERS model could be developed further and tested, along with improved supervision in the context of ongoing community mental health care change. TRIAL REGISTRATION: This trial is registered as ISRCTN95702682. FUNDING: This award was funded by the National Institute for Health and Care Research (NIHR) Programme Grants for Applied Research programme (NIHR award ref: NIHR200625) and is published in full in Programme Grants for Applied Research; Vol. 12, No. 6. See the NIHR Funding and Awards website for further award information.

Pomerantz, A. S., Shiner, B., Watts, B. V., et al. (2010). "The White River model of colocated collaborative care: A platform for mental and behavioral health care in the medical home." Fam Syst Health **28**(2): 114-129.

In the past two decades a great deal of research has demonstrated improved quality of care when mental health care is integrated into primary care. To date, most of the literature has addressed care management for specific mental illnesses. Such programs can be difficult to implement and sustain. We describe a program of "Colocated Collaborative Care," implemented in 2004 that has been sustained and grown over the 6 years since inception. The Primary Mental Health Care clinic at the White River Junction (Vermont) Veterans Affairs Medical Center offers a full spectrum of mental health care that allows 75% of referred patients to receive all of their care within the primary care clinic, thus conserving scarce specialty services for the most complex patients. The clinic is staffed by a therapist and a psychiatrist (or advanced practice nurse) and complemented by care management and health psychology. It makes use of technology to streamline assessment and track outcomes. The clinic provides a mix of care management, specialty expertise and chronic disease management. Originally developed in a capitated health care system, adherence to general principles that guided its development may be useful in any system of care.

Puac-Polanco, V., Leung, L. B., Bossarte, R. M., et al. (2021). "Treatment Differences in Primary and Specialty Settings in Veterans with Major Depression." J Am Board Fam Med **34**(2): 268-290.

INTRODUCTION: The Veterans Health Administration (VHA) supports the nation's largest primary care-mental health integration (PC-MHI) collaborative care model to increase treatment of mild to moderate common mental disorders in primary care (PC) and refer more severe-complex cases to specialty mental health (SMH) settings. It is unclear how this treatment assignment works in practice. METHODS: Patients (n = 2610) who sought incident episode VHA treatment for depression completed a baseline self-report questionnaire about depression severity-complexity. Administrative data were used to determine settings and types of treatment during the next 30 days. RESULTS: Thirty-four percent (34.2%) of depressed patients received treatment in PC settings, 65.8% in SMH settings. PC patients had less severe and fewer comorbid depressive episodes. Patients with lowest severity and/or complexity were most likely to receive PC antidepressant medication treatment; those with highest severity and/or complexity were most likely to receive combined treatment in SMH settings. Assignment of patients across settings and types of treatment was stronger than found in previous civilian studies but less pronounced than expected (cross-validated AUC = 0.50-0.68). DISCUSSION: By expanding access to evidence-based treatments, VHA's PC-MHI increases consistency of treatment assignment. Reasons for assignment being less pronounced than expected and implications for treatment response will require continued study.

Phelps, J. R. et James, J., 3rd (2017). "Psychiatric consultation in the collaborative care model: The "bipolar sieve" effect." Med Hypotheses **105**: 10-16.

Around the world, psychiatrists are in exceptionally short supply. The majority of mental health treatment is delivered in primary care. In the United States, the Collaborative Care Model (CCM) addresses the shortfall of psychiatrists by providing indirect consultation in primary care. A Cochrane meta-analysis affirms the efficacy this model for depression and anxiety. However, our experience with the CCM suggests that most patients referred for consultation have problems far more complex than simple depression and anxiety. Based on preliminary data, we offer five linked hypotheses: (1) in an efficient collaborative care process, the majority of mental illnesses can be handled by providers who are less expensive and more plentiful than psychiatrists. (2) A majority of the remaining cases will be bipolar disorder variations. Differentiating these from PTSD, the most common alternative or comorbid diagnosis, is challenging and often requires a psychiatrist's input. (3) Psychiatric consultants can teach their primary care colleagues that bipolar diagnoses are estimations based on rigorously assessed probabilities, and that cases fall on a spectrum from unipolar to bipolar. (4) All providers must recognize that when bipolarity is missed, antidepressant prescription often follows. Antidepressants can induce bipolar mixed states, with extreme anxiety and potentially dangerous impulsivity and suicidality. (5) Psychiatrists can help develop clinical approaches in primary care that identify bipolarity and differentiate it from (or establish comorbidity with) PTSD; and psychiatrists can facilitate appropriate treatment, including bipolar-specific psychotherapies as well as use of mood stabilizers.

Ramanuj, P. P., Talley, R., Breslau, J., et al. (2018). "Integrating Behavioral Health and Primary Care Services for People with Serious Mental Illness: A Qualitative Systems Analysis of Integration in New York." Community Ment Health J **54**(8): 1116-1126.

People with co-occurring behavioral and physical conditions receive poorer care through traditional health care services. One solution has been to integrate behavioral and physical care services. This study assesses efforts to integrate behavioral health and primary care services in New York. Semi-structured interviews were conducted with 52 professionals in either group or individual settings. We aimed to identify factors which facilitate or hinder

integration for people with serious mental illness and how these factors inter-relate. Content analysis identified structural, process, organizational ("internal") and contextual ("external") themes that were relevant to integration of care. Network analysis delineated the interactions between these. We show that effective integration does not advance along a single continuum from minimally to fully integrated care but along several, parallel pathways reliant upon consequential factors that aid or hinder one another.

Ramanuj, P., Ferenchik, E., Docherty, M., et al. (2019). "Evolving Models of Integrated Behavioral Health and Primary Care." Curr Psychiatry Rep **21**(1): 4.

PURPOSE OF REVIEW: Mental and physical disorders commonly co-occur leading to higher morbidity and mortality in people with mental and substance use disorders (collectively called behavioral health disorders). Models to integrate primary and behavioral health care for this population have not yet been implemented widely across health systems, leading to efforts to adapt models for specific subpopulations and mechanisms to facilitate more widespread adoption. RECENT FINDINGS: Using examples from the UK and USA, we describe recent advances to integrate behavioral and primary care for new target populations including people with serious mental illness, people at the extremes of life, and for people with substance use disorders. We summarize mechanisms to incentivize integration efforts and to stimulate new integration between health and social services in primary care. We then present an outline of recent enablers for integration, concentrating on changes to funding mechanisms, developments in quality outcome measurements to promote collaborative working, and pragmatic guidance aimed at primary care providers wishing to enhance provision of behavioral care. Integrating care between primary care and behavioral health services is a complex process. Established models of integrated care are now being tailored to target specific patient populations and policy initiatives developed to encourage adoption in particular settings. Wholly novel approaches to integrate care are significantly less common. Future efforts to integrate care should allow for flexibility and innovation around implementation, payment models that support delivery of high value care, and the development of outcome measures that incentivize collaborative working practices.

Reilly, S., Hobson-Merrett, C., Gibbons, B., et al. (2024). "Collaborative care approaches for people with severe mental illness." Cochrane Database Syst Rev **5**(5): Cd009531.

BACKGROUND: Collaborative care for severe mental illness (SMI) is a community-based intervention that promotes interdisciplinary working across primary and secondary care. Collaborative care interventions aim to improve the physical and/or mental health care of individuals with SMI. This is an update of a 2013 Cochrane review, based on new searches of the literature, which includes an additional seven studies. OBJECTIVES: To assess the effectiveness of collaborative care approaches in comparison with standard care (or other non-collaborative care interventions) for people with diagnoses of SMI who are living in the community. SEARCH METHODS: We searched the Cochrane Schizophrenia Study-Based Register of Trials (10 February 2021). We searched the Cochrane Common Mental Disorders (CCMD) controlled trials register (all available years to 6 June 2016). Subsequent searches on Ovid MEDLINE, Embase and PsycINFO together with the Cochrane Central Register of Controlled Trials (with an overlap) were run on 17 December 2021. SELECTION CRITERIA: Randomised controlled trials (RCTs) where interventions described as 'collaborative care' were compared with 'standard care' for adults (18+ years) living in the community with a diagnosis of SMI. SMI was defined as schizophrenia, other types of schizophrenia-like psychosis or bipolar affective disorder. The primary outcomes of interest were: quality of life, mental state and psychiatric admissions at 12 months follow-up. DATA COLLECTION AND

ANALYSIS: Pairs of authors independently extracted data. We assessed the quality and certainty of the evidence using RoB 2 (for the primary outcomes) and GRADE. We compared treatment effects between collaborative care and standard care. We divided outcomes into short-term (up to six months), medium-term (seven to 12 months) and long-term (over 12 months). For dichotomous data we calculated the risk ratio (RR) and for continuous data we calculated the standardised mean difference (SMD), with 95% confidence intervals (CIs). We used random-effects meta-analyses due to substantial levels of heterogeneity across trials. We created a summary of findings table using GRADEpro. MAIN RESULTS: Eight RCTs (1165 participants) are included in this review. Two met the criteria for type A collaborative care (intervention comprised of the four core components). The remaining six met the criteria for type B (described as collaborative care by the trialists, but not comprised of the four core components). The composition and purpose of the interventions varied across studies. For most outcomes there was low- or very low-certainty evidence. We found three studies that assessed the quality of life of participants at 12 months. Quality of life was measured using the SF-12 and the WHOQOL-BREF and the mean endpoint mental health component scores were reported at 12 months. Very low-certainty evidence did not show a difference in quality of life (mental health domain) between collaborative care and standard care in the medium term (at 12 months) (SMD 0.03, 95% CI -0.26 to 0.32; 3 RCTs, 227 participants). Very low-certainty evidence did not show a difference in quality of life (physical health domain) between collaborative care and standard care in the medium term (at 12 months) (SMD 0.08, 95% CI -0.18 to 0.33; 3 RCTs, 237 participants). Furthermore, in the medium term (at 12 months) low-certainty evidence did not show a difference between collaborative care and standard care in mental state (binary) (RR 0.99, 95% CI 0.77 to 1.28; 1 RCT, 253 participants) or in the risk of being admitted to a psychiatric hospital at 12 months (RR 5.15, 95% CI 0.67 to 39.57; 1 RCT, 253 participants). One study indicated an improvement in disability (proxy for social functioning) at 12 months in the collaborative care arm compared to usual care (RR 1.38, 95% CI 0.97 to 1.95; 1 RCT, 253 participants); we deemed this low-certainty evidence. Personal recovery and satisfaction/experience of care outcomes were not reported in any of the included studies. The data from one study indicated that the collaborative care treatment was more expensive than standard care (mean difference (MD) international dollars (Int$) 493.00, 95% CI 345.41 to 640.59) in the short term. Another study found the collaborative care intervention to be slightly less expensive at three years. AUTHORS' CONCLUSIONS: This review does not provide evidence to indicate that collaborative care is more effective than standard care in the medium term (at 12 months) in relation to our primary outcomes (quality of life, mental state and psychiatric admissions). The evidence would be improved by better reporting, higher-quality RCTs and the assessment of underlying mechanisms of collaborative care. We advise caution in utilising the information in this review to assess the effectiveness of collaborative care.

Sharpe, M., Walker, J., Holm Hansen, C., et al. (2014). "Integrated collaborative care for comorbid major depression in patients with cancer (SMaRT Oncology-2) : : a multicentre randomised controlled effectiveness trial".

BACKGROUND: Medical conditions are often complicated by major depression, with consequent additional impairment of quality of life. We aimed to compare the effectiveness of an integrated treatment programme for major depression in patients with cancer (depression care for people with cancer) with usual care. METHODS: SMaRT Oncology-2 is a parallel-group, multicentre, randomised controlled effectiveness trial. We enrolled outpatients with major depression from three cancer centres and their associated clinics in Scotland, UK. Participants were randomly assigned in a 1:1 ratio to the depression care for people with cancer intervention or usual care, with stratification (by trial centre) and minimisation (by age, primary cancer, and sex) with allocation concealment. Depression care

for people with cancer is a manualised, multicomponent collaborative care treatment that is delivered systematically by a team of cancer nurses and psychiatrists in collaboration with primary care physicians. Usual care is provided by primary care physicians. Outcome data were collected up until 48 weeks. The primary outcome was treatment response (≥50 per cent reduction in Symptom Checklist Depression Scale [SCL-20] score, range 0–4) at 24 weeks. Trial statisticians and data collection staff were masked to treatment allocation, but participants could not be masked to the allocations. Analyses were by intention to treat. This trial is registered with Current Controlled Trials, number ISRCTN40568538. FINDINGS: 500 participants were enrolled between May 12, 2008, and May 13, 2011; 253 were randomly allocated to depression care for people with cancer and 247 to usual care. 143 (62 per cent) of 231 participants in the depression care for people with cancer group and 40 (17 per cent) of 231 in the usual care group responded to treatment: absolute difference 45 per cent (95 per cent CI 37–53), adjusted odds ratio 8·5 (95 per cent CI 5·5–13·4), p<0·0001. Compared with patients in the usual care group, participants allocated to the depression care for people with cancer programme also had less depression, anxiety, pain, and fatigue; and better functioning, health, quality of life, and perceived quality of depression care at all timepoints (all p<0·05). During the study, 34 cancer-related deaths occurred (19 in the depression care for people with cancer group, 15 in the usual care group), one patient in the depression care for people with cancer group was admitted to a psychiatric ward, and one patient in this group attempted suicide. None of these events were judged to be related to the trial treatments or procedures. INTERPRETATION: Our findings suggest that depression care for people with cancer is an effective treatment for major depression in patients with cancer. It offers a model for the treatment of depression comorbid with other medical conditions. FUNDING: Cancer Research UK and Chief Scientist Office of the Scottish Government. [Summary]

Schnitzer, K. et Cather, C. (2021). "Individual- and System-Level Solutions for Promoting Integrated Medical Care for People with Serious Mental Illness in Public and Community Psychiatry." Psychiatric Annals **51**(6): 261-265.

People with serious mental illness (SMI) face a striking mortality disparity of 10 to 28 years as compared to the general population, largely attributable to chronic and preventable disease. In this article, we highlight a few practical steps that individual psychiatrists can take to implement recommended screening, monitoring, and treatment strategies for metabolic risk parameters as well as guidance for promoting tobacco cessation. We introduce several selected multicomponent behavioral interventions with demonstrated effectiveness for obesity and diabetes in this population. The article closes with a brief overview of organizational models for collaborative care and reverse integrated care, which aim to improve health outcomes for those with SMI through a team-based approach to medical and psychiatric care-such models may be considered by service providers at the institutional level.

Schnitzer, K., Cather, C., Zvonar, V., et al. (2021). "Patient Experience and Predictors of Improvement in a Group Behavioral and Educational Intervention for Individuals With Diabetes and Serious Mental Illness: Mixed Methods Case Study." J Particip Med **13**(1): e21934.

BACKGROUND: In a previous study, participation in a 16-week reverse integrated care and group behavioral and educational intervention for individuals with diabetes and serious mental illness was associated with improved glycemic control (hemoglobin A(1c)) and BMI.

To inform future implementation efforts, more information about the effective components of the intervention is needed. OBJECTIVE: The goal of this study is to identify the aspects of the intervention participants reported to be helpful and to evaluate the predictors of outcomes. METHODS: This study involved qualitative evaluation and post hoc quantitative analysis of a previous intervention. Qualitative data were collected using semistructured interviews with 69% (24/35) of the individuals who attended 1 or more group sessions and 35% (9/26) of the individuals who consented but attended no sessions. Quantitative mixed effects modeling was performed to test whether improved diabetes knowledge, diet, and exercise or higher group attendance predicted improved hemoglobin A(1c) and BMI. These interview and modeling outcomes were combined using a mixed methods case study framework and integrated thematically. RESULTS: In qualitative interviews, participants identified the application of health-related knowledge gained to real-world situations, accountability for goals, positive reinforcement and group support, and increased confidence in prioritizing health goals as factors contributing to the success of the behavioral intervention. Improved knowledge of diabetes was associated with reduced BMI (β=-1.27, SD 0.40; P=.003). No quantitative variables examined were significantly associated with improved hemoglobin A(1c) levels. CONCLUSIONS: In this mixed methods analysis of predictors of success in a behavioral diabetes management program, group participants highlighted the value of positive reinforcement and group support, accountability for goals set, and real-world application of health-related knowledge gained. Improved diabetes knowledge was associated with weight loss.

Schuster, J., Reynolds, C., III, Carney, T., et al. (2019). "PCORI Final Research Reports". In: [Using Wellness Coaches and Extra Support to Improve the Health and Wellness of Adults with Serious Mental Illness]. Washington (DC), Patient-Centered Outcomes Research Institute (PCORI)

BACKGROUND: Individuals with serious mental illness (SMI) are vulnerable to chronic medical diseases and substantially decreased life expectancy. Many causes of morbidity and mortality are preventable or reversible with appropriate lifestyle modifications. Unfortunately, complex system-, provider-, and individual-level barriers can impede individuals with SMI from care that effectively prevents or manages chronic conditions. Community mental health centers (CMHCs) can help address the unmet medical needs of individuals with SMI, as they are often a primary point of contact with the health care system for this population. OBJECTIVES: The University of Pittsburgh Medical Center for High-value Health Care and patient, provider, and payer partners evaluated 2 promising interventions—provider-supported integrated care (provider-supported) and patient self-directed care (self-directed)—for promoting the health and recovery of adults with SMI. Primary Aim 1: Compare the effectiveness of the interventions on 3 primary patient-centered outcomes: patient activation in care, health status, and engagement in primary/specialty care. Primary Aim 2: Examine the moderating role of gender for the 3 primary patient-centered outcomes. Secondary Aim 1: Explore the impact of the interventions on secondary outcomes: hope, quality of life, functional status, care satisfaction, medication adherence, emergent care, and laboratory monitoring. Secondary Aim 2: Explore the mediating role of patient engagement in the interventions for primary and secondary outcomes. METHODS: The study population comprised Medicaid-enrolled adults diagnosed with SMI who received care at 1 of 11 CMHCs. We used a cluster randomized design and mixed-methods approach. We captured patient self-report measures and insurance claims at 5 time points across 2 years of implementation. We conducted qualitative interviews with service users and staff members to understand barriers and facilitators to intervention success and dissemination. Using generalized linear mixed models and generalized estimating equations, we analyzed the impact of interventions

on primary and secondary outcomes. To assess heterogeneity of treatment effects, we analyzed the role of gender as a moderator. We used an editing approach to develop a qualitative analysis codebook and analyzed narratives for relevant themes. Finally, we employed a learning collaborative approach to support implementation. RESULTS: Among the 1229 men (37%) and women (63%) with SMI who were enrolled in the study, 713 participated in provider-supported and 516 participated in self-directed. The mean age of participants was 43, and most were White (90%). Over the 18 to 24 months of follow-up, intervention type had a differential impact on patient activation: Provider-supported participants experienced an increase in activation score at 6 months and self-directed participants experienced an increase at 18 months (P < .0001). Additionally, women in provider-supported were more likely to report increased activation compared with men (P < .0001). Both interventions positively affected mental health status (P < .0001) and engagement in primary/specialty care (P < .0001). Several secondary outcomes improved, although perceived physical health status declined (P < .0001). CMHC staff and service users reported positive experiences in both interventions. We identified barriers (eg, staff turnover, lack of service user motivation to change health habits) and facilitators (eg, integration of intervention components into routine practice, availability of a wellness nurse [provider-supported only]) to intervention success. Use of the learning collaborative allowed for consistent improvement on process and outcomes goals over time and promoted high levels of implementation. All sites continue to implement the interventions poststudy, and staff at additional CMHCs have been trained and supported to deliver similar models of care. CONCLUSIONS: Both provider-supported and self-directed affected patient-centered outcomes, including patient activation, engagement in primary/specialty care, and quality of life. This study promotes national efforts to avoid comorbidity and early mortality among individuals with SMI and provides information about scalable models that hold promise for successful uptake in other behavioral health treatment settings. LIMITATIONS: Our use of historical claims data limited the accuracy of prestudy eligibility estimates at each study site, resulting in lower enrollment, a sample size imbalance across study arms, and reduced statistical power to conduct proposed heterogeneity of treatment effect analyses beyond the role of gender. The completeness of self-report data across all 5 time points is a clear limitation but not unexpected in the context of real-world community mental health settings. Our use of claims data enhanced data completeness, thereby permitting examination of the intervention's impact on several important patient-centered outcomes.

