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REVIEW OPEN ACCESS

Effectiveness and Challenges of Integrated Care Models in Managing Mental Health in Chronic Illness and Disability: A Literature Review

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Abstract

Chronic illnesses and disabilities often lead to psychological comorbidities like depression and anxiety, worsening physical symptoms and quality of life. Integrated care models offer a collaborative approach to bridge gaps between primary and mental healthcare, providing holistic solutions. This review highlighted the benefits of implementing integrated care models in the care of patients with chronic illnesses and the barriers limiting their effectiveness and widespread adoption. A search of databases such as SCOPUS, CINAHL and Ovid-Medline, was conducted using keywords like "mental health," "chronic illnesses," and "integrated care." peer-reviewed articles were then selected based on relevance, recency, and methodological rigour. Studies highlight a link between chronic illnesses, disabilities, and mental health disorders, exacerbated by factors like financial stress, mobility issues, and pain. Integrated care models, which coordinate primary and mental health services, improve outcomes such as treatment adherence, emotional well-being, and quality of life. Despite its advantages, many systemic, provider and patient level barriers exist to properly implementing integrated care models. Integrated care addresses the interconnectedness of mental and physical health, offering comprehensive treatment for patients with chronic illnesses and disabilities. Despite its benefits, challenges such as funding issues, technological limitations, and insufficient interdisciplinary training hinder implementation. Addressing these barriers is crucial for broader adoption. Integrated care models improve patient outcomes through holistic care but face systemic and provider-level barriers. Future research should explore long-term impacts, cost-effectiveness, and culturally adaptable frameworks to maximize the potential of these models and enhance healthcare delivery.

Keywords: interdisciplinary care; diseases; mental illnesses

Introduction

While modern medicine has advanced at an unprecedented pace, the global burden of chronic illnesses continues to climb, exposing gaps in prevention and system-wide care delivery [1]. In Canada, nearly 45% of the population lives with at least one chronic illness, and 1 in 12 individuals manage three or more chronic conditions, underscoring the growing public health challenge posed by these diseases and circumstances [2]. According to the U.S. Centers for Disease Control and Prevention (CDC), chronic disease is often used as an umbrella term, referring to conditions that persist for a year or more that limit activities of daily living and/or require ongoing medical attention. Common examples include: heart disease, stroke, cancer and diabetes [3]. Disability, on the other hand, refers to a condition of the body or mind that limits or makes it more difficult for an individual to engage in certain activities and interact with their environment. [4]. While there is considerable overlap, as chronic illnesses can lead to disabilities, and vice versa, these are distinct terms, and this review will treat both concepts as mutually exclusive for clarity.

Psychological Adaptation to Chronic Illness and Disabilities

Individuals with chronic illnesses and disabilities often face a dual burden of physical and mental health challenges, with significantly higher rates of depression and anxiety compared to the general population [5]. According to Revenson and Hoyt (2016), adapting to chronic illnesses involves adjustments across both intrapersonal and interpersonal domains, which can be further categorized into cognitive, emotional, physical and behavioural components [6]. Intrapersonal domains include internal factors such as coping style or self-esteem, whereas interpersonal domains involve relationships and social support systems. Research indicates that these domains and components are deeply interconnected and the causal relationships among them are bidirectional. For instance, stress and depression can worsen physical symptoms, and reduce adherence to treatment

regimens, including medication, diet and exercise. This can create a psychosomatic cycle, where deteriorating mental health leads to poorer physical health outcomes, which in turn increase healthcare utilization and compound psychological distress. [6-8]. The reciprocal relationship is seen to be true where, pain and limited mobility restricts daily activities, increasing depressive symptoms [6]. In addition to the direct health impacts, individuals living with chronic illness and disability often encounter compounding psychosocial stressors such as financial strain, limited social support, physical pain, and mobility limitations. These challenges not only heighten psychological distress by contributing to increased feelings of helplessness and social exclusion but also significantly diminish overall quality of life [5-7].

