Primary care and mental health: Where do we go from here?

Nathalie Moise, Milton Wainberg, Ravi Navin Shah

Abstract

Primary care has been dubbed the “de facto” mental health system of the United States since the 1970s. Since then, various forms of mental health delivery models for primary care have proven effective in improving patient outcomes and satisfaction and reducing costs. Despite increases in collaborative care implementation and reimbursement, prevalence rates of major depression in the United States remain unchanged while anxiety and suicide rates continue to climb. Meanwhile, primary care task forces in countries like the United Kingdom and Canada are recommending against depression screening in primary care altogether, citing lack of trials demonstrating improved outcomes in screened vs unscreened patients when the same treatment is available, high false-positive results, and small treatment effects. In this perspective, a primary care physician and two psychiatrists address the question of why we are not making headway in treating common mental health conditions in primary care. In addition, we propose systemic changes to improve the dissemination of mental health treatment in primary care.

Key Words: Mental health; Collaborative care; Primary care; Depression; Integrated care; Anxiety

©The Author(s) 2021. Published by Baishideng Publishing Group Inc. All rights reserved.
Challenges Primary Care Physicians Face in Treating Mental Health

Policymakers, providers and researchers developed CC models, in part, to address gaps in the access to quality mental health treatment in primary care and to offload busy primary care providers (PCPs). The lynchpin of these models are care managers, typically nurses or licensed social workers, who provide monitoring (using standardized screening tools) and problem-solving therapy under the supervision of a psychiatrist who assists with case review and complex cases. It remains unknown whether the programs can handle or even effectively treat the new deluge of patients with mental health issues. In fact, studies from multiple countries conducted in 2020 (53 studies; $n = 158000$) report high point prevalence estimates of stress (29%-31%), depression (25%-47%), anxiety (32%-47%), sleep disturbances (34%-36%), and posttraumatic stress disorder (16%-18%)[9-17].

At the systems level, even prior to COVID-19, settings with CC programs reported insufficient resources (e.g., care manager fulltime equivalents) to address the volume and complexity of common mental health disorders seen in real-world primary care settings[18]. This remains an issue despite inroads in payment models and an expanded non-physician workforce. There are a variety factors contributing factors to the insufficient number of care managers to meet patient demand, including low reimbursement rates, limited time due to competing demands (i.e., coordination vs therapy), low job satisfaction, and suboptimal relationships with PCPs, particularly in large primary care settings with numerous PCPs per care manager[18]. Relatedly, CC outcomes also hinge on having a strong, integrated primary health care system[1], which has also historically been difficult to widely implement[19]. Furthermore, the rapid uptake of telemedicine during the COVID-19 pandemic affected clinical roles,
particularly for medical assistants who traditionally administered depression screening but lack pre-visit telemedicine workflows. Meanwhile, communication infrastructures among staff, patients, and providers have become fragmented. Due to the economic effects of COVID-19, many medical settings now have a greater percentage of uninsured, Medicare and Medicaid patients and higher costs on a case-mix adjusted basis. Few studies, however, examine the unique barriers to CC implementation in settings that operate in fee-for-service models that devalue mental health care[18].

Provider engagement is also crucial to CC implementation[18,20], but PCPs increasingly face shortened, now remote, visits, administrative/teaching/telemedicine onboarding tasks, high turnover (i.e., of trainees) as well competing quality improvement priorities (e.g., diabetes targets, domestic violence screening), all resulting in fatigue and burnout[18]. Many providers in academic settings are not always physically present in clinics (e.g., have half day sessions) and lack formal mental health/CC training in residency, producing physicians ill-equipped to successfully manage their patients’ mental health conditions and provide population health-based ‘shared-care’ with a psychiatrist[21]. Increasing rates of provider psychological distress may also make it difficult to detect and address mental health issues in patients[7]. Finally, direct communication between PCPs and psychiatrists remains rare in these models despite the fact that physician-to-physician engagement often fosters a medical learning environment that enhances the psychiatric treatment skills of PCPs. This may explain why even successfully implemented CC programs see remission in less than half of patients[22].

Meanwhile, patient level barriers include stigma, fear of side-effects, low treatment availability and preferences for focusing on physical concerns resulting in patient nonadherence[23], which is compounded by chronic, resistant, psychosomatic symptoms often seen in primary care settings. It’s unclear whether the mental but also long-term physical sequelae of COVID-19 can be effectively managed by the short-term treatment provided by CC.