Sheiman, I. (2014). "Integrated Health Care Payment Methods: Typology, Evidence And Pre-Conditions Of Implementation". Moscou, H.S.E.
http://www.hse.ru/data/2014/09/25/1315606082/18PA2014.pdf

Many countries have recently started the search for new payments methods with the specific objective to encourage integration in health care delivery – teamwork of providers, their coordination and continuity of care. This paper suggests the typology of three major integrated payment methods – pay-for-performance, episode based bundled payment and global payment. A brief overview of these methods in the USA and Europe, including Russia, indicates that there is still no strong evidence of their effects on integration and other dimensions of medical service delivery performance. It is argued that relative to other integrated methods global payment is the most promising method, since it provides incentives for comprehensive organizational changes. The major pre-conditions for global payment implementation are risk bearing in integrated networks, shared savings schemes, performance transparency system, infrastructure for coordination and collaboration. It is also argued that global payment is hard to implement – mostly due to a high probability of

excessive financial risks placed on providers in integrated networks. The activities to mitigate these risks are discussed based on the approaches piloted in Russia.

Sherwood, Z. S., Sandford, J. et Jacob, S. (2022). "Can collaborative working improve diabetic retinal screening rates in individuals also diagnosed with a severe mental illness?" Future Healthc J **9**(2): 161-165.

AIM: We aimed to create a collaborative data sharing project between two NHS trusts to improve attendance and access to diabetic retinopathy screening in individuals with severe mental illness (SMI). METHODS: The eligible patient lists were analysed before and after interventions to assess their effectiveness over two data runs. RESULTS: Screening attendance rates increased by 31% and 25% in the data runs; a significant number of patients (15%) who were screened required onward referral to hospital eye services. Patient registrations increased from 35% to 86% for previously not registered individuals. Inpatients were around 50% more likely to get screened and registered than community patients. CONCLUSION: Information sharing and collaborative working between services can improve patient health outcomes, increasing the number of eligible individuals with SMI registered and improving attendance. The project shows the potential for future data sharing collaborations, highlighting the need for further improvement, development and investment.

Siantz, E., Redline, B. et Henwood, B. (2021). "Practice Facilitation in Integrated Behavioral Health and Primary Care Settings: a Scoping Review." J Behav Health Serv Res **48**(1): 133-155.

Little is known about the contributions of practice facilitators in settings aiming to deliver integrated behavioral health and primary care. This scoping review identifies peer-reviewed articles that describe efforts to deliver integrated behavioral health care with the support of practice facilitators. Five databases were systematically searched to identify empirical and conceptual papers. Fourteen articles met the following inclusion criteria: (1) empirical studies evaluating the effectiveness of practice facilitation (n = 4), (2) study protocols that will test the effectiveness of practice facilitation (n = 2), (3) studies that included practice facilitators as part of a larger intervention without evaluating their effectiveness (n = 5), and (4) conceptual manuscripts endorsing practice facilitation for integrated care (n = 3). Practice facilitators can potentially support health systems in delivering integrated behavioral health care, but future research is needed to understand their necessary qualifications, the effectiveness of practice facilitation these efforts, and what study outcomes are appropriate for evaluating whether practice facilitation has been effective.

Siskind, D., Yen, W., Thuzar, M., et al. (2022). "Outcomes of a co-located approach for metabolic health care for people with schizophrenia." Australas Psychiatry **30**(4): 518-522.

OBJECTIVE: Metabolic syndrome is highly prevalent among people with schizophrenia. This study aims to assess the impact on metabolic and attendance outcomes of a co-located, dedicated, endocrinologist-led metabolic clinic in a stand-alone public community mental health service. METHODS: Demographic and metabolic data on the first 48 consecutive referrals over a 12-month period were retrospectively collected and analysed. Attendance rates at the co-located clinic were compared to the general hospital obesity and diabetes clinics. RESULTS: Clinic attendees had significant reductions in triglycerides and total cholesterol, but not mean weight, BMI, waist circumference, blood pressure or HbA1c. Attendance rates were significantly higher in the co-located clinic compared to the general hospital obesity and diabetes clinics for both initial consult (80.0% vs 51.2%, $p < 0.001$) and review appointment (64.3% vs 47.6%, $p < 0.001$). CONCLUSION: The co-location of a specialist

metabolic clinic within a mental health service resulted in enhanced engagement and improvement of metabolic health in people with schizophrenia.

Stein, F., Lancaster, M., Yaggy, S., et al. (2011). "Co-location of behavioral health and primary care services: Community Care of North Carolina and the Center of Excellence for Integrated Care." N C Med J **72**(1): 50-53.

The North Carolina Division of Mental Health, Developmental Disabilities, and Substance Abuse Services works with partners to reduce the impact of behavioral health conditions in communities throughout the state. We review state-funded behavioral health initiatives that provide support to military personnel and their families, with special attention to public services and co-location efforts.

Strunz, M., Jiménez, N. P., Gregorius, L., et al. (2022). "Interventions to Promote the Utilization of Physical Health Care for People with Severe Mental Illness: A Scoping Review." Int J Environ Res Public Health **20**(1).

BACKGROUND: The main contributor to excess mortality in severe mental illness (SMI) is poor physical health. Causes include unfavorable health behaviors among people with SMI, stigmatization phenomena, as well as limited access to and utilization of physical health care. Patient centered interventions to promote the utilization of and access to existing physical health care facilities may be a pragmatic and cost-effective approach to improve health equity in this vulnerable and often neglected patient population. OBJECTIVE/METHODS: In this study, we systematically reviewed the international literature on such studies (sources: literature databases, trial-registries, grey literature). Empirical studies (quantitative, qualitative, and mixed methods) of interventions to improve the utilization of and access to medical health care for people with a SMI, were included. RESULTS: We identified 38 studies, described in 51 study publications, and summarized them in terms of type, theoretical rationale, outcome measures, and study author's interpretation of the intervention success. CONCLUSIONS: Useful interventions to promote the utilization of physical health care for people with a SMI exist, but still appear to be rare, or at least not supplemented by evaluation studies. The present review provides a map of the evidence and may serve as a starting point for further quantitative effectiveness evaluations of this promising type of behavioral intervention.

Sunderji, N., Kurdyak, P. A., Sockalingam, S., et al. (2018). "Can Collaborative Care Cure the Mediocrity of Usual Care for Common Mental Disorders?" Can J Psychiatry **63**(7): 427-431.

Theodoridou, A., Hengartner, M. P., Gairing, S. K., et al. (2015). "Evaluation of a new person-centered integrated care model in psychiatry." Psychiatr Q **86**(2): 153-168.

The present study evaluated a new integrated treatment concept offering inpatient care, acute psychiatric day hospital and outpatient treatment by the same therapeutic team. 178 patients participated in this randomized controlled trial. Data on psychopathology, global and social functioning, patient satisfaction, continuity of care and administrative data was gathered on admission, throughout the course of treatment, upon discharge and at 1-year follow-up. In addition, the physicians in charge rated the therapeutic relationship. The data analysis consists of group-wise comparisons and regression analyses (cross-tabulations and χ(2) test statistics for categorical data and Mann-Whitney U tests for continuous data). Differences between groups over time were analyzed with a series of generalized linear mixed model. The integrated care group showed a significant reduction in psychopathological

impairment (20.7%) and an improvement of psychosocial functioning (36.8%). The mean number of days before re-admission was higher in the control group when compared to the integrated care group (156.8 vs. 91.5). There was no difference in the number of re-admissions and days spent in psychiatric institutions. This new approach offers a treatment model, which facilitates continuity of care. Beside it improves psychopathological outcome measures and psychosocial functioning in patients with mental illness.

Thielke, S., Vannoy, S. et Unützer, J. (2007). "Integrating mental health and primary care." Prim Care **34**(3): 571-592, vii.

Mental health and primary care delivery systems have evolved to operate differently. For example, attention to multiple medical issues, health maintenance, and structured diagnostic procedures are standard elements of primary care rarely incorporated into mental health care. A multidisciplinary treatment approach, group care, and case management are common features of mental health treatment settings only rarely used in primary care practices. Advances in treatments for mental health disorders and increased knowledge of the integral link between mental health and physical health encourage mental health disorder treatment in primary care settings, which reach the most patients. Effective integration of mental health care into primary care requires systematic and pragmatic change that builds on the strengths of both mental health and primary care.

Uga, A., Kulkarni, S., Heeramun, V., et al. (2017). "Evaluation of a Model of Integrated Care for Patients With Chronic Medical and Psychiatric Illness." Psychosomatics **58**(4): 437-440.

BACKGROUND: Chronic illnesses are prevalent in general medical and psychiatric practices, causing significant disease burden to care givers and providers. Systems of care that treat individuals with mental illness are often separate from general medical systems of care. OBJECTIVE: This study sought to compare the quality of life, satisfaction with care, and utilization of care in patients with comorbid chronic medical and mental illnesses. METHODS: A total of 64 participants from an integrated medicine and psychiatry clinic (med/psych), were compared with 52 patients from separate internal medicine and psychiatry clinics (within the same institution) for quality of life, satisfaction with care, and utilization of care. RESULT: Patients receiving integrated care reported being more satisfied with care compared with patients treated separately. There were no differences in quality of life between the groups. A nonsignificant trend toward fewer emergency room visits and fewer hospital stays for the integrated care group compared with the separate care group was observed. CONCLUSION: This study demonstrated that integrated care for psychiatric and medical disorders improved the patients' experience of care and therefore may have positively affected the outcome of care. Further work is needed to compare medical and psychiatric comorbidities and costs of care and quality measures in these 2 groups.

Vogel, M. E., Kanzler, K. E., Aikens, J. E., et al. (2017). "Integration of behavioral health and primary care: current knowledge and future directions." J Behav Med **40**(1): 69-84.

Integrated behavioral health in primary care has spread rapidly over the past three decades, although significant questions remain unanswered regarding best practices in clinical, financial and operational worlds. Two key models have emerged over time: care management and Primary Care Behavioral Health. Research to date has been promising; however, there is a significant need for more sophisticated multi-level scientific methodologies to fill in the gaps in current knowledge of integrated primary care. In this

paper, we summarize current scientific knowledge about integrated primary care and critically evaluate the strengths and weaknesses of this knowledge base, focusing on clinical, financial and operational factors. Finally, we recommended priorities for future research, dissemination, real-world implementation, and health policy implications.

Von Korff, M. (2004). "Can care management enhance integration of primary and specialty care?" Bmj **329**(7466): 605.

Walker, J., Hansen, C. H., Martin, P., et al. (2014). "Integrated collaborative care for major depression comorbid with a poor prognosis cancer (SMaRT Oncology-3): a multicentre randomised controlled trial in patients with lung cancer." Lancet Oncol **15**(10): 1168-1176.

BACKGROUND: The management of depression in patients with poor prognosis cancers, such as lung cancer, creates specific challenges. We aimed to assess the efficacy of an integrated treatment programme for major depression in patients with lung cancer compared with usual care. METHODS: Symptom Management Research Trials (SMaRT) Oncology-3 is a parallel-group, multicentre, randomised controlled trial. We enrolled patients with lung cancer and major depression from three cancer centres and their associated clinics in Scotland, UK. Participants were randomly assigned in a 1:1 ratio to the depression care for people with lung cancer treatment programme or usual care by a database software algorithm that used stratification (by trial centre) and minimisation (by age, sex, and cancer type) with allocation concealment. Depression care for people with lung cancer is a manualised, multicomponent collaborative care treatment that is systematically delivered by a team of cancer nurses and psychiatrists in collaboration with primary care physicians. Usual care is provided by primary care physicians. The primary outcome was depression severity (on the Symptom Checklist Depression Scale [SCL-20], range 0-4) averaged over the patient's time in the trial (up to a maximum of 32 weeks). Trial statisticians and data collection staff were masked to treatment allocation, but patients and clinicians could not be masked to the allocations. Analyses were by intention to treat. This trial is registered with Current Controlled Trials, number ISRCTN75905964. FINDINGS: 142 participants were recruited between Jan 5, 2009, and Sept 9, 2011; 68 were randomly allocated to depression care for people with lung cancer and 74 to usual care. 43 (30%) of 142 patients had died by 32 weeks, all of which were cancer-related deaths. No intervention-related serious adverse events occurred. 131 (92%) of 142 patients provided outcome data (59 in the depression care for people with lung cancer group and 72 in the usual care group) and were included in the intention-to-treat primary analysis. Average depression severity was significantly lower in patients allocated to depression care for people with lung cancer (mean score on the SCL-20 1·24 [SD 0·64]) than in those allocated to usual care (mean score 1·61 [SD 0·58]); difference -0·38 (95% CI -0·58 to -0·18); standardised mean difference -0·62 (95% CI -0·94 to -0·29). Self-rated depression improvement, anxiety, quality of life, role functioning, perceived quality of care, and proportion of patients achieving a 12-week treatment response were also significantly better in the depression care for people with lung cancer group than in the usual care group. INTERPRETATION: Our findings suggest that major depression can be treated effectively in patients with a poor prognosis cancer; integrated depression care for people with lung cancer was substantially more efficacious than was usual care. Larger trials are now needed to estimate the effectiveness and cost-effectiveness of this care programme in this patient population, and further adaptation of the treatment will be necessary to address the unmet needs of patients with major depression and even shorter life expectancy. FUNDING: Cancer Research UK and Chief Scientist Office of the Scottish Government.

Ward, M. C. et Druss, B. G. (2017). "Reverse Integration Initiatives for Individuals With Serious Mental Illness." Focus (Am Psychiatr Publ) **15**(3): 271-278.

> Medical progress has greatly extended the life span of individuals living in the United States, yet certain groups have lagged behind in achieving wellness and longevity. Prominent among these are individuals with serious mental illness. Because of this, various initiatives have been launched at the community, state, and national level to improve the medical care of those with serious mental illness. Many of these initiatives promote "reverse integration," or the provision of collaborative care services in behavioral health locations. Despite significant barriers to implementation, these initiatives have shown moderate success in improving medical outcomes for those with serious mental illness, in both research and "real-life" settings. Additionally, the role of psychiatrists in addressing physical health has been explored, and there is a need for educational opportunities to optimize competency in this area. Overall, work still needs to be done before the mortality gap for those with serious mental illness dissipates.

Wells, R., Breckenridge, E. D., Ajaz, S., et al. (2019). "Integrating Primary Care Into Community Mental Health Centres in Texas, USA: Results of a Case Study Investigation." Int J Integr Care **19**(4): 1.

> INTRODUCTION: Despite evidence that people with serious mental illness benefit from receiving primary care within mental health care settings, there is little research on this type of integration. The objective of this study was to characterize how providers and patients experienced implementation of primary care into specialty mental health services. METHODS: During site visits, study team members interviewed staff and conducted focus groups with patients at 10 United States community mental health centres then beginning to integrate primary into their practices. One year later, follow up phone interviews with key centre staff informants validated and updated findings. Data analysis included thematic coding of results from staff interviews and patient focus groups. RESULTS: Findings included the importance of the scope of primary care services provided on site, given limited alternatives available to patients; rapid scale-up; overcoming challenges in provider recruitment and retention; and adaptations to engage patients as well as to improve communication between mental health and primary care providers. CONCLUSION: Providers and patients perceived improvements through integrated care. However, the majority of patients were uninsured, and the funding was short term. The long-term viability of integrated care for community mental health centre patients may hinge on adequate, predictable public funding.

Yohannes, A. M., Newman, M. et Kunik, M. E. (2019). "Psychiatric Collaborative Care for Patients With Respiratory Disease." Chest **155**(6): 1288-1295.

> Psychiatric disorders are common in patients with advanced respiratory diseases, including COPD and asthma. These comorbid illnesses are often associated with poor compliance with medical treatment, increased disability, heightened health-care utilization, and premature mortality. Seeking to improve patient outcomes, improve patient satisfaction, and decrease the cost of care has led to the creation of alternative care and reimbursement models. One of the most mature of these models is the collaborative care model (CoCM). This model is team-based care; team members being the primary care provider, a care manager, and a psychiatric care provider. Studies have shown improved outcomes, improved patient satisfaction, and decreased cost when this model has been used to care for patients with general medical illness and psychiatric comorbidities. The primary care provider really drives the care, identifying the comorbidities and enlisting the patient's participation with care.

Care managers could include nurses, social workers, or psychologists. Their responsibilities include monitoring symptoms, brief behavioral interventions, and other activities including case review with the psychiatric care provider. The psychiatric care provider is not expected to be on-site but will review cases with the care manager, who will communicate recommendations back to the primary care provider. Those services could be billed for under other Current Procedural Terminology (CPT) codes. As of January 1, 2018, report CoCM services using CPT codes 99492, 99493, and 99494 have been utilized for psychiatric collaborative care, in this new model to provide mental health services to patients with chronic medical conditions such as advanced respiratory diseases. They are endorsed by the Centers for Medicare and Medicaid Services, these new CPT codes support CoCM services and replace the 2017 codes G0502, G0503, and G0504 for Behavioral Health Integration. This article provides guidance on CoCM for patients with advanced respiratory disease and the new CPT codes for reimbursement of these services.