Fragmented Healthcare

Despite the evident need for collaborative care for the growing population of individuals living with chronic illnesses and disabilities, current healthcare systems remain fragmented and often fail to address the complex needs of those with co-occurring physical and mental health conditions [9].Fragmented care refers to the disjointed care from various specialists or healthcare professionals and is associated with negative health outcomes for patients, such as low adherence to treatment plans, disease progression, and disabilities due to delayed care [10]. Individuals with chronic illnesses and disabilities experience high rates of care fragmentation because they often require continuous care. Due to the disconnect between health practitioners, the individual may receive limited or redundant care, resulting in missed or delayed diagnoses, overuse of healthcare services and higher mortality rates [11].

Integrated care models (ICMs) are an alternative approach to delivering care. They offer a promising solution to this issue by fostering collaboration among primary care providers, mental health professionals, community services and patients' families. These models are designed to address the whole person by integrating mental and physical healthcare, breaking down silos, and providing holistic, patient-centred treatment [12]. However, to fully optimize ICMs in addressing the mental health challenges associated with chronic illnesses and disabilities, several barriers, including systemic inefficiencies, provider-level challenges, and technological limitations must be faced [13]. This literature review critically examines the potential benefits of integrated care models for managing chronic illness and mental health comorbidities, while identifying the key systemic, organizational, and practical barriers hindering their widespread implementation.

Methods

To identify relevant literature on the effectiveness and challenges of integrated care models in managing mental health among individuals with chronic illnesses and disabilities, a structured and comprehensive search strategy was employed. Multiple academic databases were consulted, including PubMed, PsycINFO, CINAHL, and Scopus, to ensure a broad and interdisciplinary scope. The search aimed to capture both quantitative and qualitative studies that addressed mental health integration within chronic illness or disability care contexts. To ensure a focused review, the search was restricted to peer-reviewed journal articles published in English between 2010 and 2024.

A range of search terms was developed using both keywords and controlled vocabulary where applicable. Terms such as “integrated care,” “collaborative care,” “mental health,” “chronic illness”, “long-term condition,” “disability,” and “co-occurring conditions” were used in various combinations. Boolean operators such as AND and OR were applied to refine the results and capture relevant intersections of mental and physical health in care delivery. Search strings were iteratively modified to ensure inclusivity of diverse care models and population groups.

The initial search produced a large volume of articles, numbering over 500 results across all databases. These were first screened by title and abstract to assess their relevance to the review objectives. Studies that discussed integrated care models in the context of primary care, hospital settings, or community mental health were included if they specifically addressed populations with chronic physical illnesses and coexisting mental health challenges. Articles were excluded if they focused solely on physical or mental health conditions in isolation, or if they examined general care coordination without a defined integration framework.

Following the abstract screening phase, full-text reviews were conducted on approximately 60 articles. This led to the inclusion of studies that offered empirical findings, systematic reviews, or theoretical frameworks concerning integrated care implementation, outcomes, and barriers. Despite the comprehensive approach, very few studies explicitly addressed integrated care models for individuals with disabilities as a primary focus, especially when combined with mental health concerns.

Results

Twenty studies from the CINAHL database, one from Scopus, and two from Ovid MEDLINE met the inclusion criteria. These studies employed diverse methodologies, including clinical studies, qualitative designs, and mixed-method approaches, and focused on populations with diabetes, multiple sclerosis, and individuals with general chronic illnesses or disabilities.

Overview of Integrated Care Models

Three prominent variations of integrated care models (ICMs) were identified: the Patient-Centered Medical Home (PCMH), the Collaborative Care Model (CCM), and the Chronic Care Model (CCM). The key features and observed outcomes of the identified models are summarized in Table 1.

Patient-Centered Medical Home (PCMH) Model

The PCMH model, implemented in regions such as California, emphasizes care coordination through team-based, patient-centred primary care. This model aims to reduce healthcare fragmentation and improve health equity, particularly in low-income populations, by leveraging existing infrastructure and data to provide coordinated care [14, 15].

Collaborative Care Model (CCM)/Multidisciplinary Care Model

The Collaborative Care Model integrates physical, psychological, cognitive, and social health to deliver holistic support for individuals with multimorbid conditions. A key feature of this model is collaboration between physicians and case managers. CCMs are frequently used in older populations, particularly in managing conditions such as dementia, and emphasize interdisciplinary teamwork to address complex health needs [16].

