

—John Williams, Jr. and Allen Dietrich

INTEGRATING MENTAL AND PHYSICAL HEALTH CARE TO BETTER IDENTIFY AND TREAT DEPRESSION

The primary care doctor's office could be a key setting for diagnosing and treating mental disorders, but several barriers stand in the way. Only about one-half of patients with depression or anxiety disorders are accurately diagnosed in primary care settings. Only about one-fourth to one-half of those accurately diagnosed with depression by primary care physicians receives guideline-concordant treatment. Some of the barriers to effective treatment include patient discouragement, stigma surrounding mental disorders, strong preferences for psychotherapy that may be difficult to access, and the brief, infrequent nature of primary care visits and lack of follow-up or monitoring.

Seeking to improve these outcomes, the MacArthur Foundation Initiative on Depression and Primary Care launched the Re-engineering Systems for the Treatment of Depression in Primary Care (RESPECT) trial. As John Williams and Allen Dietrich show in their paper for the *Fundamental Policy – Spotlight on Mental Health Conference*, the trial tested a systematic approach to depression management that involved three components: the primary care physician working in a prepared practice; a care manager; and a psychiatrist all working collaboratively with the patient to improve treatment and outcomes.

Care Managers Are Integral to Success

One key component of this effort is the role of the care manager, often a nurse who facilitates collaboration between primary care and mental health providers and promotes the use of evidence-based treatments. Care managers also

do follow-up assessments. In some cases, but not in the MacArthur Initiative, the care managers may provide psychotherapies.

Most of the work of a care manager is done over the phone, although face-to-face visits are also used in some adaptations. Care managers call patients at a specified time over three to twelve months to assess symptoms, treatment adherence, problems with treatment and to promote self-management. Another core component of the plan is a mental health expert available to consult informally with primary care physicians. The mental health expert supervises the care manager's caseload, offers emergency back-up and crisis management, and offers both care managers and primary care physicians ongoing educational support. The mental health expert also can recommend changes in treatment for patients who are not improving, and facilitate in-person consultation for more complex cases.

Building Blocks of Success

Success relies on solid training in all components of the care plan for both care managers and physicians and a broadly shared vision and commitment to the approach. Other essential elements include systematic screening, patient self-management, symptom and adherence monitoring, and decision support for medication management. Early evaluations of similar collaborative care models are encouraging. Patients in care management systems were about twice as likely to experience a sizable reduction in depressive symptoms.

Areas for Future Focus

The authors and the MacArthur Initiative on Depression and Primary Care have worked with numerous groups to implement and improve care management models for treating depression in primary care settings. These groups have included major insurers, large health plans, community-based practices, and the Department of Defense. On the basis of these experiences, the authors offer several directions for continued experimentation and progress.

A major impediment to implementing new models is financial. Even though evidence shows the benefits of collaborative care models, medical costs will increase modestly under the plan and are therefore a significant barrier to widespread implementation. To counter this barrier, it is imperative that research continue to evaluate the effectiveness of these models and their ability to lower long-term costs.

It is also imperative to explore the most efficient ways to fund depression care management, such as integrating such care into existing disease management programs for chronic medical illness such as diabetes.

Research should also determine the effects of care management for multiple, coexisting chronic illnesses.

Effects on model fidelity, costs, and patient outcomes also need to be better defined.

Breaking down barriers to effective integration of medical and behavioral health care is critical to continued advances. Policies for sharing appropriate clinical information across care settings, integrated electronic medical records, and training in team approaches should be examined.

The recent President's New Freedom Commission on Mental Health calls on care providers to recognize that mental health and physical health problems are interrelated. Primary care physicians are often the first contact for people with mental disorders seeking help. As former Surgeon General David Satcher has said, "Primary care practitioners are a critical link in identifying and addressing mental disorders ... Opportunities are missed to improve mental health and general medical outcomes when a mental illness is under-recognized and under-treated in primary care settings." Care management models such as RESPECT can help millions receive better care.

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The MacArthur Foundation Network on Mental Health Policy Research has worked to develop a knowledge base linking mental health policies, financing, and organization to their effects on access to quality care. www.macfound.org