Walker, J., Walker, J., Holm Hansen, C., et al. (2014). "Integrated collaborative care for major depression comorbid with a poor prognosis cancer (SMaRT Oncology-3) : : a multicentre randomised controlled trial in patients with lung cancer".

BACKGROUND: The management of depression in patients with poor prognosis cancers, such as lung cancer, creates specific challenges. We aimed to assess the efficacy of an integrated treatment programme for major depression in patients with lung cancer compared with usual care. METHODS: Symptom Management Research Trials (SMaRT) Oncology-3 is a parallel-group, multicentre, randomised controlled trial. We enrolled patients with lung cancer and major depression from three cancer centres and their associated clinics in Scotland, UK. Participants were randomly assigned in a 1:1 ratio to the depression care for people with lung cancer treatment programme or usual care by a database software algorithm that used stratification (by trial centre) and minimisation (by age, sex, and cancer type) with allocation concealment. Depression care for people with lung cancer is a manualised, multicomponent collaborative care treatment that is systematically delivered by a team of cancer nurses and psychiatrists in collaboration with primary care physicians. Usual care is provided by primary care physicians. The primary outcome was depression severity (on the Symptom Checklist Depression Scale [SCL-20], range 0–4) averaged over the patient's time in the trial (up to a maximum of 32 weeks). Trial statisticians and data collection staff were masked to treatment allocation, but patients and clinicians could not be masked to the allocations. Analyses were by intention to treat. This trial is registered with Current Controlled Trials, number ISRCTN75905964. FINDINGS: 142 participants were recruited between Jan 5, 2009, and Sept 9, 2011; 68 were randomly allocated to depression care for people with lung cancer and 74 to usual care. 43 (30 per cent) of 142 patients had died by 32 weeks, all of which were cancer-related deaths. No intervention-related serious adverse events occurred. 131 (92 per cent) of 142 patients provided outcome data (59 in the depression care for people with lung cancer group and 72 in the usual care group) and were included in the intention-to-treat primary analysis. Average depression severity was significantly lower in patients allocated to depression care for people with lung cancer (mean score on the SCL-20 1·24 [SD 0·64]) than in those allocated to usual care (mean score 1·61 [SD 0·58]); difference −0·38 (95 per cent CI −0·58 to −0·18); standardised mean difference −0·62 (95 per cent CI −0·94 to −0·29). Self-rated depression improvement, anxiety, quality of life, role functioning, perceived quality of care, and proportion of patients achieving a 12-week treatment response were also significantly better in the depression care for people with lung cancer group than in the usual care group. INTERPRETATION: Our findings suggest that major depression can be treated effectively in patients with a poor prognosis cancer; integrated depression care for people with lung cancer was substantially more efficacious

than was usual care. Larger trials are now needed to estimate the effectiveness and cost-effectiveness of this care programme in this patient population, and further adaptation of the treatment will be necessary to address the unmet needs of patients with major depression and even shorter life expectancy. FUNDING: Cancer Research UK and Chief Scientist Office of the Scottish Government. [Summary]

Williams, J. W., Jr. et Manning, J. S. (2008). "Collaborative mental health and primary care for bipolar disorder." J Psychiatr Pract **14 Suppl 2**: 55-64.

This article discusses the use of integrated care models, in particular, collaborative care, in the treatment of bipolar disorder. Dr. Williams first discusses how care delivered via a collaboration between primary care and psychiatric providers has the potential to improve both mental health and general medical outcomes for patients with bipolar disorder. He describes promising findings from studies of the use of collaborative care in the treatment of depression, an area where this model has received the most study. Dr. Williams then discusses how such collaborative care models might best be implemented in the treatment of bipolar disorder. In the second half of the article, Dr. Manning focuses on five key issues that are an especially appropriate focus for collaborative care for bipolar disorder and for which the STAndards for BipoLar Excellence (STABLE) Project developed quality improvement performance measures: assessment for risk of suicide, assessment for substance use/abuse, monitoring for extrapyramidal symptoms, monitoring of metabolic parameters (e.g., monitoring for weight gain, hyperglycemia, hyperlipidemia), and provision of bipolar-specific psychoeducation.

World Health Organization (2008). "Integrating mental health into primary care : a global perspective". Geneva, World Health Organization
http://www.who.int/mental_health/policy/services/integratingmhintoprimarycare/en/

This report provides the rationale and know-how on successfully integrating mental health into primary health care. Readers will find out how providing mental health care into primary health care settings produces better health outcomes, learn from other countries that have successfully integrated their mental health services into primary health care, and discover 10 common principles that underlie all successful mental health integration, regardless of country resource level

Wulsin, L. R., Söllner, W. et Pincus, H. A. (2006). "Models of integrated care." Med Clin North Am **90**(4): 647-677.

This article describes the range of options for integrating medicine and psychiatry, with a focus on the advantages and limitations of each model. The models were developed in different countries with specific health care cultures. This article illustrates the range of in- and outpatient options as currently practiced, with case reports from practitioners when possible, and describes qualifications for practicing in each model, the settings, the patient populations, the relevant financial issues, and the advantages and disadvantages of practicing in each model. It closes with comments on the next steps for advancing integrated care and the barriers to be overcome.

Young, A. S., Cohen, A. N., Chang, E. T., et al. (2018). "A clustered controlled trial of the implementation and effectiveness of a medical home to improve health care of people with serious mental illness: study protocol." BMC Health Serv Res **18**(1): 428.

BACKGROUND: People with serious mental illness (SMI) die many years prematurely, with rates of premature mortality two to three times greater than the general population. Most premature deaths are due to "natural causes," especially cardiovascular disease and cancer. Often, people with SMI are not well engaged in primary care treatment and do not receive high-value preventative and medical services. There have been numerous efforts to improve this care, and few controlled trials, with inconsistent results. While people with SMI often do poorly with usual primary care arrangements, research suggests that integrated care and medical care management may improve treatment and outcomes, and reduce treatment costs. METHODS: This hybrid implementation-effectiveness study is a prospective, cluster controlled trial of a medical home, the SMI Patient-Aligned Care Team (SMI PACT), to improve the healthcare of patients with SMI enrolled with the Veterans Health Administration. The SMI PACT team includes proactive medical nurse care management, and integrated mental health treatment through regular psychiatry consultation and a collaborative care model. Patients are recruited to receive primary care through SMI PACT based on having a serious mental illness that is manageable with treatment, and elevated risk for hospitalization or death. In a site-level prospective controlled trial, this project studies the effect, relative to usual care, of SMI PACT on provision of appropriate preventive and medical treatments, health-related quality of life, satisfaction with care, and medical and mental health treatment utilization and costs. Research includes mixed-methods formative evaluation of usual care and SMI PACT implementation to strengthen the intervention and assess barriers and facilitators. Investigators examine relationships among organizational context, intervention factors, and patient and clinician outcomes, and identify patient factors related to successful patient outcomes. DISCUSSION: This will be one of the first controlled trials of the implementation and effectiveness of a patient centered medical home for people with serious mental illness. It will provide information regarding the value of this strategy, and processes and tools for implementing this model in community healthcare settings. TRIAL REGISTRATION: ClinicalTrials.gov, NCT01668355 . Registered August 20, 2012.

Les soins intégrés inversés 'Reversed integrated care : un modèle innovant'

> La plupart des pays se caractérisent par une fragmentation des soins de santé mentale et physique, qui sont souvent financés et délivrés séparément. Cette situation ne favorise pas un bon accès aux soins, notamment en termes de prévention, ni une bonne coordination entre les professionnels de santé. *Face à ce constat, un mouvement international récent soutient des dispositifs de soins intégrés dits « inversés » : la délivrance des soins primaires se fait au sein de structures spécialisées en santé mentale, qui sont souvent le principal point de contact avec le système de santé des personnes vivant avec un trouble psychique sévère, dans une approche globale de la santé centrée sur les individus.*[6]

Alakeson, V., Frank, R. G. et Katz, R. E. (2010). "Specialty Care Medical Homes For People With Severe, Persistent Mental Disorders." Health Affairs **29**(5): 867-873.

> The patient-centered medical home concept is central to discussions about the reform of the health care delivery system. Most descriptions of the concept assume that a primary care practice would serve as the hub of the medical home. However, for people with severe and persistent mental disorders, specialty health care settings serve as the principal point of contact with the health care system. For them, a patient-centered medical home in a specialty setting would be the most expedient way to address their urgent health care needs. Among other issues, implementing this idea would mean reimbursement strategies to support the integration and coordination of primary care in specialty settings.

Ambreen, M., Canning, C., Lo, B., et al. (2025). "Strengthening the Delivery of Physical Healthcare for Adults Living With Serious Mental Illness - A Qualitative Description of Patient and Family Member Perspectives." Health Expect **28**(2): e70224.

> BACKGROUND: Individuals with serious mental illness (SMI) have higher rates of comorbid physical health conditions, poorer associated health outcomes, and die on average 10-20 years earlier than the general population. This qualitative study aimed to explore the perspectives and experiences of adults living with SMI and family members with accessing physical healthcare within primary and mental health settings in Canada. METHODS: We conducted a qualitative descriptive study using semi-structured interviews with 20 adults living with SMI and five focus groups with 18 family members between July 2023 and April 2024. After coding by two authors, thematic analysis was completed with the support of a data analysis team to identify overarching themes capturing participant experiences with accessing physical healthcare, care needs and preferences. RESULTS: Four main themes emerged from participant narratives: (1) The centrality of mental health problems in the lives of people with SMI; (2) Challenges in accessing physical healthcare; (3) The role of families in supporting access to care; (4) Perceived health priorities and preferences. There was a high degree of congruence between the perspectives of individuals living with SMI and family members. Both participant groups described challenges accessing primary care settings, fragmented health services, and a desire for person-centred, whole-person health within mental health settings, with family member support where available. CONCLUSIONS: Findings from this study highlight the need for advancing the integration of physical healthcare within mental health settings for adults living with SMI, who are less likely to

[6] Extrait de : Gandré, C, McGinty, E. (2024). *Bridging the gap*. L'implication de structures de santé mentale ambulatoires dans les soins primaires aux Etats-Unis : enseignements pour une prise en charge intégrée des troubles psychiques sévères en France. Questions d'Economie de la santé, n°292 A lire pour une description synthétique du modèle.

engage with community-based primary care services. Enhanced access to physical healthcare could leverage multidisciplinary resources in these settings and partnerships with families. These findings can inform efforts to provide whole-person healthcare for individuals experiencing SMI. PATIENT OR PUBLIC CONTRIBUTION: The study team collaborated closely with community organizations and individuals with lived experience at every stage of this research. This included contributions to the funding proposal, the study protocol, participant recruitment, study materials, data analysis and preparing the manuscript. Individuals with lived experience and family members actively participated in management and project meetings for the duration of the study.

Annamalai, A. A.-O., Staeheli, M., Cole, R. A., et al. (2018). "Establishing an Integrated Health Care Clinic in a Community Mental Health Center: Lessons Learned." Psychiatr Q **89**: 169-181. https://www.ncbi.nlm.nih.gov/pubmed/28664447

Integrating primary care with behavioral health services at community mental health centers is one response to the disparity in mortality and morbidity experienced by adults with serious mental illnesses and co-occurring substance use disorders. Many integration models have been developed in response to the Primary and Behavioral Health Care Integration (PBHCI) initiative of the Substance Abuse and Mental Health Services Administration (SAMHSA). One model is a primary care clinic co-located within the mental health center. The Connecticut Mental Health Center (CMHC) Wellness Center is one such co-located clinic developed as a partnership between CMHC and a Federally Qualified Health Center (FQHC). In this article, we describe the process of developing this on-site clinic along with lessons learned during implementation. We review different aspects of building and maintaining such a clinic and outline lessons learned from both successes and challenges. We briefly describe the demographics and health characteristics of the patient population served in this clinic. We make recommendations for providers and agencies that are considering or are already developing a model for integrating care. Finally, we briefly review status of our clinic after completion of grant funding. FAU - Annamalai, Aniyizhai

Antenucci, C., Schreiber, S., Clegg, K., et al. (2021). "Integrating primary care into a community mental health center." J Fam Pract **70**(3): 137-139.

Our initiation of a reverse-integration practice model revealed numerous advantages and rewards, as well as many challenges, for which we found solutions.

Bandara, S. N., Kennedy-Hendricks, A., Stuart, E. A., et al. (2020). "The effects of the Maryland Medicaid Health Home Waiver on Emergency Department and inpatient utilization among individuals with serious mental illness." General Hospital Psychiatry **64**: 99-104.

OBJECTIVE: The Maryland Medicaid health home program, established through the Affordable Care Act's Medicaid health home waiver, integrates primary care services into specialty mental health programs for adults with serious mental illness (SMI). We evaluated the effect of this program on all-cause, physical, and behavioral health emergency department (ED) and inpatient utilization. METHOD: Using marginal structural modeling to control for time-invariant and time-varying confounding, we analyzed Medicaid administrative claims data for 12,232 enrollees with SMI from October 1, 2012 to December 31, 2016; 3319 individuals were enrolled in a BHH and 8913 were never enrolled. RESULTS: Health home enrollment was associated with reduced probability of all-cause (PP: 0.23 BHH enrollment vs. 0.26 non-enrollment, $p < 0.01$) and physical health ED visits (PP: 0.21 BHH

enrollment vs. 0.24 non-enrollment, p < 0.01) and no effect on inpatient admissions per person-three-month period. CONCLUSION: These results suggest the Maryland Medicaid health home waiver's focus on supporting physical health care coordination by specialty mental health programs may be preventing ED visits among adults with SMI, although effect sizes are small.

Bartels, S. J., DiMilia, P. R., Fortuna, K. L., et al. (2020). "Integrated Care for Older Adults with Serious Mental Illness and Medical Comorbidity: Evidence-Based Models and Future Research Directions." Clin Geriatr Med **36**(2): 341-352.

The excess risk of early mortality, medical comorbidity, early institutionalization, and high costs among older adults with serious mental illness necessitates development and dissemination of effective and sustainable integrated care models that simultaneously address mental and physical health needs. This overview highlights current, evidence-based integrated care models, which predominantly adopt the following approaches: (1) psychosocial skills training, (2) integrated illness self-management, and (3) collaborative care and behavioral health homes. Finally, innovative models that build on these approaches by incorporating novel uses of telehealth, mobile health technology and peer support, and strategies from developing economies are discussed.

Beil, H., Feinberg, R. K., Patel, S. V., et al. (2019). "Behavioral Health Integration With Primary Care: Implementation Experience and Impacts From the State Innovation Model Round 1 States." Milbank Q **97**(2): 543-582.

Policy Points Individuals with behavioral health (BH) conditions comprise a medically complex population with high costs and high health care needs. Considering national shortages of BH providers, primary care providers serve a critical role in identifying and treating BH conditions and making referrals to BH providers. States are increasingly seeking ways to address BH conditions among their residents. States funded by the Centers for Medicare and Medicaid Services under the first round of the State Innovation Models (SIM) Initiative all invested in BH integration. States found sharing data among providers, bridging professional divides, and overcoming BH provider shortages were key barriers. Nonetheless, states made significant strides in integrating BH care. Beyond payment models, a key catalyst for change was facilitating informal relationships between BH providers and primary care physicians. Infrastructure investments such as promoting data sharing by connecting BH providers to a health information exchange and providing tailored technical assistance for both BH and primary care providers were also important in improving integration of BH care. CONTEXT: Increasing numbers of states are looking for ways to address behavioral health (BH) conditions among their residents. The first round of the State Innovation Models (SIM) Initiative provided financial and technical support to six states since 2013 to test the ability of state governments to lead health care system transformation. All six SIM states invested in integration of BH and primary care services. This study summarizes states' progress, challenges, and lessons learned on BH integration. Additionally, the study reports impacts on expenditure, utilization, and quality-of-care outcomes for persons with BH conditions across four SIM states. METHODS: We use a mixed-methods design, drawing on focus groups and key informant interviews to reach conclusions on implementation and quantitative analysis using Medicaid claims data to assess impact. For three Medicaid accountable care organization (ACO) models funded under SIM, we used a difference-in-differences regression model to compare outcomes for model participants with BH conditions and an in-state comparison group before-and-after model implementation. For the behavioral health home (BHH) model in Maine, we used a pre-post design to assess how outcomes for model

participants changed over time. FINDINGS: Informal relationship building, tailored technical assistance, and the promotion of data sharing were key factors in making progress. After three years of implementation, the growth in total expenditures was less than the comparison group by $128 (-$253, -$3; p < 0.10) and $62 (-$87, -$36; p < 0.001) per beneficiary per month for beneficiaries with BH conditions attributed to an ACO in Minnesota and Vermont, respectively. Likewise, there were reductions in emergency department use for ACO participants in all three states after two to four years of implementation. However, there was no improvement in BH-related quality metrics for ACO beneficiaries in all three states. Although participants in the BHH model had increased expenditures after two years of implementation, use of primary care and specialty care services increased by 3% and 8%, respectively, and antidepressant medication adherence also improved. CONCLUSIONS: The SIM Round 1 states made considerable progress in integrating BH and primary care services, and there were promising findings for all models. Taken together, there is some evidence that Medicaid payment models can improve patterns of care for beneficiaries with BH conditions.

Beishon, L., Hickey, B., Desai, B., et al. (2024). "Integrated Physical-Mental Healthcare Services in Specialist Settings to Improve Outcomes for Older People Living With Mental Health Diagnoses: A Systematic Review." Int J Geriatr Psychiatry **39**(9): e6146.