Chronic Care Model

The Chronic Care Model comprises six core components: community resources, health systems, self-management support, delivery system design, decision support, and clinical information systems. This model was designed to improve care delivery and health outcomes for individuals with chronic illnesses [17].

Table 1. Overview of Integrated Care Models

Model	Key Features	Target Populations	Notable Outcomes
Patient-Centred Medical Home (PCMH) [14, 15]	Emphasizes team-based, patient-centred primary care; reduces healthcare fragmentation.	Low-income populations	Improved care coordination and equity.
Collaborative Care Model (CCM) [16]	Integrates physical, psychological, cognitive, and social health; interdisciplinary collaboration.	Older adults, patients with dementia	Enhanced management of multimorbid conditions.
Chronic Care Model [17]	Six components: community resources, health systems, self-management, delivery design, decision support, and clinical info systems.	Patients with chronic illnesses	Improved care delivery and chronic illness outcomes.

Efficacy of Integrated Care Models in Addressing Mental Health

Individuals with serious mental illnesses face a significantly higher risk of premature mortality, with estimates indicating a loss of 10 to 20 years of life compared to the general population [18]. Research consistently shows a high prevalence of comorbid physical health conditions in this population, such as cardiovascular disease, diabetes, and obesity. These comorbidities contribute to a diminished quality of life and increased healthcare utilization. The complex interplay between mental illness and physical health creates a vicious cycle that exacerbates symptoms on both fronts, further deteriorating overall well-being [9, 18].

Mental illnesses, disabilities, and long-term conditions (LTCs) are interrelated and often co-occur, creating a web of challenges that complicates treatment and care. These conditions are not only mutually reinforcing but also contribute to delays in care, increased symptom severity, and reduced life expectancy. Integrated care models (ICMs) aim to address these multifaceted needs by replacing fragmented care systems with coordinated, person-centred approaches [18]. Through enhanced collaboration among providers, ICMs improve communication, reduce redundancies, and address both physical and mental health in tandem.

Maintaining good mental health is especially critical for individuals with LTCs, as it significantly affects their ability to adhere to medical regimens and maintain lifestyle changes. Evidence suggests that ICMs improve adherence to medication, appointment attendance, and recommended self-care practices [7, 15]. Patients receiving integrated care frequently exhibit improved emotional stability and are more likely to complete treatment plans when compared to those receiving standard, uncoordinated care [19]. These benefits have been documented across a wide range of patient demographics, clinical backgrounds, and healthcare settings.

In a randomized study conducted by Theodoridou et al. (2015), hospitalized psychiatric patients receiving care under an ICM demonstrated more substantial reductions in psychopathological symptoms and greater improvements in psychosocial functioning than those receiving standard care. These improvements are thought to result from the continuity of care and better provider coordination inherent in integrated models. Patients benefited from clearer communication, more consistent follow-up, and a sense of stability in their care journey. This suggests that ICMs are particularly effective in managing complex psychiatric and physical health needs within institutional settings [20].

Other studies have echoed these findings, with consistent reductions in depression and anxiety symptoms observed among patients enrolled in integrated care programs [21-23]. Peterson et al. (2019), for example, found that LTC patients under ICMs reported better mental health and functional ability at three-month follow-up assessments, in contrast to those who received standard care [23]. These patients also

experienced greater satisfaction with their care, underscoring the value of patient engagement and collaborative decision-making. Such outcomes support the argument that integrated care can lead to more sustainable and effective long-term management [23].

ICMs have also been associated with reduced hospitalizations and emergency room visits, which enhances cost-efficiency within healthcare systems [19, 21, 24]. However, some studies caution that the increased use of primary and mental health services in ICMs may initially result in higher overall healthcare expenditures [15]. This has prompted calls for robust cost-benefit analyses to evaluate the long-term economic implications of ICM implementation. Despite these concerns, proponents argue that the initial investment in integrated care yields substantial savings over time by preventing complications and reducing acute care needs [25].

