# Integrated Mental and Behavioral Health Care

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# PREFACE

The VA Evidence Synthesis Program (ESP) was established in 2007 to conduct timely, rigorous, and independent systematic reviews to support VA clinicians, program leadership, and policymakers improve the health of Veterans. ESP reviews have been used to develop evidence-informed clinical policies, practice guidelines, and performance measures; to guide implementation of programs and services that improve Veterans' health and wellbeing; and to set the direction of research to close important evidence gaps. Four ESP Centers are located across the US. Centers are led by recognized experts in evidence synthesis, often with roles as practicing VA clinicians. The Coordinating Center, located in Portland, Oregon, manages program operations, ensures methodological consistency and quality of products, engages with stakeholders, and addresses urgent evidence synthesis needs.

Nominations of review topics are solicited several times each year and submitted via the ESP website. Topics are selected based on the availability of relevant evidence and the likelihood that a review on the topic would be feasible and have broad utility across the VA system. If selected, topics are refined with input from Operational Partners (below), ESP staff, and additional subject matter experts. Draft ESP reviews undergo external peer review to ensure they are methodologically sound, unbiased, and include all important evidence on the topic. Peer reviewers must disclose any relevant financial or non-financial conflicts of interest. In seeking broad expertise and perspectives during review development, conflicting viewpoints are common and often result in productive scientific discourse that improves the relevance and rigor of the review. The ESP works to balance divergent views and to manage or mitigate potential conflicts of interest.

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### *Operational Partners*

Operational partners are system-level stakeholders who help ensure relevance of the review topic to the VA, contribute to the development of and approve final project scope and timeframe for completion, provide feedback on the draft report, and provide consultation on strategies for dissemination of the report to the field and relevant groups.

**Jennifer Patterson, PhD, ABPP**
*National Director, Integrated Services*
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### *Key Informants*

The ESP sought input from key informants with diverse experiences and perspectives relevant to the review topic. Key informants included:

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**Disclosures**

This report was prepared by the Evidence Synthesis Program Center located at the **VA Greater Los Angeles Healthcare System,** directed by Paul Shekelle, MD, PhD and Isomi Miake-Lye, PhD and funded by the Department of Veterans Affairs, Veterans Health Administration, Health Systems Research.

The findings and conclusions in this document are those of the author(s) who are responsible for its contents and do not necessarily represent the views of the Department of Veterans Affairs or the United States government. Therefore, no statement in this article should be construed as an official position of the Department of Veterans Affairs. The final research questions, methodology, and/or conclusions may not necessarily represent the views of contributing operational and content experts. No investigators have affiliations or financial involvement (*eg*, employment, consultancies, honoraria, stock ownership or options, expert testimony, grants or patents received or pending, or royalties) that conflict with material presented in the report.

# *Executive Summary*

# KEY FINDINGS

- There is insufficient evidence from the published literature to guide how best to integrate mental health care into specialty medical care.
- In the VA setting, the intervention with the most evidence to support its beneficial effect is a specialty-clinic modification of TIDES (Translating Initiatives in Depression into Effective Solutions).

A small proportion of Veterans account for nearly half of Veterans Affairs (VA) costs, most of which is hospitalization for medical (not mental health) conditions. But, almost half of such patients have a major mental health diagnosis. These mental health conditions, many of which are potentially treatable, are risk markers (and potentially risk factors) for future emergency visits and admissions for ambulatory care-sensitive conditions. Thus, better identification and treatment of mental health conditions can improve not just mental health but physical health as well. VA has led the way in integrating mental health into primary care and is now considering initiating efforts at doing so in outpatient specialty clinics as well. Thus, the VHA Office of Mental Health asked the Evidence Synthesis Program for a review of recently published studies of mental health integration into outpatient specialty care.

## CURRENT REVIEW

This review searched Medline and PsycInfo for studies published in the last 10 years that assessed the integration of mental health care into adult specialty clinic care. We did not assess the inclusion of palliative care into oncology clinic, but otherwise had few constraints on study design or type of integration or outcome being measured. The level of integration was assessed by content experts using the Center for Integrated Health Solutions 6 levels of integration framework.

From 6,392 titles, we identified 16 relevant publications. One study was level 6 integration (full collaboration in a transformed/merged integration practice), 1 study was level 5 integration (close collaboration approaching an integrated practice), 2 studies were level 4 integration (close collaboration onsite with some system integration), 7 studies (in 9 publications) were level 3 integration (basic collaboration onsite), and 3 studies were level 2 integration (basic collaboration at a distance). Eight studies were randomized trials and 6 studies used nonrandomized designs, of which 4 were case series/pre-post studies. All studies but 1 had 1 or more domains at high risk of bias. Nine of the studies were performed in single clinic or practice locations, and 5 studies (in 7 publications) were multisite. Three studies were performed in VA settings, 4 studies were performed in the United Kingdom, and the rest were conducted at single US sites. Two studies described their intervention as being embedded in clinic care, 2 studies (in 4 publications) described their intervention as being based on TIDES, 4 studies described their intervention as collaborative care, 4 related studies from the United Kingdom variously described their intervention as collaborative care and integrated care, 1 study described its intervention as co-managed care, and the last study could not be classified with any of the others.

The strongest evidence of success in the VA setting were the 2 RCTs of TIDES-based interventions, one in a liver clinic and the other in an HIV clinic, which both found improvements in depression outcomes. Only 2 studies were of level 5 or 6 integration, and 1 of these was not relevant to VA while the other study included psychosocial collaborative care as part of a multicomponent intervention for

patients with acute cardiac issues, requiring hospital admission, and found some improvements in depression, anxiety, and fatigue relative to usual care. Beyond that, evidence was sparse given lack of studies for effective interventions in a VA setting.

## CONCLUSIONS

The findings from this review are that: 1) there are no published studies relevant to VA of full collaboration in a transformed/integrated practice for integrating mental health into specialty clinics; 2) there are only 3 published studies of close collaboration approaching an integrated practice or close collaboration onsite with some system integration (in other words, anything greater than basic collaboration); and 3) the studies most relevant to VA (done in VA settings) had interventions based on TIDES, modified for specific diseases (liver disease and HIV). Both studies were randomized trials and both found improvements in intervention patients compared to usual care on depression outcomes.