BACKGROUND: Many older people are now living with co-occurring physical and mental health disorders, but these often managed separately. The aim of this systematic review was to explore integrated physical-mental health care services available internationally for older people living with mental health diagnoses, and whether these result in improved health outcomes. METHODS: Medline, Embase, CINAHL, PsycINFO and Scopus were searched with a predefined search strategy (PROSPERO: CRD42022383824), generating 6210 articles. Studies were included where an integrated physical-mental health care service model was utilised in a population of older people (aged >60 years) with a mental health diagnosis (including dementia or cognitive impairment) and at least one concomitant physical health condition requiring physical health care input. All studies were assessed for risk of bias (ROB 2.0, ROBINS-I) and results were synthesised narratively. RESULTS: Nine studies were included across inpatient (n = 6, 1262 patients) and community (n = 3, 466 patients) settings. Studies were rated as low-moderate risk of bias. These covered joint physical-mental health wards, liaison services, embedded physicians in mental health wards, and joint multidisciplinary teams. Services with greater integration (e.g., joint wards) had more benefits for patients and carers. There were few benefits to traditional outcomes (e.g., hospital admissions, mortality), but greater care quality, carer satisfaction, and improved mood and engagement were demonstrated. CONCLUSIONS: Multidisciplinary integrated care resulted in improvement of a range of health outcomes for older people with combined physical and mental health needs. Larger and more robust studies are needed to explore the development of these service models further, with cost-effectiveness analyses.

Berghöfer, A., Martin, L., Hense, S., et al. (2020). "Quality of life in patients with severe mental illness: a cross-sectional survey in an integrated outpatient health care model." Qual Life Res **29**(8): 2073-2087.

PURPOSE: This study (a) assessed quality of life (QoL) in a patient sample with severe mental illness in an integrated psychiatric care (IC) programme in selected regions in Germany, (b) compared QoL among diagnostic groups and (c) identified socio-demographic, psychiatric anamnestic and clinical characteristics associated with QoL. METHODS: This cross-sectional

study included severely mentally ill outpatients with substantial impairments in social functioning. Separate dimensions of QoL were assessed with the World Health Organisation's generic 26-item quality of life (WHOQOL-BREF) instrument. Descriptive analyses and analyses of variance (ANOVAs) were conducted for the overall sample as well as for diagnostic group. RESULTS: A total of 953 patients fully completed the WHOQOL-BREF questionnaire. QoL in this sample was lower than in the general population (mean 34.1; 95% confidence interval (CI) 32.8 to 35.5), with the lowest QoL in unipolar depression patients (mean 30.5; 95% CI 28.9 to 32.2) and the highest in dementia patients (mean 53.0; 95% CI 47.5 to 58.5). Main psychiatric diagnosis, living situation (alone, partner/relatives, assisted), number of disease episodes, source of income, age and clinical global impression (CGI) scores were identified as potential predictors of QoL, but explained only a small part of the variation. CONCLUSION: Aspects of health care that increase QoL despite the presence of a mental disorder are essential for severely mentally ill patients, as complete freedom from the disorder cannot be expected. QoL as a patient-centred outcome should be used as only one component among the recovery measures evaluating treatment outcomes in mental health care.

Briot, P., Bréchat, P.-H., Reiss-Brennan, B., et al. (2015). "Prise en charge intégrée des maladies mentales : l'exemple d'Intermountain Healthcare (USA)." Santé Publique **S1**(HS): 199-208. https://www.cairn.info/revue-sante-publique-2015-HS-page-199.htm

Contexte : Parmi les maladies chroniques, la santé mentale est une priorité de santé publique en France et aux États-Unis. Si des progrès sont possibles en France, l'expérience d'Intermountain Healthcare (IH), Utah, aux États-Unis, peut être source d'expérimentations probantes. Objectif : Identifier les enseignements de l'intégration clinique des spécialistes en santé mentale avec la médecine de ville de soins primaires, appelé Mental Health Integration (MHI) qui pourraient être utiles en France. Méthodes : Cette recherche s'appuie sur l'analyse qualitative de données issues de travaux entre experts, de recherches bibliographiques, et de regroupements par item correspondant aux trois objectifs du Triple Aim de l'Institute for Healthcare Improvement (IHI).Résultats : MHI réalise les objectifs du Triple Aim d'IHI : la satisfaction de l'usager ; l'amélioration de la santé de la population ; la réduction des coûts des soins de santé par habitant. MHI améliore le modèle des soins chroniques (Chronic Care Model) en y intégrant une équipe de spécialistes en santé mentale créant une équipe pluridisciplinaire centrée sur les besoins des patients et de leur famille. Cela crée une prise en charge multidisciplinaire globale protocolisée, stratifiée, planifiée et suivie des pathologies mentales par le continuum. La prévention et les soins ambulatoires intégrant les soins spécialisés de second recours aux soins de premier recours, sont développés. Les usagers et leurs familles sont co-responsables de leur santé. L'évaluation, systématique, se base sur des indicateurs spécifiques. Discussion : L'efficience et l'efficacité clinique et organisationnelle créées permettent des économies pour l'Assurance maladie ainsi que l'accroissement de l'égalité d'accès aux soins et à la santé.

Burner, A., Wahl, C. et Struwe, L. (2024). "Factors to Improve Reverse Integration: A Mixed Method Embedded Design Study." Community Ment Health J **60**(3): 525-535.

Individuals with serious mental illness face inequity in receiving primary care services. The Substance Abuse and Mental Health Services Administration (SAMHSA) granted funds to Certified Community Behavioral Health Clinics (CCBHC) to integrate primary care and behavioral health specialties to increase access to care. This mixed method study aimed to measure the SAMHSA-defined levels of reverse integration at a CCBHC at one point in time. Providers and patients provided feedback through semi-structured interviews. Qualitative data was investigated for themes, while the quantitative data was run through inferential analysis with the Kruskal Wallis H test. Clinically meaningful results showed people using

primary care at the integrated clinic were more satisfied and were more apt to continue seeing their current providers than those receiving non-integrated care. The CCBHC achieved level 4 integration; factors investigated confirmed proximity alone does not necessitate integration without effective communication and implementation of practice changes.

Chambers, M. K., Thomas, M., Brimmer, M. J., et al. (2023). "Whole person care: Outcomes from a 5-year care model integrating primary care into a behavioral health clinic." Fam Syst Health **41**(3): 332-341.

INTRODUCTION: Integrated mental and physical health care has the potential to improve health outcomes. A behavioral health organization established a reverse integration program site using a co-located model to provide primary care services to patients receiving behavioral health services. We ask whether this model of co-located care was effective in improving a range of physical health outcomes for clients. This program was funded with a grant from the Substance Abuse and Mental Health Services Administration Primary and Behavioral Health Care Integration. METHOD: Patients received services in a community mental health setting that embedded primary care services. The population included adult patients with mental illness, substance use disorder (SUD), or co-occurring medical diagnoses in an urban setting. Just under half of the patients identified as non-White, and over one quarter identified as Hispanic. These characteristics demonstrate a medically complex and underserved population. This description and exploratory analysis utilized National Outcome Measures data and clinical health measures from electronic health records. We stratified data by SUD and mental illness diagnoses. We measured changes in health outcomes for this complex population of 532 patients from 2015 to 2019. RESULTS: From enrollment to last visit, patient outcomes improved for blood pressure and cholesterol. Conversely, waist circumference and breath carbon monoxide levels significantly worsened. DISCUSSION: This reverse integration co-location program demonstrates that positive health outcomes can be achieved through evidence-based care, adaptable clinic arrangements, and robust community connections and support. More work is needed to generate positive health outcomes in medically complex patients. (PsycInfo Database Record (c) 2023 APA, all rights reserved).

Cheung, S., Spaeth-Rublee, B., Shalev, D., et al. (2019). "A Model to Improve Behavioral Health Integration into Serious Illness Care." J Pain Symptom Manage **58**(3): 503-514.e501.

Behavioral health problems are highly prevalent among people with serious medical illness. Individuals living with these comorbidities have complex clinical and social needs yet face siloed care, high health care costs, and poor outcomes. Interacting factors contribute to these inequalities including historical separation of behavioral and physical health provision. Several care models for integrating behavioral health and general medical care have been developed and tested, but the evidence base focuses primarily on primary care populations and settings. This article advances that work by proposing a Behavioral Health-Serious Illness Care model. Developed through a mixed methods approach combining literature review, surveys, interviews, and input from an expert advisory panel, it provides a conceptual framework of building blocks for behavioral health integration tailored to serious illness care populations and the range of settings in which they receive care. The model is intended to serve as foundation to support the development and implementation of integrated behavioral health and serious illness care. The key components of the model are described, barriers to implementation discussed, and recommendations for policy approaches to address these barriers presented.

Cunningham, C., Carlo, A. et Dixon, L. B. (2022). "Integrated Care Refresh, Part 2: Reverse Integration of Care and Integrated Care in the Inpatient Setting." Psychiatr Serv **73**(3): 362-363.

Damian, A. J. et Gallo, J. J. (2018). "Models of care for populations with chronic conditions and mental/behavioral health comorbidity." Int Rev Psychiatry **30**(6): 157-169.

> Recent decades have seen increased interest in the integration of mental and physical healthcare. Healthcare reform in the US has provided an opportunity for integration of evidence-based mental health programmes. Three quarters of patients with behavioural health disorders are seen in medical settings, where behavioural problems are largely unaddressed. The human and economic toll of unaddressed mental and behavioural health needs is enormous and often hidden from view, since the behavioural or mental health implications of medical conditions like heart disease and diabetes have only recently begun to be appreciated. This paper has three goals: (1) to review models of integrated services delivery, providing a framework for making sense of strategies for integration; (2) to consider some evidence for clinical outcomes when care is integrated; and (3) to highlight some factors that enhance or impede integration in practice. The review concludes with comments on where the field is going.

Dandona, R. (2019). "Mind and body go together: the need for integrated care." Lancet Psychiatry **6**(8): 638-639.

Daumit, G. L., Stone, E. M., Kennedy-Hendricks, A., et al. (2019). "Care Coordination and Population Health Management Strategies and Challenges in a Behavioral Health Home Model." Medical Care **57**(1): 79-84.

> OBJECTIVES: Behavioral health home (BHH) models have been developed to integrate physical and mental health care and address medical comorbidities for individuals with serious mental illnesses. Previous studies identified population health management capacity and coordination with primary care providers as key barriers to BHH implementation. This study examines the BHH leaders' perceptions of and organizational capacity to conduct these functions within the community mental health programs implementing BHHs in Maryland. METHODS: Interviews and surveys were conducted with 72 implementation leaders and 627 front-line staff from 46 of 48 Maryland BHH programs. In-depth coding of the population health management and primary care coordination themes identified subthemes related to these topics. RESULTS: BHH staff described cultures supportive of evidence-based practices, but limited ability to effectively perform population health management or primary care coordination. Tension between population health management and direct, clinical care, lack of experience, and state regulations for service delivery were identified as key challenges for population health management. Engaging primary care providers was the primary barrier to care coordination. Health information technology and staffing were barriers to both functions. CONCLUSIONS: BHHs face a number of barriers to effective implementation of core program elements. To improve programs' ability to conduct effective population health management and care coordination and meaningfully impact health outcomes for individuals with serious mental illness, multiple strategies are needed, including formalized protocols, training for staff, changes to financing mechanisms, and health information technology improvements.

Davis, M. M., Gunn, R., Cifuentes, M., et al. (2019). "Clinical Workflows and the Associated Tasks and Behaviors to Support Delivery of Integrated Behavioral Health and Primary Care." J Ambul Care Manage **42**(1): 51-65.

Integrating primary care and behavioral health is an important focus of health system transformation. Cross-case comparative analysis of 19 practices in the United States describing integrated care clinical workflows. Surveys, observation visits, and key informant interviews analyzed using immersion-crystallization. Staff performed tasks and behaviors-guided by protocols or scripts-to support 4 workflow phases: (1) identifying; (2) engaging/transitioning; (3) providing treatment; and (4) monitoring/adjusting care. Shared electronic health records and accessible staffing/scheduling facilitated workflows. Stakeholders should consider these workflow phases, address structural features, and utilize a developmental approach as they operationalize integrated care delivery.

Davis, K. E., Brigell, E., Christiansen, K., et al. (2011). "Integrated primary and mental health care services: an evolving partnership model." Psychiatr Rehabil J **34**(4): 317-320.

TOPIC: Persons with serious psychiatric disabilities experience high rates of medical co-morbidities that, if properly treated, could improve overall well-being and the course of recovery. PURPOSE: This brief reports describes how two organizations-Thresholds Psychiatric Rehabilitation Centers and University of Illinois College of Nursing-partnered to offer integrated behavioral and physical health care responsive to the needs of the population and committed to consumer-centered, holistic and preventative care. Most recently, the partnership offers primary care in different community settings through different service models-tele-monitoring, home visits, group visits. SOURCES USED: A combination of published literature, staff report, and quality assurance data informs this report. CONCLUSIONS AND IMPLICATIONS FOR PRACTICE: The authors conclude that primary care outreach is a promising strategy in mental health settings and that the Chronic Care Model (CCM) provides a set of guidelines for designing and monitoring quality integrated care for a partnership model of integrated care.

Druss, B. G., von Esenwein, S. A., Glick, G. E., et al. (2017). "Randomized Trial of an Integrated Behavioral Health Home: The Health Outcomes Management and Evaluation (HOME) Study." Am J Psychiatry **174**(3): 246-255.

OBJECTIVE: Behavioral health homes provide primary care health services to patients with serious mental illness treated in community mental health settings. The objective of this study was to compare quality and outcomes of care between an integrated behavioral health home and usual care. METHOD: The study was a randomized trial of a behavioral health home developed as a partnership between a community mental health center and a Federally Qualified Health Center. A total of 447 patients with a serious mental illness and one or more cardiometabolic risk factors were randomly assigned to either the behavioral health home or usual care for 12 months. Participants in the behavioral health home received integrated medical care on-site from a nurse practitioner and a full-time nurse care manager subcontracted through the health center. RESULTS: Compared with usual care, the behavioral health home was associated with significant improvements in quality of cardiometabolic care, concordance of treatment with the chronic care model, and use of preventive services. For most cardiometabolic and general medical outcomes, both groups demonstrated improvement, although there were no statistically significant differences between the two groups over time. CONCLUSIONS: The results suggest that it is possible, even under challenging real-world conditions, to improve quality of care for patients with

serious mental illness and cardiovascular risk factors. Improving quality of medical care may be necessary, but not sufficient, to improve the full range of medical outcomes in this vulnerable population.

Errichetti, K. S., Flynn, A., Gaitan, E., et al. (2020). "Randomized Trial of Reverse Colocated Integrated Care on Persons with Severe, Persistent Mental Illness in Southern Texas." J Gen Intern Med **35**(1525-1497 (Electronic)): 2035-2042.

BACKGROUND: Persons with severe, persistent mental illness (SPMI) are at high risk for poor health and premature mortality. Integrating primary care in a mental health center may improve health outcomes in a population with SPMI in a socioeconomically distressed region of the USA. OBJECTIVE: To examine the effects of reverse colocated integrated care on persons with SPMI and co-morbid chronic disease receiving behavioral health services at a local mental health authority located at the US-Mexico border. DESIGN: Randomized trial evaluating the effect of a reverse colocated integrated care intervention among chronically ill adults. PARTICIPANTS: Participants were recruited at a clinic between November 24, 2015, and June 30, 2016. INTERVENTIONS: Receipt of at least two visits with a primary care provider and at least one visit with a chronic care nurse or dietician, compared with usual care (behavioral health only). MAIN MEASURES: The primary outcome was blood pressure. Secondary outcomes included HbA1c, BMI, total cholesterol, and depressive symptoms. Sociodemographic data were collected at baseline, and outcomes were measured at baseline and 6- and 12-month follow-ups. KEY RESULTS: A total of 416 participants were randomized to the intervention (n = 249) or usual care (n = 167). Groups were well balanced on almost all baseline characteristics. At 12 months, intent-to-treat analysis showed intervention participants improved their systolic blood pressure (β = - 3.86, p = 0.04) and HbA1c (β = - 0.36, p = 0.001) compared with usual care participants when controlling for age, sex, and other baseline characteristics. No participants withdrew from the study due to adverse effects. Per-protocol analyses yielded similar results to intent-to-treat analyses and found a significantly protective effect on diastolic blood pressure. Older and diabetic populations differentially benefited from this intervention. CONCLUSIONS: Colocation and integration of behavioral health and primary care improved blood pressure and HbA1c after 1-year follow-up for persons with SPMI and co-morbid chronic disease in a US-Mexico border community. TRIAL REGISTRATION: clinicaltrials.gov , Identifier: NCT03881657. FAU - Errichetti, Karen Sautter

Evans, C., Canning, C., Ambreen, M., et al. (2024). "A Canadian Call for Addressing Physical Health in Specialized Mental Health Settings." Healthc Policy **20**(1): 19-28.

People with serious mental illness experience poorer physical health and higher mortality rates than the general population. One option for responding to this disparity is reverse integration, which promotes physical health monitoring in secondary and tertiary mental health settings. Health leaders in Canada can learn from reverse integration approaches that have been adopted or proposed in other jurisdictions. We conducted a jurisdictional scan and applied the 3I framework for policy analysis to suggest that Canadian adaptations of existing approaches should foreground equity, build on existing infrastructure and human resources and prioritize leadership of people with lived experience.

Ferry, M., Amat, C. R., Marthoud, J., et al. (2021). "CORESO: 8 ans après, retour sur l'expérimentation d'une consultation réseau somatique au sein d'un CMP." L'information psychiatrique **97**(6): 476-480.

Les personnes suivies pour des troubles mentaux sévères présentent une surmorbi-mortalité par rapport à la population générale, liée à de nombreux facteurs de risques et à un accès trop restreint à des soins de médecine générale. Le dispositif de soin Coreso] est une consultation relais, basée sur les principes de la réhabilitation psychosociale, dont l'objectif est d'aider les patients à réinvestir leur corps et à bénéficier des soins médicaux dont ils ont besoin. Retour sur ces 8 ans de fonctionnement depuis la mise en place du dispositif.

Fitzpatrick, S. J., Perkins, D., Handley, T., et al. (2018). "Coordinating Mental and Physical Health Care in Rural Australia: An Integrated Model for Primary Care Settings." Int J Integr Care **18**(2): 19.

INTRODUCTION: The 'GP Clinic' provides primary health care to people using community mental health services in a small town in Australia. This article examines the factors that have driven successful integration in this rural location. METHODS: A multiple methods case study approach was used comprising service record data for a 24 month period and semi-structured interviews with sixteen staff members associated with the integrated rural service model. RESULTS: Processes and structures for establishing integrated care evolved locally from nurturing supportive professional and organisational relationships. A booking system that maximised attendance and minimised the work of the general practice ensured that issues to do with remuneration and the capacity for the general practitioner to provide care to those with complex needs were addressed. Strong collaborative relationships led to the upskilling of local staff in physical and mental health conditions and treatments, and ensured significant barriers for people with mental illness accessing primary care in rural Australia were overcome. CONCLUSIONS: Integrated physical and mental health service models that focus on building local service provider relationships and are responsive to community needs and outcomes may be more beneficial in rural settings than top down approaches that focus on policies, formal structures, and governance.