Bergmo et al. (2015) challenge the idea that ICMs are more expensive, asserting instead that these models are ultimately more cost-effective than traditional care approaches. They argue that patients in integrated care systems are more empowered and equipped to manage their own health, leading to fewer crises and less reliance on high-cost interventions. The emphasis on patient-centeredness in ICMs fosters greater self-efficacy, which contributes to improved clinical outcomes and lower emergency service usage. In the United Kingdom, shifting to integrated care is projected to reduce overall healthcare costs by approximately seven percent [25].

In addition to economic and clinical advantages, ICMs contribute to more culturally competent care by integrating healthcare services with community-based resources. This is exemplified in models like the Collaborative Care Model, which intentionally bridges clinical care with cultural and social support systems [16, 26]. By aligning care with patients' cultural values and social contexts, these models improve patient trust and engagement. Culturally integrated care environments are especially beneficial in mental health treatment, where stigma and cultural misunderstanding often deter individuals from seeking help [26, 27].

Wang et al. (2023) conducted a prospective randomized study on patients undergoing hip arthroplasty and found that those treated under ICMs experienced better outcomes in trauma coping, faster physical recovery, and greater self-efficacy. These improvements were attributed to the clarity of care plans and strong communication between multidisciplinary teams. The patients' active involvement in their own care played a critical role in enhancing recovery and reducing stress. This study reinforces the broader applicability of ICMs beyond mental health, demonstrating their value in surgical and rehabilitative care settings [28]. Table 2 presents a synthesis of studies and key findings that support the effectiveness of integrated care models.

Barriers to Optimizing Integrated Care Models

Table 3 outlines the principal barriers to optimizing integrated care models, categorized across system, provider, technological, and patient levels.

System-Level Barriers

Funding limitations and policy challenges often hinder the successful implementation of ICMs. Bureaucratic inefficiencies, such as lengthy approval processes between sectors, delay decision-making and resource allocation [29, 30]. Additionally, existing financial regulations and policies frequently impede budget integration, which is critical for effective care coordination [19, 30]. In some ICMs, the high demand for care and costs and reduced funding experienced by many essential organizations make it difficult to finance integrated care [30]. Fragmentation in mental and primary healthcare funding, often involving different insurers, billing codes, and reporting requirements, further complicates integration efforts [19].

Technological Support

Effective data-sharing between health and social care teams is crucial for ICMs but presents substantial challenges. Issues related to patient confidentiality, accessibility of electronic health records (EHRs), and data inconsistencies between healthcare providers hinder seamless communication [10, 29]. Organizations often utilize different IT systems, making linking databases and sharing patient information challenging. In some cases of ICM implementations, organizations had to pay or request access to use specific databases [29, 30]. Data-sharing also introduces data quality issues or information overload [30]. Licensing policies for intranet systems and omitted information in records exacerbate these challenges, limiting the effectiveness of care coordination [29].

Provider-Level Barriers

Interdisciplinary collaboration is central to ICMs but is often impeded by relational difficulties, such as inadequate teamwork and communication skills among healthcare professionals [13, 30]. Time pressures, insufficient training opportunities, and differing perceptions of patient needs further complicate care coordination. Standardizing care protocols and establishing clear team objectives across disciplines remain significant challenges [13, 23, 30, 31].

Patient-Level Barriers

Patients themselves face barriers to accessing integrated care. Chronic conditions are often accompanied by feelings of hopelessness, which may deter individuals from seeking help. Additionally, stigma surrounding mental health, resistance to diagnosis, and differing health beliefs can negatively influence patients' willingness to participate in ICMs [32].

