Integrated Care in Community Settings and Psychiatric Training

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Integrated health care serves to strengthen resources and improve health outcomes for patient groups with complex needs. For example, in caring for patients with major mental disorders, community mental health services can be integrated with family practice, medical, surgical, and obstetric-gynecological services; psychiatric inpatient and emergency services; occupational and physical therapy services; and rehabilitative, housing, and employment services [1]. Integrated health care is necessarily a multifaceted interdisciplinary and interprofessional approach that aims to provide greater service accessibility, patient education, coordination, and quality of care [2]. Just as a variety of integrated clinical care models exist, each with varying degrees of interaction and sharing between disciplines, an array of models also exist for educating psychiatry trainees to work in integrated mental health and primary care settings [3].

In this issue, we present six papers on the theme of integrated care, including three empirical reports, a review, an example curriculum, and a systematic review [4–9]. Recently, the American Psychiatric Association also published a task force report on integrated care [10]. Reardon et al. [4] surveyed program directors in general and child and adolescent psychiatry programs in order to evaluate residents' education and experiences in integrated care. Although the response

rates were low, a majority of respondents offered integrated care rotations and electives and fewer than half of responding programs provided didactic education on integrated care. Dubé et al. [5] surveyed members of the Association of Directors of Medical Student Education in Psychiatry (ADMSEP) on how physical and behavioral health were integrated at their institutions. Although response rates were again low, behavioral health was most commonly taught in courses dealing with the practice of medicine, in neurology and in reproduction courses, and in family practice clinics. Ratzliff et al. [6] surveyed a convenience sample of psychiatrists who worked in integrated care settings and identified their perceptions of topics that were important for them and their integrated team members to learn about. McCarron et al. [7] present a longitudinal, clinically-based curriculum with an emphasis on providing preventive medical care for those with severe mental illnesses. Annamalai et al. [8] contend that psychiatry trainees should learn more general medicine in order to fill leadership roles in delivering integrated medical and psychiatric care in mental health settings. Coverdale et al. [9] performed a review of published programs in which partnerships have worked to better serve vulnerable, disadvantaged, and culturally diverse patient populations with major mental disorders by integrating psychiatric services with family planning, sexual health, and obstetrics-gynecology services. The American Psychiatric Association task force report [10] describes the integrated care model, examines methods for teaching, and provides recommendations for promoting psychiatric education and training in integrated care. These publications each advocate for teaching on integrated care in concert with the provision of relevant clinical experiences.

According to one of the articles in this issue [4], psychiatry trainees most commonly experienced integrated care as a traditional psychiatric consultation within primary care clinics. Fewer than 50 % of the responding programs provided

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didactic training on integrated care and smaller numbers again provided didactics in multidisciplinary formats. There may be many practical, administrative, or financial barriers to offering integrated care experiences for residents, and as noted, not all programs embrace integration with primary care [4]. In addition, ADMSEP members responded that clinical care settings were uncommonly used in the clinical years of the curriculum [5].

We appreciate that the concept of integrated care embodies varying meanings and connotations. For example, it also includes close partnerships with medical services in the service of patients with mental disorders at primary psychiatric sites. Here, we briefly comment on one narrower aspect of integrated care, a model that concerns the identification and management of cases in the community and occurs through collaboration with our colleagues in family practice and other medical specialties. Screening for mental disorders in family practice or general medical clinics is an essential component of secondary prevention. Detecting early signs and treating early symptoms may be more challenging than recognizing established cases of mental disorders, and our colleagues in family practice and internal medicine should be assisted in doing so [11, 12]. Valid, reliable, and (most important) very feasible screening instruments can be readily deployed in primary care settings. In the adult population in the integrated care setting, the most commonly studied and applied instrument has been the PHQ 9 [13]. In the pediatric population, one successful screening instrument is the Pediatric Symptom Checklist, which is brief, may be completed by parents before an appointment, and has been demonstrated to be effective in detecting psychiatric disorder or risk of disorder in children [14].

Robust studies examining the impact of collaborative, integrated mental health and medical care have been conducted in several settings, including the SMaRT oncology study [15], the management of sadness and anxiety in cardiology study (MOSAIC, [16]), and the IMPACT trial in the diabetes setting [17]. Such studies have shown integrated medical and mental health care to improve not only mental health outcomes but also medical outcomes such as diabetes and cholesterol control and, very importantly, quality of life and health care costs. Empirical work has also demonstrated that psychiatrists were only a part, albeit an important part, of an integrated team care approach.

Early community recognition and prevention of mental disorders including psycho-education, the diagnosis and treatment of concomitant medical disorders by family medicine physicians and other medical colleagues, and the management of early warning signs by psychopharmacological interventions, may reduce the need for emergency services and expensive hospital-based services and further shift the locus of care to the community. An extension of this model might include the provision of evidence-based cognitive-behavioral

therapies in the community for patients and their primary care providers and family members including problem solving and communication and social skills training for major mental disorders [18–21]. These psychosocial interventions generally serve to reduce stress in patients and their families or primary care providing groups so as to increase the threshold for recurrences of illness episodes and to reduce the need for hospitalizations. With strong administrative support and careful planning, multidisciplinary psychiatric teams, including nursing, pharmacy, occupational and physical therapists, licensed chemical dependency counselors, case managers, cognitive-behavioral therapists, and other allied professionals, can work in close conjunction with the medical groups identified above and with these goals in mind. Moreover, crisis management can sometimes be effectively provided in community locations given adequate staffing, funding, and training [22], further reducing the pressure on hospital-based services.

These goals of improving health outcomes, raising standards of care, enhancing access, and minimizing health service burdens can only be achieved with the close coordination of teams across disciplines and across medical and psychiatric services to enhance the efficiency and effectiveness of preventive interventions. Training family medicine clinicians and other medical and surgical specialists in the early recognition and assessment of mental disorders using validated tools for doing so will help in identifying individuals with treatable conditions and in monitoring individual and group progress and will allow the evaluation of the adequacy of services. Early recognition and identification of those with mental disorders also makes possible other comprehensive and evidence-based components of a program to reduce the disability and burden associated with mental disorders. Integrating psychiatric services with other medical services may also serve to diminish patients' experience of stigma in being treated for mental disorders.

Psychiatrists and other mental health professionals must, as members of teams, support the education and clinical care needs of our colleagues, including distinguishing when specialist treatment is needed. We must show our willingness not only to be consultants but to care for those with severe and refractory mental illness. Training is optimally provided in a multidisciplinary fashion in order to enhance the integration and coordination of services and to provide comprehensive, evidence-based, and patient-centered care across services, including family practice and other medical services; across emergency, inpatient, and outpatient services; and across bio-psycho-social domains in treatment.

We strongly encourage the development and close integration of community-based mental health programs with primary care, family medicine, and related medical services. The papers in this special collection underscore the importance of developing integrated programs across medical practice disciplines and the role of innovation

in psychiatric education. Such partnerships and integrated care programs would surely serve to benefit the secondary prevention of mental disorders and to enrich the clinical experiences and quality of education for all learners, particularly in the domain of interprofessional education. This is a competency best learned in truly collaborative and integrated care settings.

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