Fortuna, K. L., DiMilia, P. R., Lohman, M. C., et al. (2020). "Systematic Review of the Impact of Behavioral Health Homes on Cardiometabolic Risk Factors for Adults With Serious Mental Illness." Psychiatr Serv **71**(1): 57-74.

OBJECTIVE: This systematic review examined the impact of health homes on cardiometabolic risk among adults with serious mental illness. METHODS: The Preferred Reporting Items for Systematic Reviews and Meta-Analyses procedures were used to conduct the systematic review. Databases were searched for peer-reviewed articles published between 1946 and August 2018 that compared health homes with a control condition (e.g., usual care and secondary data analyses using matched samples). Participants, interventions, comparisons, outcomes, and study design criteria were used to assess study eligibility. Studies were assessed for methodological quality by using the Quality Assessment of Before and After Studies With No Control Group and the Quality Assessment of Controlled Intervention Studies. RESULTS: Eighteen studies (i.e., 11 observational studies, four quasi-experimental studies, and three randomized controlled trials) reported on 17 health homes. Most studies reported increases in receipt of screening for cardiometabolic risk factors and service use. There was a modest reduction in selected cardiometabolic risk factors among people with serious mental illness, but clinical outcomes varied widely among studies. CONCLUSIONS: Improvement in cardiometabolic risk factors varied across the studies, and the clinical significance of these reductions was not clear. Peer support and self-management training may represent strategies to improve cardiometabolic risk factors. Colocation of services may not be enough to significantly affect cardiometabolic risk factors. Health homes that include standardized screening, peer support and self-management training, and intervention

components that target interdependent risk factors may have a greater impact on clinical outcomes.

Kennedy-Hendricks, A., Daumit, G. L., Choksy, S., et al. (2018). "Measuring Variation Across Dimensions of Integrated Care: The Maryland Medicaid Health Home Model." Adm Policy Ment Health **45**(6): 888-899.

Despite the proliferation of initiatives to integrate services for people with serious mental illness (SMI), measures of distinct dimensions of integration, such as spatial arrangement and care team expertise, are lacking. Such measures are needed to support organizations' assessment of progress toward integrated service delivery. We developed measures characterizing integration of behavioral, somatic, and social services to operationalize the integrated care dimensions conceived by the Agency for Healthcare Research and Quality. In a survey fielded to 46 Maryland Medicaid health homes (response rate: 96%) serving adults with SMI during 2015-2016, we found that these measures provided a useful description of variation across dimensions of integration.

Gleason, H. A., Truong, D., Biebel, K., et al. (2017). "Perceived Barriers to and Facilitators of Engagement in Reverse Integrated Care." J Behav Health Serv Res **44**(2): 296-303.

Jespers, V., et al. (2021). "Somatic health care in a psychiatric setting". Bruxelles, K.C.E. (KCE Report 338)
https://kce.fgov.be/fr/node/7901

Les personnes atteintes de maladies mentales telles que la schizophrénie, les troubles psychotiques, les troubles bipolaires ou la dépression grave décèdent beaucoup plus précocement et ont un accès plus difficile aux soins de santé que la population générale. Le Centre fédéral d'Expertise des Soins de santé (KCE) a tenté de comprendre pourquoi. Une étude qualitative menée auprès de patients et d'équipes soignantes de soins psychiatriques résidentiels montre que les limitations rencontrées peuvent être dues à la fois à des préjugés et à des considérations administratives distinguant la santé physique de la santé mentale. Or, de nos jours, tous les guidelines internationaux s'accordent à dire que cette distinction est obsolète et que l'hospitalisation psychiatrique doit être vue comme un moment et un lieu où l'objectif principal est la santé globale du patient, dans un esprit de rétablissement et d'autonomisation. Le KCE propose donc quelques pistes en ce sens et souligne que les réformes en cours de la nomenclature et du financement des hôpitaux sont des opportunités à saisir pour faire évoluer la situation.

Levkovich, N. et Nielsen, M. (2019). "Who Is Driving Change, and Where Is It Taking Us? Interview With an Expert." Families Systems & Health **37**(2): 173-175.

In addition to providing critical behavioral health services for those with mental health issues and substance use disorders, some Community Mental Health Centers (CMHCs) in the United States have begun integrating primary care services, referred to as "reverse integration". Representing the interests of CMHCs across the United States, the National Council for Behavioral Health (NCBH) represents over 3,000 member organizations delivering mental health and/or addictions treatment and services to roughly 10 million patients and families. This article reflects a recent wide-ranging conversation with Linda Rosenberg, the president and CEO of NCBH. Trained as a social worker, Rosenberg was senior deputy commissioner of the New York State Office of Mental Health prior to joining the NCBH and is a dynamic and high-energy strategist and thought leader in the field of community mental health and

integrated care. We discussed issues impacting payment for integrated care, including private equity investment, capitated payment, and the role of risk, and how these market dynamics impact vulnerable populations. For the sake of brevity, we summarize our conversation with Ms. Rosenberg and offer her perspective to integrated care practitioners and researchers who largely operate outside of this world of business built on calculated risks and rewards.

Maragakis, A., Siddharthan, R., RachBeisel, J., et al. (2016). "Creating a 'reverse' integrated primary and mental healthcare clinic for those with serious mental illness." Prim Health Care Res Dev **17**(5): 421-427.

Individuals with serious mental illness (SMI) are more likely to experience preventable medical health issues, such as diabetes, hyperlipidemia, obesity, and cardiovascular disease, than the general population. To further compound this issue, these individuals are less likely to seek preventative medical care. These factors result in higher usage of expensive emergency care, lower quality of care, and lower life expectancy. This manuscript presents literature that examines the health disparities this population experiences, and barriers to accessing primary care. Through the identification of these barriers, we recommend that the field of family medicine work in collaboration with the field of mental health to implement 'reverse' integrated care (RIC) systems, and provide primary care services in the mental health settings. By embedding primary care practitioners in mental health settings, where individuals with SMI are more likely to present for treatment, this population may receive treatment for somatic care by experts. This not only would improve the quality of care received by patients, but would also remove the burden of managing complex somatic care from providers trained in mental health. The rationale for this RIC system, as well as training and policy reforms, are discussed.

McClellan, C., Maclean, J. C., Saloner, B., et al. (2020). "Integrated care models and behavioral health care utilization: Quasi-experimental evidence from Medicaid health homes." Health economics **29**(9): 1086-1097.

Integration of behavioral and general medical care can improve outcomes for individuals with behavioral health conditions-serious mental illness (SMI) and substance use disorder (SUD). However, behavioral health care has historically been segregated from general medical care in many countries. We provide the first population-level evidence on the effects of Medicaid health homes (HH) on behavioral health care service use. Medicaid, a public insurance program in the United States, HHs were created under the 2010 Affordable Care Act to coordinate behavioral and general medical care for enrollees with behavioral health conditions. As of 2016, 16 states had adopted an HH for enrollees with SMI and/or SUD. We use data from the National Survey on Drug Use and Health over the period 2010 to 2016 coupled with a two-way fixed-effects model to estimate HH effects on behavioral health care utilization. We find that HH adoption increases service use among enrollees, although mental health care treatment findings are sensitive to specification. Further, enrollee self-reported health improves post-HH.

McGinty, E. E., Presskreischer, R., Breslau, J., et al. (2021). "Improving Physical Health Among People With Serious Mental Illness: The Role of the Specialty Mental Health Sector." Psychiatr Serv **72**(11): 1301-1310.

People with serious mental illness die 10-20 years earlier, compared with the overall population, and the excess mortality is driven by undertreated physical health conditions. In

the United States, there is growing interest in models integrating physical health care delivery, management, or coordination into specialty mental health programs, sometimes called "reverse integration." In November 2019, the Johns Hopkins ALACRITY Center for Health and Longevity in Mental Illness convened a forum of 25 experts to discuss the current state of the evidence on integrated care models based in the specialty mental health system and to identify priorities for future research, policy, and practice. This article summarizes the group's conclusions. Key research priorities include identifying the active ingredients in multicomponent integrated care models and developing and validating integration performance metrics. Key policy and practice recommendations include developing new financing mechanisms and implementing strategies to build workforce and data capacity. Forum participants also highlighted an overarching need to address socioeconomic risks contributing to excess mortality among adults with serious mental illness.

McGinty, E. E., Stone, E. M., Kennedy-Hendricks, A., et al. (2020). "Effects of Maryland's Affordable Care Act Medicaid Health Home Waiver on Quality of Cardiovascular Care Among People with Serious Mental Illness." J Gen Intern Med **35**(11): 3148-3158.

BACKGROUND: Nineteen US states and D.C. have used the Affordable Care Act Medicaid health home waiver to create behavioral health home (BHH) programs for Medicaid beneficiaries with serious mental illness (SMI). BHH programs integrate physical healthcare management and coordination into specialty mental health programs. No studies have evaluated the effects of a BHH program created through the Affordable Care Act waiver on cardiovascular care quality among people with SMI. OBJECTIVE: To study the effects of Maryland's Medicaid health home waiver BHH program, implemented October 1, 2013, on quality of cardiovascular care among individuals with SMI. DESIGN: Retrospective cohort analysis using Maryland Medicaid administrative claims data from July 1, 2010, to September 30, 2016. We used marginal structural modeling with inverse probability of treatment weighting to account for censoring and potential time-dependent confounding. PARTICIPANTS: Maryland Medicaid beneficiaries with diabetes or cardiovascular disease (CVD) participating in psychiatric rehabilitation programs, the setting in which BHHs were implemented. To qualify for psychiatric rehabilitation programs, individuals must have SMI. The analytic sample included BHH and non-BHH participants, N = 2605 with diabetes and N = 1899 with CVD. MAIN MEASURES: Healthcare Effectiveness Data and Information Set (HEDIS) measures of cardiovascular care quality including annual receipt of diabetic eye and foot exams; HbA1c, diabetic nephropathy, and cholesterol testing; and statin therapy receipt and adherence among individuals with diabetes, as well as HEDIS measures of annual receipt of cholesterol testing and statin therapy and adherence among individuals with CVD. KEY RESULTS: Relative to non-enrollment, enrollment in Maryland's BHH program was associated with increased likelihood of eye exam receipt among individuals with SMI and co-morbid diabetes, but no changes in other care quality measures. CONCLUSIONS: Additional financing, infrastructure, and implementation supports may be needed to realize the full potential of Maryland's BHH to improve cardiovascular care for people with SMI.

McGinty, E. E., Thompson, D., Murphy, K. A., et al. (2021). "Adapting the Comprehensive Unit Safety Program (CUSP) implementation strategy to increase delivery of evidence-based cardiovascular risk factor care in community mental health organizations: protocol for a pilot study." Implementation science communications **2**(1): 26.

BACKGROUND: People with serious mental illnesses (SMI) such as schizophrenia and bipolar disorder experience excess mortality driven in large part by high rates of poorly controlled and under-treated cardiovascular risk factors. In the USA, integrated "behavioral health

home" models in which specialty mental health organizations coordinate and manage physical health care for people with SMI are designed to improve guideline-concordant cardiovascular care for this group. Such models have been shown to improve cardiovascular care for clients with SMI in randomized clinical trials, but real-world implementation has fallen short. Key implementation barriers include lack of alignment of specialty mental health program culture and physical health care coordination and management for clients with SMI and lack of structured protocols for conducting effective physical health care coordination and management in the specialty mental health program context. This protocol describes a pilot study of an implementation intervention designed to overcome these barriers. METHODS: This pilot study uses a single-group, pre/post-study design to examine the effects of an adapted Comprehensive Unit Safety Program (CUSP) implementation strategy designed to support behavioral health home programs in conducting effective cardiovascular care coordination and management for clients with SMI. The CUSP strategy, which was originally designed to improve inpatient safety, includes provider training, expert facilitation, and implementation of a five-step quality improvement process. We will examine the acceptability, appropriateness, and feasibility of the implementation strategy and how this strategy influences mental health organization culture; specialty mental health providers' self-efficacy to conduct evidence-based cardiovascular care coordination and management; and receipt of guideline-concordant care for hypertension, dyslipidemia, and diabetes mellitus among people with SMI. DISCUSSION: While we apply CUSP to the implementation of evidence-based hypertension, dyslipidemia, and diabetes care, this implementation strategy could be used in the future to support the delivery of other types of evidence-based care, such as smoking cessation treatment, in behavioral health home programs. CUSP is designed to be fully integrated into organizations, sustained indefinitely, and used to continually improve evidence-based practice delivery. TRIAL REGISTRATION: ClinicalTrials.gov, NCT04696653 . Registered on January 6, 2021.

McGinty, E. E., Kennedy-Hendricks, A., Linden, S., et al. (2018). "An innovative model to coordinate healthcare and social services for people with serious mental illness: A mixed-methods case study of Maryland's Medicaid health home program." Gen Hosp Psychiatry **51**: 54-62.

OBJECTIVE: We conducted a case study examining implementation of Maryland's Medicaid health home program, a unique model for integration of behavioral, somatic, and social services for people with serious mental illness (SMI) in the psychiatric rehabilitation program setting. METHOD: We conducted interviews and surveys with health home leaders (N=72) and front-line staff (N=627) representing 46 of the 48 total health home programs active during the November 2015-December 2016 study period. We measured the structural and service characteristics of the 46 health home programs and leaders' and staff members' perceptions of program implementation. RESULTS: Health home program structure varied across sites: for example, 15% of programs had co-located primary care providers and 76% had onsite supported employment providers. Most leaders and staff viewed the health home program as having strong organizational fit with psychiatric rehabilitation programs' organizational structures and missions, but noted implementation challenges around health IT, population health management, and coordination with external providers. CONCLUSION: Maryland's psychiatric rehabilitation-based health home is a promising model for integration of behavioral, somatic, and social services for people with SMI but may be strengthened by additional policy and implementation supports, including incentives for external providers to engage in care coordination with health home providers.

Mangurian, C., Niu, G., Schillinger, D., et al. (2017). "Understanding the Cost of a New Integrated Care Model to Serve CMHC Patients Who Have Serious Mental Illness." Psychiatr Serv **68**(10): 990-993.

> People with serious mental illness, such as schizophrenia and bipolar disorder, experience premature mortality, often from cardiovascular disease (CVD). Unfortunately, people with serious mental illness typically are not screened or treated for CVD risk factors despite national guideline recommendations. Access to primary preventive care in community mental health settings has the potential to reduce early mortality rates in this population. The authors review best practices for developing an integrated care model for people with serious mental illness by considering economic feasibility and sustainability from the perspective of a community mental health clinic (CMHC). A process-mapping approach was used to gather information on clinic costs (staff roles, responsibilities, time, and salary) of serving 544 patients at one CMHC. The estimated annual cost of the model was measurable and modest, at $74 per person, suggesting that this model may be financially feasible.

Mangurian, C., Niu, G. C., Schillinger, D., et al. (2017). "Utilization of the Behavior Change Wheel framework to develop a model to improve cardiometabolic screening for people with severe mental illness." Implement Sci **12**(1): 134.

> BACKGROUND: Individuals with severe mental illness (e.g., schizophrenia, bipolar disorder) die 10-25 years earlier than the general population, primarily from premature cardiovascular disease (CVD). Contributing factors are complex, but include systemic-related factors of poorly integrated primary care and mental health services. Although evidence-based models exist for integrating mental health care into primary care settings, the evidence base for integrating medical care into specialty mental health settings is limited. Such models are referred to as "reverse" integration. In this paper, we describe the application of an implementation science framework in designing a model to improve CVD outcomes for individuals with severe mental illness (SMI) who receive services in a community mental health setting. METHODS: Using principles from the theory of planned behavior, focus groups were conducted to understand stakeholder perspectives of barriers to CVD risk factor screening and treatment identify potential target behaviors. We then applied results to the overarching Behavior Change Wheel framework, a systematic and theory-driven approach that incorporates the COM-B model (capability, opportunity, motivation, and behavior), to build an intervention to improve CVD risk factor screening and treatment for people with SMI. RESULTS: Following a stepped approach from the Behavior Change Wheel framework, a model to deliver primary preventive care for people that use community mental health settings as their de facto health home was developed. The CRANIUM (cardiometabolic risk assessment and treatment through a novel integration model for underserved populations with mental illness) model focuses on engaging community psychiatrists to expand their scope of practice to become responsible for CVD risk, with significant clinical decision support. CONCLUSION: The CRANIUM model was designed by integrating behavioral change theory and implementation theory. CRANIUM is feasible to implement, is highly acceptable to, and targets provider behavior change, and is replicable and efficient for helping to integrate primary preventive care services in community mental health settings. CRANIUM can be scaled up to increase CVD preventive care delivery and ultimately improve health outcomes among people with SMI served within a public mental health care system.

Mangurian, C., Thomas, M. D., Mitsuishi, F., et al. (2022). "Lessons Learned From a New Reverse-Integration Model to Improve Primary Care Screening in Community Mental Health Settings." Psychiatr Serv **73**(8): 942-945.

The authors sought to describe a reverse-integration intervention aimed at improving preventive health screening in a community mental health clinic. The intervention, CRANIUM (cardiometabolic risk assessment and treatment through a novel integration model for underserved populations with mental illness), integrated primary care services into a large urban community mental health setting. It was implemented in 2015 and included a patient-centered team, population-based care, emphasis on screening, and evidence-based treatment. CRANIUM's strengths included provider acceptability, a patient-centered approach, sustained patient engagement, and economic feasibility. Challenges included underutilized staff, registry maintenance, and unanticipated screening barriers. The CRANIUM reverse-integration model can be feasibly implemented and was acceptable to providers.

Murphy, K. A., Daumit, G. L., Bandara, S. N., et al. (2020). "Association Between the Maryland Medicaid Behavioral Health Home Program and Cancer Screening in People With Serious Mental Illness." Psychiatr Serv **71**(6): 608-611.

> OBJECTIVE: This study evaluated the association of the Maryland Medicaid behavioral health home (BHH) integrated care program with cancer screening. METHODS: Using administrative claims data from October 2012 to September 2016, the authors measured cancer screening among 12,176 adults in Maryland's psychiatric rehabilitation program who were eligible for cervical (N=6,811), breast (N=1,658), and colorectal (N=3,430) cancer screening. Marginal structural modeling was used to examine the association between receipt of annual cancer screening and whether participants had ever enrolled in a BHH (enrolled: N=3,298, 27%; not enrolled: N=8,878, 73%). RESULTS: Relative to non-enrollment, BHH enrollment was associated with increased screening for cervical and breast cancer but not for colorectal cancer. Predicted annual rates remained low, even in BHHs. CONCLUSIONS: Despite estimates of improvements in cervical and breast cancer screening after BHH implementation, cancer screening rates remained suboptimal. Broader cancer screening interventions are needed to improve cancer screening for people with mental illness.