Table 2. Summary of Patient-Centred Study Findings on the Effectiveness of Integrated Care Models

Study	Purpose	Measurement Tools	Key Findings
Castañeda et al. (2022) [22] n = 456	To examine the effectiveness of low-intensity psychological interventions for patients with and without long-term conditions in a real-world service setting.	Patient Health Questionnaire-9 (PHQ-9), Generalized Anxiety Disorder-7 (GAD-7)	Both groups improved in depression and anxiety; patients with long-term conditions showed slightly greater depression reduction. Internet-delivered cognitive behavioral therapy was the most effective intervention.
Lee et al. (2024) [21] n = 4024	To compare usual care to a culturally adapted integrated care model for Latino patients with type 2 diabetes.	PHQ-8, GAD-7, Perceived Stress Scale-10 (PSS-10)	Integrated care group had significantly larger reductions in depression and anxiety symptoms than the usual care group over 6 months.
Millender et al. (2020) [19] n = 314	To evaluate a nurse-led interprofessional model of care for patients with co-occurring medical and mental conditions.	Mental health stability measures, access to care indicators, treatment completion rates	The model improved mental health stability, access to care, and treatment plan completion.
Peterson et al. (2019) [23] n = 1310	To evaluate a task-shared, collaborative care model for chronic patients with co-existing depressive and alcohol use disorder symptoms in South Africa.	Facility Detection Survey (FDS), PHQ-9	Significant improvements in detection of conditions and reduction in depressive symptoms in the intervention group compared to the control.
Tsuda et al. (2024) [16] n= 195	To explore collaboration models between primary care physicians and care managers for early-stage dementia care.	Survey assessing 14 items across 7 support domains	Primary care physician-led models provided more comprehensive support than stand-alone or care manager-led models.
Bergmo et al. (2015) [25] n= 600	To assess an integrated treatment model combining inpatient, day hospital, and outpatient psychiatric care.	Psychopathology assessments, global/social functioning scores, satisfaction surveys	The integrated group showed improved psychopathology and functioning but had quicker re-admissions compared to standard care.
Theodridou et al. (2015) [20] n=178	To evaluate the Patient Centred Team model for frail elderly patients in Norway.	Short Form Health Survey (SF-36), PGI, PAM, PACIC, QALYs, hospital utilization data	The study will determine if the model improves patient health outcomes and is cost-effective; results pending.
Wang et al. (2023) [28] n= 83	To examine the impact of integrated doctor-nurse care with health education on recovery after hip arthroplasty.	Harris Hip Score, coping style scales, self-efficacy and satisfaction scores	Patients receiving additional health education had better recovery, coping, self-efficacy, and satisfaction than those receiving standard integrated care.

Table 3. Summary of Findings on the Barriers to Integrated Care Models

Author and Year	Key Barriers	Examples
Ling et al. (2012) [29], Gongora-Salazar et al (2022) [30]	System Level Barriers: Funding limitations, bureaucratic delays, fragmented financial regulations.	Lengthy approval processes, integration of budgets.
Monacco et al. (2020) [10], Ling et al. (2012) [29], Gongora-Salazar et al (2022) [30]	Technological Support: Issues with EHR accessibility, data quality, and IT system incompatibility.	Data-sharing challenges, licensing costs, incomplete records [6, 21, 22].
Kumpunen et al. (2020) [13], Peterson et al. (2019) [23], Gongora-Salazar et al (2022) [30], Gidlow et al. (2024) [31]	Provider-Level: Lack of interdisciplinary collaboration, training, and standardization of care protocols.	Poor communication, time constraints, differing priorities among care providers.
Wulsin et al. (2006) [32]	Patient-Level: Stigma, hopelessness, resistance to diagnosis, and cultural differences.	Mental health stigma, differing health beliefs, low engagement.

Discussion

This review highlights the transformative potential of integrated care models (ICMs) in addressing the interconnected challenges of mental health and chronic illnesses or disabilities. By unifying physical and mental health services, ICMs enable coordinated, patient-centred care tailored to individual needs [18]. Evidence indicates that ICMs significantly enhance mental health outcomes, including reductions in anxiety and depression among individuals with long-term conditions (LTCs) [21]. Additionally, they promote greater adherence to treatment and medication regimens, which is critical in managing complex conditions [7, 15]. By addressing contributing stressors such as pain, mobility issues, and financial burden, ICMs not only reduce psychological distress but also ensure holistic treatment of co-existing physical and mental health conditions.

ICMs are notably adaptable across a variety of populations and healthcare settings, making them a viable strategy for enhancing care coordination and advancing health equity. For instance, the Patient-Centred Medical Home model strengthens care in underserved areas, while the Collaborative Care Model has demonstrated success in managing dementia in older adults [13, 14, 15]. This flexibility supports the integration of culturally competent practices and the consideration of social determinants of health, ultimately delivering personalized, inclusive care.

Despite these advantages, widespread implementation of ICMs is hindered by systemic inefficiencies, provider-level challenges, and patient-related barriers [29]. A multifaceted approach is essential to overcoming these obstacles and fully realizing ICMs' potential in transforming healthcare for individuals with chronic conditions and disabilities.

Implications and Future Directions

System-Level Strategies

To enable ICMs to effectively address mental health concerns among individuals with LTCs and disabilities, systemic reform is necessary. Policymakers should pursue integrated health budgets to mitigate financial fragmentation and incentivize interdisciplinary collaboration. Additionally, investments in interoperable electronic health records (EHRs) and secure data-sharing systems can strengthen communication across care teams and support cohesive, continuous care.

Provider-Level Interventions

Training programs for healthcare providers should emphasize shared care protocols, cultural competency, and effective interdisciplinary communication. Standardized education for team-based care should also incorporate digital tools such as telehealth and predictive analytics, equipping providers to deliver responsive, technology-enabled care.

Patient Engagement

Community education and outreach initiatives are crucial in reducing stigma and fostering trust in ICMs. These efforts should inform patients about mental health treatment options, counter misinformation, and encourage active participation in care. Tailored interventions that account for cultural and socioeconomic diversity can promote equitable service access.

Research and Innovation

Further research is needed to evaluate the long-term scalability, adaptability, and sustainability of ICMs. Special attention should be given to individuals with disabilities, who are often underrepresented in current literature. Research into telehealth integration within ICMs is particularly relevant as digital healthcare becomes more prevalent.

Economic Considerations

Evaluating the cost-effectiveness of ICMs is critical for ensuring their sustainability. Future research should identify strategies to balance cost with patient outcomes, aiming to optimize resource allocation without compromising care quality.

Strengths and Limitations

This review synthesizes a broad spectrum of evidence, underscoring ICMs' effectiveness and adaptability across varied populations. However, the relatively small number of included studies (17 from CINAHL, 1 from Scopus, and 2 from Ovid Medline) and methodological differences limit generalizability, highlighting the need for additional robust research.

Conclusions

Integrated care models provide a promising framework for addressing the dual challenges of chronic physical and mental health conditions. By prioritizing patient-centred, coordinated approaches, ICMs improve adherence, mental health outcomes, and overall quality of life. Despite ongoing challenges such as systemic fragmentation and provider limitations, targeted reforms and technological integration can unlock the full potential of ICMs. Strategic implementation holds the promise of reducing care disparities and enhancing outcomes for individuals with complex, long-term health needs.

List of Abbreviations

ICM: integrated care model
LTC: long-term conditions

Conflicts of Interest

The author declares that they have no conflict of interest.

Ethics Approval and/or Participant Consent

As this study was a literature review that analyzed existing published research, no new data were collected from human or animal subjects. Therefore, review by the research ethics board was not required.

Authors' Contributions

JLJ: The made contributions to the design of the study, collected and analyzed data, drafted the manuscript, and gave final approval of the version to be published.

Acknowledgements

The author sincerely thanks Harveen Saini for her invaluable guidance and mentorship throughout the writing process. Her support and insights have been instrumental in shaping this work.

Funding

This study was not funded.

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Article Information
Managing Editor: Jeremy Y. Ng
Peer Reviewers: Harveen Saini, Patricia Acosta
Article Dates: Received Dec 02 24; Accepted Jun 13 25; Published Jul 28 25

Citation
Please cite this article as follows:
James JL. Effectiveness and challenges of integrated care models in managing mental health in chronic illness and disability: A literature review. URNCST Journal. 2025 Jul 28: 9(6). https://urncst.com/index.php/urncst/article/view/780
DOI Link: https://doi.org/10.26685/urncst.780