Schnitzer, K. et Cather, C. (2021). "Individual- and System-Level Solutions for Promoting Integrated Medical Care for People with Serious Mental Illness in Public and Community Psychiatry." Psychiatric Annals **51**(6): 261-265.

> People with serious mental illness (SMI) face a striking mortality disparity of 10 to 28 years as compared to the general population, largely attributable to chronic and preventable disease. In this article, we highlight a few practical steps that individual psychiatrists can take to implement recommended screening, monitoring, and treatment strategies for metabolic risk parameters as well as guidance for promoting tobacco cessation. We introduce several selected multicomponent behavioral interventions with demonstrated effectiveness for obesity and diabetes in this population. The article closes with a brief overview of organizational models for collaborative care and reverse integrated care, which aim to improve health outcomes for those with SMI through a team-based approach to medical and psychiatric care-such models may be considered by service providers at the institutional level.

Schnitzer, K., Cather, C., Zvonar, V., et al. (2021). "Patient Experience and Predictors of Improvement in a Group Behavioral and Educational Intervention for Individuals With Diabetes and Serious Mental Illness: Mixed Methods Case Study." J Particip Med **13**(1): e21934.

BACKGROUND: In a previous study, participation in a 16-week reverse integrated care and group behavioral and educational intervention for individuals with diabetes and serious mental illness was associated with improved glycemic control (hemoglobin A(1c)) and BMI. To inform future implementation efforts, more information about the effective components of the intervention is needed. OBJECTIVE: The goal of this study is to identify the aspects of the intervention participants reported to be helpful and to evaluate the predictors of outcomes. METHODS: This study involved qualitative evaluation and post hoc quantitative analysis of a previous intervention. Qualitative data were collected using semistructured interviews with 69% (24/35) of the individuals who attended 1 or more group sessions and 35% (9/26) of the individuals who consented but attended no sessions. Quantitative mixed effects modeling was performed to test whether improved diabetes knowledge, diet, and exercise or higher group attendance predicted improved hemoglobin A(1c) and BMI. These interview and modeling outcomes were combined using a mixed methods case study framework and integrated thematically. RESULTS: In qualitative interviews, participants identified the application of health-related knowledge gained to real-world situations, accountability for goals, positive reinforcement and group support, and increased confidence in prioritizing health goals as factors contributing to the success of the behavioral intervention. Improved knowledge of diabetes was associated with reduced BMI (β=-1.27, SD 0.40; P=.003). No quantitative variables examined were significantly associated with improved hemoglobin A(1c) levels. CONCLUSIONS: In this mixed methods analysis of predictors of success in a behavioral diabetes management program, group participants highlighted the value of positive reinforcement and group support, accountability for goals set, and real-world application of health-related knowledge gained. Improved diabetes knowledge was associated with weight loss.

Stone, E. M., Daumit, G. L., Kennedy-Hendricks, A., et al. (2020). "The Policy Ecology of Behavioral Health Homes: Case Study of Maryland's Medicaid Health Home Program." Adm Policy Ment Health **47**(1): 60-72.

Behavioral health homes, shown to improve receipt of evidence-based medical services among people with serious mental illness in randomized clinical trials, have had limited results in real-world settings; nonetheless, these programs are spreading rapidly. To date, no studies have considered what set of policies is needed to support effective implementation of these programs. As a first step toward identifying an optimal set of policies to support behavioral health home implementation, we use the policy ecology framework to map the policies surrounding Maryland's Medicaid behavioral health home program. Results suggest that existing policies fail to address important implementation barriers.

Tajirian, T., de Lasa, C., Chessex, C., et al. (2023). "Recommendations to Enhance Physical Health for Individuals with Severe Mental Illness in Canadian Healthcare Organizations." Healthc Q **26**(1): 38-44.

As Canadians with severe mental illness remain underserved and experience a high burden of physical health challenges and premature mortality, there is an unprecedented need to provide better physical healthcare to this population. Ways of addressing this gap include the delivery of physical healthcare in mental health settings ("reverse integration"). However, there is limited guidance on how to enact this integration. In this article, we outline the development of an integrated care strategy in Canada's largest mental health hospital and discuss system- and policy-level recommendations that healthcare organizations could consider in their initiatives.

Talley, R. M., Rolin, S. A., Trejo, B. N., et al. (2019). "Perspectives of Individuals With Serious Mental Illness on a Reverse-Colocated Care Model: A Qualitative Study." Psychiatr Serv **70**(9): 793-800.

OBJECTIVE: Individuals with serious mental illness experience excess mortality related to general medical comorbidities. Reverse-integrated and reverse-colocated models of care have been proposed as a system-level solution. Such models integrate primary care services within behavioral health settings. Further understanding of consumer perspectives on these models is needed to ensure that models adequately engage consumers on the basis of their expressed needs. This qualitative study examined the perspectives of English- and Spanish-speaking individuals with serious mental illness on their current experience with the management of their medical care and on a hypothetical reverse-colocated care model. METHODS: Semistructured interviews were conducted in a purposive sample of 30 individuals with serious mental illness recruited from two outpatient mental health clinics affiliated with a comprehensive community-based program. The interview assessed the participant's current experience with the management of their health care, followed by a vignette describing a reverse--colocated care model and questions to elicit the participant's reaction to the vignette. An inductive thematic analysis was employed. RESULTS: Consumers expressed positive views of the potential for working with trusted staff, increased communication, and access to care through reverse colocation. Reflections on current health management experience were notable for an emphasis on self-efficacy and receipt of support for self-management strategies from mental health clinicians. CONCLUSIONS: Study findings add to prior literature indicating support for assistance with management of general medical health in the mental health setting among individuals with serious mental illness. Key themes similar to those in previous studies generate hypotheses for further evaluation.

Tepper, M. C., Cohen, A. M., Progovac, A. M., et al. (2017). "Mind the Gap: Developing an Integrated Behavioral Health Home to Address Health Disparities in Serious Mental Illness." Psychiatr Serv **68**(12): 1217-1224.

OBJECTIVE: This study evaluated the impact of an integrated behavioral health home (BHH) pilot on adults with psychotic and bipolar disorders. METHODS: Quasi-experimental methods were used to compare outcomes before (September 2014-August 2015) and after the intervention (September 2015-August 2016) among ambulatory BHH patients and a control group. Electronic health records were compared between 424 BHH patients (N=369, psychotic disorder; N=55, bipolar disorder) and 1,521 individuals from the same urban, safety-net health system who were not enrolled in the BHH. Groups were weighted by propensity score on the basis of sex, age, race-ethnicity, language, 2010 U.S. Census block group characteristics, Medicare and Medicaid enrollment, and diabetes diagnosis. RESULTS: BHH patients had fewer total psychiatric hospitalizations and fewer total emergency visits compared with the control group, a difference that was predominantly driven by patients with at least one psychiatric hospitalization or ED visit. There were no differences in medical hospitalizations. Although BHH patients were more likely to receive HbA1c screening, there were no differences between the groups in lipid monitoring. Regarding secondary outcomes, there were no significant differences in changes in metabolic monitoring parameters among patients with diabetes. CONCLUSIONS: Participation in a pilot ambulatory BHH program among patients with psychotic and bipolar disorders was associated with significant reductions in ED visits and psychiatric hospitalizations and increased HbA1c monitoring. This evaluation builds on prior research by specifying intervention details and the clinical target population, strengthening the evidence base for care integration to support further program dissemination.

Tew, J., Klaus, J. et Oslin, D. W. (2010). "The Behavioral Health Laboratory: building a stronger foundation for the patient-centered medical home." Fam Syst Health **28**(2): 130-145.

> The Veterans Health Affairs is in the process of implementing a new model for the delivery of primary care: The Patient-Centered Medical Home (PCMH). One critical challenge of any PCMH model will be the integration of basic mental health treatment into primary care. Such a mental health integration program must be flexible enough to incorporate new evidence-based treatments as patient demographics and health care needs evolve over time. This paper summarizes the Behavioral Health Laboratory (BHL) care management model, a program already in place in more than 20 Veterans Affairs facilities along with private sector insurance providers, as ideally suited to fill this role in the PCMH. The BHL uses a platform of standardized, software-aided mental health assessments and clinical care managers to deliver evidence-based treatments for depression, anxiety, and substance abuse in primary care settings. The authors review this comprehensive program of screening, assessment, treatment, and referral to specialty care when needed. The BHL program is consistent with the guiding principles of the Patient-Centered Medical Home: applying chronic illness disease management principles to provide more continuous, coordinated, and efficient primary care services to patients with diverse needs. Just as importantly, the authors review how this standardized platform for delivering integrated mental health services provides the flexibility to incorporate novel interventions for a changing population.

Tracy, D., Forrest, A. et Underwood, B. R. (2021). "The role of integrated mental and community physical healthcare trusts in responding to the Covid-19 pandemic in the UK. [Editorial]".

> For several decades, mental health services within the UK's National Health Service were provided by specialist mental health trusts. More recently many of these trusts have integrated community physical health services into their operations. We describe here how two integrated mental health trusts in England were able to make an enhanced response to the Covid-19 pandemic. [Summary]

Viron, M., Zioto, K., Schweitzer, J., et al. (2014). "Behavioral Health Homes: an opportunity to address healthcare inequities in people with serious mental illness." Asian J Psychiatr **10**(1876-2026 (Electronic)): 10-16.
https://www.ncbi.nlm.nih.gov/pubmed/25042945

> People with serious mental illness (SMI) face striking reductions in lifespan versus the general population, in part due to the inadequacy of healthcare systems in meeting the substantial physical health needs of this group. Integrated care, the strategic combination and coordination of behavioral health and primary care services, has been proposed as a potential healthcare service delivery solution to address these care gaps. Inspired by the primary care Patient-Centered Medical Home concept, Behavioral Health Homes bring primary care services into the community mental health center in various ways. In this paper the authors review the literature describing Behavioral Health Home interventions and highlight an integration project that provides co-located and coordinated primary care and wellness services in a community mental health center. Such approaches hold great promise for improving the health and healthcare of people with SMI.

Zatloff, J. P., Gupton, O. et Ward, M. C. (2021). "Reverse Integration Pilot in a Public Safety-Net Hospital's Outpatient Behavioral Health Clinic." Community Ment Health J **57**(2): 262-267.

Individuals with severe mental illness are at a higher risk for medical illness and premature death and yet receive poorer quality healthcare. Often mental healthcare is the only care this population receives, thus models of integration are being explored. This study examined medical outcomes and care utilization patterns among patients at an outpatient behavioral health center where primary care was integrated with psychiatric and behavioral healthcare. A retrospective chart review of patients seen at the clinic both for mental and primary healthcare was performed and 147 patients were monitored over the course of one year. While medical outcome changes were not significant in the year after enrollment, primary care visits did increase, and emergency department visits decreased over the year analyzed. Decreased emergency department visits and increased attendance at primary care visits suggests this model of integration allows patients access to continuity of care and primary care services.

Quelques revues systématiques ou comparatives

Banstola, A., Pokhrel, S., Hayhoe, B., et al. (2023). "Economic evaluations of interventional opportunities for the management of mental-physical multimorbidity: a systematic review." BMJ Open **13**(2): e069270.

> OBJECTIVES: Economic evaluations of interventions for people with mental-physical multimorbidity, including a depressive disorder, are sparse. This study examines whether such interventions in adults are cost-effective. DESIGN: A systematic review. DATA SOURCES: MEDLINE, CINAHL Plus, PsycINFO, Cochrane CENTRAL, Scopus, Web of Science and NHS EED databases were searched until 5 March 2022. ELIGIBILITY CRITERIA: We included studies involving people aged ≥18 with two or more chronic conditions (one being a depressive disorder). Economic evaluation studies that compared costs and outcomes of interventions were included, and those that assessed only costs or effects were excluded. DATA EXTRACTION AND SYNTHESIS: Two authors independently assessed risk of bias in included studies using recommended checklists. A narrative analysis of the characteristics and results by type of intervention and levels of healthcare provision was conducted. RESULTS: A total of 19 studies, all undertaken in high-income countries, met inclusion criteria. Four intervention types were reported: collaborative care, self-management, telephone-based and antidepressant treatment. Most (14 of 19) interventions were implemented at the organisational level and were potentially cost-effective, particularly, the collaborative care for people with depressive disorder and diabetes, comorbid major depression and cancer and depression and multiple long-term conditions. Cost-effectiveness ranged from £206 per quality-adjusted life year (QALY) for collaborative care programmes for older adults with diabetes and depression at primary care clinics (USA) to £79 723 per QALY for combining collaborative care with improved opportunistic screening for adults with depressive disorder and diabetes (England). Conclusions on cost-effectiveness were constrained by methodological aspects of the included studies: choice of perspectives, time horizon and costing methods. CONCLUSIONS: Economic evaluations of interventions to manage multimorbidity with a depressive disorder are non-existent in low-income and middle-income countries. The design and reporting of future economic evaluations must improve to provide robust conclusions. PROSPERO REGISTRATION NUMBER: CRD42022302036.

Bajraktarov, S., Kalpak, G. et Jovanovic, N. (2020). "Community mental healthcare: new developments and innovative strategies." Curr Opin Psychiatry **33**(5): 491-500.

> PURPOSE OF REVIEW: The aim of this scoping review was to identify and map the available evidence on recent innovations in community mental healthcare across the globe. RECENT FINDINGS: This review highlights the different innovative approaches and strategies being currently used in the field of community mental health. Key approaches found in the reviewed studies include collaborative care with the inclusion of peer workers, growing use of e-health and telepsychiatry, improved reforms on national mental health policies and de-institutionalization, modification of outreach models and mental health promotion in the community. The studies reviewed here suggest that continued innovation and implementation of new models and strategies have the potential to reduce the burden of disease and increase the quality of life for patients with mental health issues. SUMMARY: Growing body of evidence shows that integrative care is the new standard of care for people with mental illnesses, with necessity of continuity of care from emergency department to

community mental health services. Social determinants of rehabilitation and recovery, and peers support remain a new main topic of research in area of treatment of people with severe mental illnesses. E-health tools are becoming prevalent in the processes of promotion, prevention and treatment in mental healthcare.

Beishon, L., Hickey, B., Desai, B., et al. (2024). "Integrated Physical-Mental Healthcare Services in Specialist Settings to Improve Outcomes for Older People Living With Mental Health Diagnoses: A Systematic Review." Int J Geriatr Psychiatry **39**(9): e6146.

BACKGROUND: Many older people are now living with co-occurring physical and mental health disorders, but these often managed separately. The aim of this systematic review was to explore integrated physical-mental health care services available internationally for older people living with mental health diagnoses, and whether these result in improved health outcomes. METHODS: Medline, Embase, CINAHL, PsycINFO and Scopus were searched with a predefined search strategy (PROSPERO: CRD42022383824), generating 6210 articles. Studies were included where an integrated physical-mental health care service model was utilised in a population of older people (aged >60 years) with a mental health diagnosis (including dementia or cognitive impairment) and at least one concomitant physical health condition requiring physical health care input. All studies were assessed for risk of bias (ROB 2.0, ROBINS-I) and results were synthesised narratively. RESULTS: Nine studies were included across inpatient (n = 6, 1262 patients) and community (n = 3, 466 patients) settings. Studies were rated as low-moderate risk of bias. These covered joint physical-mental health wards, liaison services, embedded physicians in mental health wards, and joint multidisciplinary teams. Services with greater integration (e.g., joint wards) had more benefits for patients and carers. There were few benefits to traditional outcomes (e.g., hospital admissions, mortality), but greater care quality, carer satisfaction, and improved mood and engagement were demonstrated. CONCLUSIONS: Multidisciplinary integrated care resulted in improvement of a range of health outcomes for older people with combined physical and mental health needs. Larger and more robust studies are needed to explore the development of these service models further, with cost-effectiveness analyses.

Bradford, D. W., Cunningham, N. T., Slubicki, M. N., et al. (2013). "An evidence synthesis of care models to improve general medical outcomes for individuals with serious mental illness: a systematic review." J Clin Psychiatry **74**(8): e754-764.

OBJECTIVE: To conduct a systematic review of studies of interventions that integrated medical and mental health care to improve general medical outcomes in individuals with serious mental illness. DATA SOURCES: English-language publications in MEDLINE (via PubMed), EMBASE, PsycINFO, and the Cochrane Library, from database inception through January 18, 2013, were searched using terms for our diagnoses of interest, a broad set of terms for care models, and a set of terms for randomized controlled trials (RCTs) or quasi-experimental design. Bibliographies of included articles were examined for additional sources. ClinicalTrials.gov was searched using the terms for our diagnoses of interest (serious mental illness,SMI,bipolar disorder,schizophrenia,orschizoaffective disorder) to assess for evidence of publication bias and ongoing studies. STUDY SELECTION: 4 RCTs were included from 1,729 articles reviewed. Inclusion criteria were RCT or quasi-experimental design; adult outpatient population with 25% or greater carrying a diagnosis of schizophrenia, schizoaffective disorder, or bipolar disorder; intervention with a stated goal to improve medical outcomes through integration of care, using a comparator of usual care or other quality improvement strategy; and outcomes assessing process of care, clinical outcomes, or

physical functioning. DATA EXTRACTION: A trained researcher abstracted the following data from the included articles: study design, funding source, setting, population characteristics, eligibility and exclusion criteria, number of subjects and providers, intervention(s), comparison(s), length of follow-up, and outcome(s). These abstracted data were then overread by a second reviewer. RESULTS: Of the 4 studies reviewed, 2 good-quality studies (according to the guidelines of the Agency for Healthcare Research and Quality) that evaluated processes of preventive and chronic disease care demonstrated positive effects of integrated care. Specifically, integrated care interventions were associated with increased rates of immunization and screening. All 4 RCTs evaluated changes in physical functioning, with mixed results: 2 studies demonstrated small improvements in the physical health component of the 36-Item Short-Form Health Survey (SF-36) and the 12-Item Short-Form Health Survey, and 2 studies demonstrated no significant difference in SF-36 scores. No studies reported on clinical outcomes related to preventive care or chronic medical care. CONCLUSIONS: Integrated care models have positive effects on processes of preventive and chronic disease care but have inconsistent effects on physical functioning for individuals with serious mental illness. The relatively small number of trials and limited range of treatment models tested and outcomes reported point to the need for additional study in this important area.

Coates, D., Coppleson, D. et Schmied, V. (2020). "Integrated physical and mental healthcare: an overview of models and their evaluation findings." Int J Evid Based Healthc **18**(1): 38-57.

BACKGROUND: Comorbid physical and mental health problems are common across the age spectrum. However, services addressing these health concerns are typically siloed and disconnected. Over the past 2 decades efforts have been made to design integrated services to address the physical and mental health needs of the population but little is known about the characteristics of effective integrated care models. The aim of the review was to map the design of integrated care initiatives/models and to describe how the models were evaluated and their evaluation findings. METHOD: Using a scoping review methodology, quantitative and qualitative evidence was systematically considered. To identify studies, Medline, PubMed, PsychINFO, CINAHL were searched for the period from 2003 to 2018, and reference lists of included studies and review articles were examined. RESULTS: The current review identified 43 studies, describing 37 models of integrated physical and mental healthcare. Although modest in terms of evaluation design, it is evident that models are well received by consumers and providers, increase service access, and improve physical and mental health outcomes. Key characteristics of models include shared information technology, financial integration, a single-entry point, colocated care, multidisciplinary teams, multidisciplinary meetings, care coordination, joint treatment plan, joint treatment, joint assessment/joint assessment document, agreed referral criteria and person-centred care. Although mostly modest in term of research design, models were well received by consumers and providers, increased service access and improved physical and mental health outcomes. There was no clear evidence regarding whether models of integrated care are cost neutral, increase or reduce costs. CONCLUSION: Future research is needed to identify the elements of integrated care that are associated with outcomes, measure cost implications and identify the experiences and priorities of consumers and clinicians.

Evans, T. S., Berkman, N., Brown, C., et al. (2016). "AHRQ Comparative Effectiveness Technical Briefs". In: [Disparities Within Serious Mental Illness]. Rockville (MD), Agency for Healthcare Research and Quality (US).

BACKGROUND: Adults with serious mental illness (SMI) often experience gaps in access to needed health care compared with other populations. Such disparities may be even more pronounced between certain groups of patients with SMI, differing by race, ethnicity, gender, economic disadvantage (including housing stability) and socioeconomic status, and geographic location (chiefly, rural versus urban residence); disparities arise as well for individuals identifying as lesbian, gay, bisexual, and transgender (LGBT) and those who have difficulty communicating in English (because it is a second language). PURPOSE: The primary goal of this Technical Brief is to describe and review the effectiveness of interventions that address disparities among adult patients with SMI in these important groups. METHODS: We reviewed the published and gray literature and interviewed Key Informants (KIs) to address four Guiding Questions (GQs). The four refined GQs for this Technical Brief focus on the critical areas of concern in relation to mental health treatment disparities—access to health insurance with appropriate coverage for these SMI conditions, accurate diagnostic evaluations, receipt of necessary and appropriate therapeutic services, quality of the health services, adherence to treatment over the long term, and various outcomes of care. The principal focus for the first three GQs is a description of the interventions (GQ 1), the context in which they are implemented (GQ 2), and a description of the evidence about the effectiveness of the interventions (GQ 3); GQ 4 presents conclusions, examines the gaps in the knowledge base, and identifies high-priority needs for future research. We include interventions addressing diagnosis, access to, and quality of treatment and support services among disparity groups of adults with SMI. FINDINGS: We identified 42 descriptive articles meeting inclusion criteria for GQs 1, 2, and 4, plus 37 articles measuring intervention effectiveness reporting on 26 unique studies (GQ 3). For GQ 1, the goals of each intervention were related to the specific diagnosis and disparity group that the intervention was targeting. Increased service use and treatment adherence were the most common intervention goals. For GQ 2, settings involved primarily mental health specialists being colocated in nonpsychiatric locations. These were usually primary care, but sometimes they were obstetrics-gynecology clinics, perinatal health care settings, and community mental health entities. For GQ 3, most interventions tested adding enhanced services to usual available care, including culturally adapted collaborative care or other therapies, integrated services, case management and telemedicine. We found no studies of interventions for individuals identifying as LGBT or focusing only on English as a second language, addressing access to health care coverage, or addressing diagnostic accuracy. We found one study of the elderly, a group that can be predicted to have a larger number of physical comorbidities and difficulties obtaining necessary care because of their SMI. CONCLUSIONS: Future research should identify interventions that are effective in reducing disparities all along the health care continuum and determine whether such interventions are equally effective for particular groups within the SMI population. Many promising interventions focused on disadvantaged individuals, including homeless individuals and racial or ethnic minority disparity groups. Future research can include comparative findings between minority and majority group patients and subgroup analyses to evaluate effectiveness among different disparity groups. Most interventions targeted depressive and psychotic disorders. The use of collaborative care, intensive case management approaches, such as the Critical Time Intervention (CTI) and Assertive Community Treatment (ACT), and specific culturally adapted therapies, including those involving families of individuals with SMI, were the most noticeable modifications to interventions, but were not widely applied across groups. Gaps persist both in terms of the diversity of disparity groups included in studies (particularly individuals who identify as LGBT and the elderly) and approaches considered.

Fogarty, F., McCombe, G., Brown, K., et al. (2021). "Physical health among patients with common mental health disorders in primary care in Europe: a scoping review." Ir J Psychol Med **38**(1): 76-92.

INTRODUCTION: Mental disorders are increasingly common among adults in both the developed and developing world and are predicted by the WHO to be the leading cause of disease burden by 2030. Many common physical conditions are more common among people who also have a common mental disorder. This scoping review aims to examine the current literature about the prevention, identification and treatment of physical problems among people with pre-existing mental health disorders in primary care in Europe. METHODS: The scoping review framework comprised a five-stage process developed by Arksey & O'Malley (2005). The search process was guided by the Preferred Reporting Items for Systematic Reviews and Meta-Analyses. Both quantitative and qualitative studies were included, with no restriction on study design. RESULTS: The initial search identified 299 studies, with a further 28 added from the hand-search (total n = 327) of which 19 were considered relevant to the review research question and included for full analysis. Depression was the mental health condition most commonly studied (nine studies), followed by depression and anxiety (seven studies), with three studies examining any mental disorder. Eleven studies examined the effects of various interventions to address physical and mental comorbidity, with the most commonly studied intervention being collaborative care. CONCLUSIONS: With just 19 studies meeting our criteria for inclusion, there is clearly a paucity of research in this area. Further research is essential in order to understand the pathophysiological mechanisms underlying the association between mental disorders and chronic conditions.

Franx, G., Kroon, H., Grimshaw, J., et al. (2008). "Organizational change to transfer knowledge and improve quality and outcomes of care for patients with severe mental illness: a systematic overview of reviews." Can J Psychiatry **53**(5): 294-305.

OBJECTIVE: To provide a comprehensive overview of the research on organizational changes aimed at improving health care for patients with severe mental illness and to learn lessons for mental health practice from the results. METHOD: We searched for systematic literature reviews published in English during 2000 to 2007 in PubMed, PsycINFO, CINAHL, EMBASE, and the Cochrane Central Register of Systematic Reviews. Three reviewers independently selected and assessed the studies' quality. Studies involving changes of who delivers health care, how care is organized, or where care is delivered were included. We categorized the studies using an existing taxonomy of 6 broad categories of strategies for organizational change. RESULTS: A total of 21 reviews were included. Among these, 17 had reasonably good methodological quality, Almost all reviews included or intended to include randomized controlled trials (RCTs), 6 reviews did not identify studies that met eligibility criteria. Multidisciplinary teams and integrated care models had been reviewed most frequently (a total of 15 reviews). In most studies, these types of changes showed better outcomes in terms of symptom severity, functioning, employment, and housing, compared with conventional services. Different results were found on cost savings. Other types of organizational changes, such as changing professional roles or introducing quality management or knowledge management, were much less frequently reviewed. Very few reviews looked at effects of organizational changes on professional performance. CONCLUSIONS: There is a fairly large body of evidence of the positive impact of multidisciplinary teams and integrated care changes on symptom severity, functioning, employment, and housing of people with severe mental illness, compared with conventional services. Other strategies, such as changes in professional roles, quality or knowledge management, have either not been the subject of systematic reviews or have not been

evaluated in RCTs. There is still a lack of insight in the so-called black box of change processes and the impact of change on professional performance.

Happell, B., Galletly, C., Castle, D., et al. (2015). "Scoping review of research in Australia on the co-occurrence of physical and serious mental illness and integrated care." Int J Ment Health Nurs **24**(5): 421-438.

The physical health of people with serious mental illness (SMI) has become a focal area of research. The aim of the present study was to ascertain the attention and distribution of research from within Australia on physical illness and SMI co-occurrence, and to identify gaps. A scoping review of peer-reviewed research literature from Australia, published between January 2000 and March 2014, was undertaken through an electronic literature search and coding of papers to chart trends. Four trends are highlighted: (i) an almost threefold increase in publications per year from 2000-2006 to 2007-2013; (ii) a steady release of literature reviews, especially from 2010; (iii) health-related behaviours, smoking, integrated-care programmes, and antipsychotic side-effects as the most common topics presented; and (iv) paucity of randomized, controlled trials on integrated-care models. Despite a marked increase in research attention to poorer physical health, there remains a large gap between research and the scale of the problem previously identified. More papers were descriptive or reviews, rather than evaluations of interventions. To foster more research, 12 research gaps are outlined. Addressing these gaps will facilitate the reduction of inequalities in physical health for people with SMI. Mental health nurses are well placed to lead multidisciplinary, consumer-informed research in this area.

Hellstern, R. B., Lamson, A. L., Jensen, J. F., et al. (2025). "Physical and mental health outcomes of integrated care: Systematic review of study." Families, systems & health : the journal of collaborative family healthcare.

Heyeres, M., McCalman, J., Tsey, K., et al. (2016). "The Complexity of Health Service Integration: A Review of Reviews." Front Public Health **4**: 223.

BACKGROUND: The aim of health service integration is to provide a sustainable and integrated health system that better meets the needs of the end user. Yet, definitions of health service integration, methods for integrating health services, and expected outcomes are varied. This review was commissioned by Queensland Health, the government department responsible for health service delivery in Queensland, Australia, to inform efforts to integrate their mental health services. This review reports on the characteristics, reported outcomes, and design quality of studies included in systematic reviews of health service integration research. METHOD: The review was developed by systematically searching nine electronic databases to find peer-reviewed Australian and international systematic reviews with a focus on health service integration. Reviews were included if they were in the English language and published between 2000 and 2015. A standardized assessment tool was used to analyze the study design quality of included reviews. Data relating to the integration types, methods, and reported outcomes of integration were synthesized. RESULTS: Seventeen publications met the inclusion criteria. Eleven (65%) reviews were published during the past 5 years, which may indicate a trend for increased awareness of the need for service integration. The majority of reviews were published by researchers in the UK (8/47%), USA (3/18%), and Australia (3/18%). Included reviews focused on a variety of integration types, including integrated care pathways, governance models, integration of interventions, collaborative/integrated care models, and integration of different types of health care. Most

(53%) of the reviews reported on the cost-effectiveness of service integration, e.g., positive results, no effect, or inconclusive. Only one of the reviews reported on the importance of consumer involvement. The overall design of 70% of the reviews was high, 18% medium, and 12% low. CONCLUSION: There is no "one size fits all" approach to health service integration. Instead, this literature review highlighted the complexity of service integration, which in most primary studies involved a range of strategies. Rigorous assessments of cost-effectiveness and reporting on consumer involvement are required in future research.

Hussain, M. et Seitz, D. (2014). "Integrated models of care for medical inpatients with psychiatric disorders: a systematic review." Psychosomatics **55**(4): 315-325.

OBJECTIVE: Psychiatric disorders are common among medical inpatient settings and management of psychiatric disorders can be challenging in this setting. Integrated models of care (IMCs) combining psychiatric and medical specialties within a single service may improve psychiatric and medical outcomes, although evidence for IMCs in medical inpatient settings has not been well described. METHOD: We searched MEDLINE, Embase, and Google scholar for relevant articles. We included all randomized controlled trials or quasi-experimental studies in English that evaluated IMCs for medical inpatients with psychiatric disorders when compared with usual care. We defined IMCs as models of care where psychiatric and medical providers had joint responsibility for all patients within a given service. We extracted information on the characteristics of IMCs and on the effects of IMCs on psychiatric, medical, and health service outcomes. RESULTS: Four studies met the inclusion criteria, thereby including 716 participants overall. All studies differed in the study design, models of IMCs, and outcomes reported. In 2 studies, IMCs improved psychiatric symptoms compared with those admitted to a general medical service. Two studies demonstrated reductions in length of stay with IMCs compared with usual care. One study reported an improvement in functional outcomes and a decreased likelihood of long-term care admission associated with IMCs when compared with usual care. CONCLUSIONS: There is preliminary evidence that IMCs may improve a number of outcomes for medical inpatients with psychiatric disorders. Additional well-designed studies of IMCs are required to further evaluate the effect of IMCs on patient outcomes and costs of care.

Isaacs, A. N. et Mitchell, E. K. L. (2024). "Mental health integrated care models in primary care and factors that contribute to their effective implementation: a scoping review." Int J Ment Health Syst **18**(1): 5.

BACKGROUND: In the state of Victoria, Australia, the 111-day lockdown due to the COVID-19 pandemic exacerbated the population's prevailing state of poor mental health. Of the 87% of Australians who visit their GP annually, 71% of health problems they discussed related to psychological issues. This review had two objectives: (1) To describe models of mental health integrated care within primary care settings that demonstrated improved mental health outcomes that were transferable to Australian settings, and (2) To outline the factors that contributed to the effective implementation of these models into routine practice. METHODS: A scoping review was undertaken to synthesise the evidence in order to inform practice, policymaking, and research. Data were obtained from PubMed, CINAHL and APA PsycINFO. RESULTS: Key elements of effective mental health integrated care models in primary care are: Co-location of mental health and substance abuse services in the primary care setting, presence of licensed mental health clinicians, a case management approach to patient care, ongoing depression monitoring for up to 24 months and other miscellaneous elements. Key factors that contributed to the effective implementation of mental health integrated care in routine practice are the willingness to accept and promote system change,

integrated physical and mental clinical records, the presence of a care manager, adequate staff training, a healthy organisational culture, regular supervision and support, a standardised workflow plan and care pathways that included clear role boundaries and the use of outcome measures. The need to develop sustainable funding mechanisms has also been emphasized. CONCLUSION: Integrated mental health care models typically have a co-located mental health clinician who works closely with the GP and the rest of the primary care team. Implementing mental health integrated care models in Australia requires a 'whole of system' change. Lessons learned from the Mental Health Nurse Incentive Program could form the foundation on which this model is implemented in Australia.

Kappelin, C., Carlsson, A. C. et Wachtler, C. (2021). "Specific content for collaborative care: a systematic review of collaborative care interventions for patients with multimorbidity involving depression and/or anxiety in primary care." Family Practice **39**(4): 725-734.

In primary care (PC) many patients suffer from multimorbidity involving depression and/or anxiety. Collaborative care (CC) has shown promising results for patients with depression, anxiety, and multimorbidity involving depression. However, specific content in CC for patients with multimorbidity involving depression and/or anxiety is unknown.(i) To examine the effect of CC interventions in patients with multimorbidity involving depression and/or anxiety compared with usual care; (ii) to identify specific content of CC.We conducted a systematic literature review of randomized controlled trial studies evaluating CC models for adults with multimorbidity involving depression and/or anxiety in PC settings. PubMed, CINAHL, Web of Science, and PsycInfo were searched in December 2019. We conducted a qualitative synthesis using an existing framework and developed a new framework to map the content for each studied intervention.We identified 1,447 studies. Twelve publications were included. Eleven had medium-to-high quality of CC for patients with multimorbidity involving depression. Specific content of CC in these studies is: A stepped care model, involving medication and psychotherapy delivered by a nurse or psychologist Care Manager (CM) focusing on problem-solving techniques; follow-up including monitoring of symptoms and function, and relapse prevention strategies; scheduled CM supervision. Specific content for CC for patients with multimorbidity involving depression is identified from current research. Research gaps were found regarding CC for patients with multimorbidity and anxiety, depression and anxiety, and depression and/or anxiety and more than 2 diseases.Most patients in primary care have multimorbidity, defined as 2 or more chronic diseases. Depression and/or anxiety are common in this population. Collaborative care (CC) can improve symptoms for patients with multimorbidity involving depression. In CC, a Care Manager (CM) establishes a care plan with the patient, cooperates with the patient's physician, and has scheduled patient follow-ups. However, CC can differ in design and content. The focus of this systematic review and qualitative synthesis was to examine effectiveness of CC for patients suffering from multimorbidity involving depression and/or anxiety and identify specific content of CC for patients with multimorbidity involving depression and/or anxiety. We identified specific content of CC for patients with multimorbidity involving depression in medium-to-high-quality studies with positive effect: CM (nurse or psychologist) collaborating with the patient's physician in a stepped care model involving both medication and/or CM-delivered problem-solving psychological treatment; scheduled patient follow-ups with symptom and function monitoring, medication adherence and relapse prevention; regular CM supervision. No conclusions can be drawn regarding the effectiveness of CC in patients with multimorbidity involving anxiety, depression and anxiety, or depression and/or anxiety and more than 2 diseases.

Kronenberg, C., Doran, T., Goddard, M., et al. (2017). "Identifying primary care quality indicators for people with serious mental illness: a systematic review." Br J Gen Pract **67**(661): e519-e530.

BACKGROUND: Serious mental illness (SMI) - which comprises long-term conditions such as schizophrenia, bipolar disorder, and other psychoses - has enormous costs for patients and society. In many countries, people with SMI are treated solely in primary care, and have particular needs for physical care. AIM: The objective of this study was to systematically review the literature to create a list of quality indicators relevant to patients with SMI that could be captured using routine data, and which could be used to monitor or incentivise better-quality primary care. DESIGN AND SETTING: A systematic literature review, combined with a search of quality indicator databases and guidelines. METHOD: The authors assessed whether indicators could be measured from routine data and the quality of the evidence. RESULTS: Out of 1847 papers and quality indicator databases identified, 27 were included, from which 59 quality indicators were identified, covering six domains. Of the 59 indicators, 52 could be assessed using routine data. The evidence base underpinning these indicators was relatively weak, and was primarily based on expert opinion rather than trial evidence. CONCLUSION: With appropriate adaptation for different contexts, and in line with the relative responsibilities of primary and secondary care, use of the quality indicators has the potential to improve care and to improve the physical and mental health of people with SMI. However, before the indicators can be used to monitor or incentivise primary care quality, more robust links need to be established, with improved patient outcomes.

Langkilde, K., Nielsen, M. H., Damgaard, S., et al. (2025). "A systematic review of randomized controlled trials in a general practice setting aiming to reduce excess all-cause mortality and enhance cardiovascular health in patients with severe mental illness." Gen Hosp Psychiatry **93**: 131-143.

OBJECTIVE: People with severe mental illness (SMI) have a reduced life expectancy, primarily due to chronic somatic diseases like cardiovascular disorders. Integrated care in general practice addressing mental and physical health may reduce excess mortality in this population. This review assessed the effectiveness of collaborative care, general integrated care, and physical health interventions in reducing overall mortality in patients with SMI. Secondary outcomes included disease-specific mortality, cardiovascular health indicators, and health-related quality of life. METHODS: We searched PubMed, PsycINFO, Cochrane Library, and Embase for randomized controlled trials published before April 24, 2024. Eligible studies focused on integrated care interventions targeting somatic health in patients with SMI. Two reviewers independently conducted data extraction and risk of bias assessment. The study was registered with PROSPERO (CRD42022328464). RESULTS: Of 2904 identified publications, 17 were included (covering 13 studies). Seven studies reported mortality data, with one showing reduced mortality in patients with major depressive disorder receiving collaborative care. No studies examined disease-specific mortality. Nine studies assessed cardiovascular outcomes, with three reporting reduced cardiovascular risk in collaborative care interventions simultaneously targeting depression and cardiovascular factors. Seven studies reported on quality of life, with three finding improvements. Study quality was rated moderate to high. CONCLUSION: We found low-certainty evidence that collaborative care reduces mortality in depression. There was moderate evidence that collaborative care models, simultaneously addressing mental and cardiovascular health could potentially improve cardiovascular health in depression. The limited number of studies and their focus on depression limit the generalizability of these findings to other SMIs.

Martens, N., Destoop, M. et Dom, G. (2021). "Organization of Community Mental Health Services for Persons with a Severe Mental Illness and Comorbid Somatic Conditions: A Systematic Review on Somatic Outcomes and Health Related Quality of Life." Int J Environ Res Public Health **18**(2).

> It is well established that persons with a severe mental illness (SMI) have a greater risk of physical comorbid conditions and premature mortality. Most studies in the field of community mental health care (CMHC) have only focused on improving cardiovascular health in people with a SMI using lifestyle approaches. Studies using organizational modifications are rather scarce. This systematic review aimed to synthesize and describe possible organizational strategies to improve physical health for persons with a SMI in CMHC. The primary outcome was Health-related Quality of Life (HR-QOL). Results suggested modest effects on quality of life and were inconsistent throughout all the included studies. Despite these findings, it appears that a more integrated approach had a positive effect on health outcomes, patient satisfaction and HR-QOL. The complexity of the processes involved in community care delivery makes it difficult to compare different models and organizational approaches. Mental health nurses were identified as possible key professionals in care organization, but no clear description of their role was found. This review could provide new insights into contributing factors for integrated care. Future research targeting the identification of the nurses' role and facilitating factors in integrated care, in order to improve treatment and follow-up of somatic comorbidities, is recommended.

Menear, M., Gilbert, M. et Fleury, M.-J. (2017). "Améliorer la santé mentale des populations par l'intégration des soins de santé mentale aux soins primaires." Santé mentale au Québec **42**(1): 243-271.
https://www.cairn.info/revue-sante-mentale-au-quebec-2017-1-page-243.htm

> L'intégration des soins de santé mentale dans les soins primaires est une stratégie importante pour améliorer la santé mentale et le bien-être des populations. Dans la dernière décennie, le Québec a adopté plusieurs mesures pour renforcer les soins de santé mentale primaires, mais certains problèmes d'intégration persistent. Cette synthèse a été réalisée afin d'identifier et comparer les grandes initiatives internationales liées à l'intégration des soins de santé mentale aux soins primaires et de résumer les leçons tirées de ces initiatives qui sont pertinentes pour le Québec. Vingt initiatives ont été sélectionnées, décrites dans 153 articles et rapports. Trois initiatives portaient sur la santé mentale des jeunes, quatorze portaient principalement sur les adultes et trois autres initiatives portaient sur la santé mentale des aînés. La majorité des initiatives ont visé à implanter des modèles de soins de collaboration pour améliorer la gestion des troubles mentaux courants par les intervenants en soins primaires. Les initiatives ont été comparées sur les stratégies d'intégration adoptées, leurs effets, et les enjeux d'implantation rencontrés. Les leçons pour le Québec incluent le besoin de consolider davantage les soins en collaboration en santé mentale, de promouvoir des services informés par des processus d'amélioration continue de la qualité et de favoriser une plus grande utilisation des technologies qui soutiennent l'intégration.

Murphy, K. A., Daumit, G. L., Stone, E., et al. (2018). "Physical health outcomes and implementation of behavioural health homes: a comprehensive review." International review of psychiatry (Abingdon, England) **30**(6): 224-241.

> People with serious mental illness (SMI) have mortality rates 2-3-times higher than the general population, mostly driven by physical health conditions. Behavioural health homes (BHHs) integrate primary care into specialty mental healthcare settings with the goal of improving management of physical health conditions among people with SMI.

Implementation and evaluation of BHH models is increasing in the US. This comprehensive review summarized the available evidence on the effects of BHHs on physical healthcare delivery and outcomes and identified perceived barriers and facilitators that have arisen during implementation to-date. This review found 11 studies reporting outcomes data on utilization, screening/monitoring, health promotion, patient-reported outcomes, physical health and/or costs of BHHs. The results of the review suggest that BHHs have resulted in improved primary care access and screening and monitoring for cardiovascular-related conditions among consumers with SMI. No significant effect of BHHs was reported for outcomes on diabetes control, weight management, or smoking cessation. Overall, the physical health outcomes data is limited and mixed, and implementation of BHHs is variable.

Novikov, Z., Glover, W. et Trepman, P. C. (2016). "How do integrative practices influence patient-centered care? : an exploratory study comparing diabetes and mental health care". Health Care Manage Rev. **41**(2):113-26

BACKGROUND: Integration between organizational units to achieve common goals has been of interest to health systems because of the potential to improve patient-centered care. However, the means by which integrative practices actually influence patient-centered care remain unclear. Whereas many studies claim a positive association between implementation of integrative practices and patient-centered care, others raise concerns that integrative practices may not necessarily improve patient-centered care. PURPOSE: The aim of this study was to explore the mechanism by which integrative practices influence patient-centered care and to suggest a systematic approach for effective integration. APPROACH: We conducted a qualitative study comparing diabetes and mental health services through focus groups with 60 staff members from one health maintenance organization. We developed quantitative indicators to support the suggested model. FINDINGS: We identified a five-category framework of integrative practices that each directly and distinctively influences patient-centered care. Moreover, our findings suggest that integrative practices influence patient-centered care indirectly through creation of interdependent treatment competence, which enables providers to repeatedly deliver interdependent treatment in a flexible and adaptive way. PRACTICAL IMPLICATIONS: Providers should carefully implement integrative practices considering patient and disease characteristics, as our findings suggest that more implementation of integrative practices is not necessarily better for patient-centered care. Specifically, optimal implementation refers to the collective implementation of different integrative practices and thus encompasses both the extent (i.e., the amount of currently implemented practices out of those considered important to implement) and the extensiveness (i.e., the amount relative to the implementation of other practices) that may lead to interdependent treatment competence and higher patient-centered care. We suggest a creative measurement method of comparing the relative implementation of integrative practices that may assist managers and policy makers in developing interdependent treatment competence. [Abstract]

Park, J. H., Breitinger, S. A., Savitz, S. T., et al. (2025). "Delays in bipolar depression treatment in primary care vs. integrated behavioral health and specialty care." J Affect Disord **369**: 404-410.

INTRODUCTION: While bipolar disorder is not uncommon in primary care, collaborative care models for bipolar depression treatment are underdeveloped. Our aim was to compare initial pharmacological treatment patterns for an episode of bipolar depression in different care models, namely primary care (PC), integrated behavioral health (IBH), and mood specialty clinic (SC). METHODS: A retrospective study of adults diagnosed with bipolar disorder who received outpatient care in 2020 was completed. Depressive episodes were captured based

on DSM-5 criteria, ICD codes, or de novo emergent symptom burden (PHQ-9 ≥ 10). Pharmacological strategies were classified as 1) continuation of current regimen, 2) dose increase or 3) augmentation 4) switch to monotherapy or 5) a combination of more than two different strategies. Logistic regression was applied. RESULTS: A total of 217 encounters (PC = 32, IBH = 53, SC = 132) representing 186 unique patients were identified. PC was significantly more likely to continue the current regimen, while combination strategies were significantly more likely recommended in IBH and SC. Mood stabilizers were significantly more utilized in IBH and SC. There were no significant group differences in antidepressant use. LIMITATIONS: Retrospective study design at a single site. CONCLUSIONS: This study provides evidence of delays in depression care in bipolar disorder. This is the first study to compare treatment recommendations for bipolar depression in different clinical settings. Future studies are encouraged to better understand this gap and to guide future clinical practice, regardless of care model, emphasizing the potential benefits of decision support tools and collaborative care models tailored for bipolar depression.

Rodgers, M., Dalton, J., Harden, M., et al. (2016). "Integrated care to address the physical health needs of people with severe mental illness: a rapid review. ." Health Services and Delivery Research **4**(13).

BACKGROUND: People with mental health conditions have a lower life expectancy and poorer physical health outcomes than the general population. Evidence suggests that this discrepancy is driven by a combination of clinical risk factors, socioeconomic factors and health system factors. OBJECTIVE(S): To explore current service provision and map the recent evidence on models of integrated care addressing the physical health needs of people with severe mental illness (SMI) primarily within the mental health service setting. The research was designed as a rapid review of published evidence from 2013–15, including an update of a comprehensive 2013 review, together with further grey literature and insights from an expert advisory group. SYNTHESIS: We conducted a narrative synthesis, using a guiding framework based on nine previously identified factors considered to be facilitators of good integrated care for people with mental health problems, supplemented by additional issues emerging from the evidence. Descriptive data were used to identify existing models, perceived facilitators and barriers to their implementation, and any areas for further research. FINDINGS AND DISCUSSION: The synthesis incorporated 45 publications describing 36 separate approaches to integrated care, along with further information from the advisory group. Most service models were multicomponent programmes incorporating two or more of the nine factors: (1) information sharing systems; (2) shared protocols; (3) joint funding/commissioning; (4) colocated services; (5) multidisciplinary teams; (6) liaison services; (7) navigators; (8) research; and (9) reduction of stigma. Few of the identified examples were described in detail and fewer still were evaluated, raising questions about the replicability and generalisability of much of the existing evidence. However, some common themes did emerge from the evidence. Efforts to improve the physical health care of people with SMI should empower people (staff and service users) and help remove everyday barriers to delivering and accessing integrated care. In particular, there is a need for improved communication between professionals and better information technology to support them, greater clarity about who is responsible and accountable for physical health care, and awareness of the effects of stigmatisation on the wider culture and environment in which services are delivered. LIMITATIONS AND FUTURE WORK: The literature identified in the rapid review was limited in volume and often lacked the depth of description necessary to acquire new insights. All members of our advisory group were based in England, so this report has limited information on the NHS contexts specific to Scotland, Wales and Northern

Ireland. A conventional systematic review of this topic would not appear to be appropriate in the immediate future, although a more interpretivist approach to exploring this literature might be feasible. Wherever possible, future evaluations should involve service users and be clear about which outcomes, facilitators and barriers are likely to be context-specific and which might be generalisable. FUNDING: The research reported here was commissioned and funded by the Health Services and Delivery Research programme as part of a series of evidence syntheses under project number 13/05/11. For more information visit www.nets.nihr.ac.uk/projects/hsdr/130511.

Rodgers, M., Dalton, J., Harden, M., et al. (2018). "Integrated care to address the physical health needs of people with severe mental illness : a mapping review of the recent evidence on barriers, facilitators and evaluations".
https://www.ijic.org/articles/10.5334/ijic.2605/

People with mental health conditions have a lower life expectancy and poorer physical health outcomes than the general population. Evidence suggests this is due to a combination of clinical risk factors, socioeconomic factors, and health system factors, notably a lack of integration when care is required across service settings. Several recent reports have looked at ways to better integrate physical and mental health care for people with severe mental illness (SMI). We built on these by conducting a mapping review that looked for the most recent evidence and service models in this area. This involved searching the published literature and speaking to people involved in providing or using current services. Few of the identified service models were described adequately and fewer still were evaluated, raising questions about the replicability and generalisability of much of the existing evidence. However, some common themes did emerge. Efforts to improve the physical health care of people with SMI should empower staff and service users and help remove everyday barriers to delivering and accessing integrated care. In particular, there is a need for improved communication among professionals and better information technology to support them, greater clarity about who is responsible and accountable for physical health care, and greater awareness of the effects of stigmatisation on the wider culture and environment in which services are delivered. [Abstract]

Searby, A., Burr, D., Carolin, R., et al. (2025). "Barriers and Facilitators to Mental Health Service Integration: A Scoping Review." Int J Ment Health Nurs **34**(1): e13449.

Mental health service integration currently has no consensus definition and exists in a variety of settings, including primary care, addiction treatment and chronic disease management, and mental health nurses have often experienced efforts at service integration with varying degrees of success. The intent of mental health service integration is to enable collaboration between mental health services and other healthcare providers to improve service access and the care provided to individuals with mental health issues or mental illness. This scoping review aimed to explore service integration between mental health services and with a specific focus on those evaluated in peer-reviewed, primary literature, to determine facilitators and barriers to service integration. Using the Arksey and O'Malley's framework for scoping reviews, we located 3148 studies, with screening narrowing final papers for inclusion to 18. Facilitators to service integration included clinician education, adequate resourcing and an interdisciplinary approach, while barriers included staff factors such as a reluctance to work with individuals with mental illness, consumer level barriers such as poor mental health literacy, 'territorialism' among staff and organisational climate. Research indicates that service integration is an effective means to detect and treat mental health issues in settings that do not traditionally provide mental health care, lowering the costs of providing

healthcare and providing improved care for mental health needs; however, there are several barriers to be addressed to achieve full implementation of integration models.

Steele Gray, C., Zonneveld, N., Breton, M., et al. (2020). "Comparing International Models of Integrated Care: How Can We Learn Across Borders?" Int J Integr Care **20**(1): 14.

INTRODUCTION: Providers, managers, health system leaders, and researchers could learn across countries implementing system-wide models of integrated care, but require accessible methods to do so. This study assesses if a common framework could describe and compare key components of international models of integrated care. THEORY AND METHODS: A framework developed for an international study of programs that address high needs high cost patients was used to describe and compare 11 case studies analyzed in two international research projects; the Implementing Integrated Care for Older Adults with Complex Health Needs (iCOACH) study in Canada and New Zealand, and the Vilans research group exploring models in the Netherlands. Comparative summaries were generated, with findings discussed at a 2019 International Conference on Integrated Care workshop. RESULTS: The template was found to be useful to compare integrated case analyses in different contexts, and stands apart from other case comparison approaches as it is easily applied and can provide practical guidance for frontline staff and managers. Areas of improvement for the template are identified and two updated versions are presented. CONCLUSIONS AND DISCUSSION: There is value to using a common template to provide guidance in international comparison of models of integrated care. We discuss the applicability of the approach to support scale and spread of integrated care internationally.

Tranberg, K., Colnadar, B., Nielsen, M. H., et al. (2024). "Interventions targeting patients with co-occuring severe mental illness and substance use (dual diagnosis) in general practice settings - a scoping review of the literature." BMC Prim Care **25**(1): 281.

BACKGROUND: People with dual diagnosis die prematurely compared to the general population, and general practice might serve as a setting in the healthcare system to mend this gap in health inequity. However, little is known about which interventions that have been tested in this setting. AIM: To scope the literature on interventions targeting patients with dual diagnosis in a general practice setting, the outcomes used, and the findings. DESIGN AND SETTING: A scoping review of patients with dual diagnosis in general practice. METHODS: From a predeveloped search string, we used PubMed (Medline), PsychInfo, and Embase to identify scientific articles on interventions. Studies were excluded if they did not evaluate an intervention, if patients were under 18 years of age, and if not published in English. Duplicates were removed and all articles were initially screened by title and abstract and subsequent fulltext were read by two authors. Conflicts were discussed within the author group. A summative synthesis of the findings was performed to present the results. RESULTS: Seven articles were included in the analysis. Most studies investigated integrated care models between behavioural treatment and primary care, and a single study investigated the delivery of Cognitive Behavioral treatment (CBT). Outcomes were changes in mental illness scores and substance or alcohol use, treatment utilization, and implementation of the intervention in question. No studies revealed significant outcomes for patients with dual diagnosis. CONCLUSION: Few intervention studies targeting patients with dual diagnosis exist in general practice. This calls for further investigation of the possibilities of implementing interventions targeting this patient group in general practice.

Wilk, K., Kowalewska, E., Jakubowska, M., et al. (2025). "The Comparison of Four Models of Community Psychiatry—A Systematic Review and Preliminary Meta-Analysis of the ACT Model." Clinical Psychology & Psychotherapy 32(1): e70048.
https://doi.org/10.1002/cpp.70048

ABSTRACT Background The aim of this systematic review and preliminary meta-analysis is to summarize the effectiveness of selected models of community psychiatry: community mental health center, flexible assertive community treatment, community mental health team and assertive community treatment. Methods In order to determine the results of therapeutic interventions, comparison of symptom severity, level of functioning, use of institutional care, quality of life/well-being/recovery and satisfaction at baseline and during follow-up was conducted. Thirty-seven quantitative studies were selected, grouped according to the study model and compared in terms of positive, neutral and negative impact on patients according to efficacy factors. Additionally, a preliminary random-effects meta-analysis was performed on 11 studies to investigate the effectiveness of assertive community treatment. Results Review shows the overall positive results of the selected models. The best documented effects were an increase in the level of functioning and a reduction in institutional care. The number of articles collected indicates that community mental health center and assertive community treatment are better researched than community mental health team and flexible assertive community treatment models. Meta-analysis on assertive community treatment studies showed significant pooled effect sizes for domains of functioning, quality of life, hospitalizations and symptom severity. Conclusions The community mental health center and assertive community treatment are most likely to indicate efficiency and safety. The community mental health team and flexible assertive community treatment models should be explored in future studies. Results of the preliminary meta-analysis provide further evidence for the effectiveness of assertive community treatment.