ROLE DISCORDANCE: CHALLENGES FOR PSYCHIATRISTS

Integrated care models require psychiatrists to step back from direct patient care and collaborate with a care manager who provides therapy and communicates with the PCP for medication management. Although in an idealized CC setting, psychiatrist time would be focused on educating the team and supervising the care manager, often the psychiatrist’s limited time quickly becomes filled with direct patient consults. This is the result of several factors. Psychiatry residency, like all the other medical residency training programs, offers little if any training in supervising other clinicians (e.g., care managers) or liaising with PCPs during psychiatry residency. Concrete data does not exist to dictate whether a patient would be better suited for independent care by the PCP as opposed to direct or indirect (via care manager) psychiatric consultation, resulting in a patchwork of unnecessary psychiatric consultations or patients remaining in primary care who need referral to more specialized treatment. In addition, like in most other specialty residency training programs, many physicians enter psychiatry specifically to spend time delivering individual care to patients, creating a tendency to veer towards direct vs indirect consultation. Combined with the general psychiatrist workforce shortage, these factors make locating psychiatrists for these roles challenging. Finally, while the advent of telepsychiatry comes with improvements in access and convenience for patients and providers, corresponding decreases in direct face-to-face interaction with PCPs and care managers can create unique challenges, such as reduction in non-verbal cues and informal interactions that are often necessary for clarifying clinical and process details and building team-based trust and rapport[24].

LEVERAGING ADVANCES IN MENTAL HEALTH AWARENESS AND TREATMENT TO ADDRESS PRIMARY CARE NEED IN THE POST-COVID ERA

In the post-COVID era, telehealth both for primary care and mental health is increasingly the norm and will at least partially remain in place, offering a rare opportunity to address the above barriers and expand and improve the delivery of CC
for mental disorders in primary care. Prior research suggests that off-site telemedicine-based CC may yield better outcomes than local practice-based CC albeit through better fidelity\cite{25}, but widespread implementation will require innovative, multi-disciplinary solutions and adaptations. In Table 1, we recommend several interventions to improve mental healthcare in the primary care setting, starting with requiring dedicated time during outpatient internal medicine residency rotations to learn psychopharmacological and CC principles but also self-care strategies for reducing provider burnout. The Advancing Integrated Mental Health Solutions Center is a valuable resource for CC training. In addition, groups like the Association of American Medical Colleges have begun to create online curricula and modules for residents, and topics include cognitive behavioral therapy for insomnia and trauma informed care. Second, telemedicine era primary care settings may benefit from leveraging technology to make psychoeducation, cognitive behavior therapy (CBT) apps, and symptom self-monitoring, all proven effective in prevention and/or managing mild symptoms, part of routine care\cite{26} (perhaps as part of new pre-visit telehealth roles of medical assistants or patient portals). This may be particularly important given the deluge of patients with mental health concerns in the post-COVID-19 era\cite{6}. The American Psychiatric Association developed toolkits of telepsychiatry and CBT apps, which will be important resources.

Regardless, medication and therapy remain first-line in moderate-severe cases\cite{26}. Patient-preference driven or precise, individualized algorithms (e.g., machine learning) for targeting screening and treatment according to patient depression phenotypes or risk\cite{27} is now possible with integrated electronic health records and may further help address resource limitations, patient engagement and treatment efficiency. In CC settings, improved designations for referrals to care management vs direct psychiatry, ideally both remotely delivered, will also be essential and improve efficiency and engagement. Care will need to be taken to avoid technology-driven disparities among the socioeconomically disadvantaged populations often seen in community and academic medical centers (e.g., addressing concerns with stigma and confidentiality; offering phone vs video visits). True inroads in mental health treatment in primary care will require flexibility and acknowledging that not every setting is suitable for CC and may instead benefit from improving psychiatry-PCP communication, particularly in non-integrated medical settings where collaboration remains siloed\cite{28}. Advances in telemedicine and technology have the potential to improve communication and make “colocation” even more possible, particularly in settings where a higher density of PCPs and psychiatrists practice.

DISSEMINATING SKILLS FOR PSYCHIATRISTS WORKING IN PRIMARY CARE

While the Accreditation Council for Graduate Medical Education-required experience in consultation-liaison psychiatry provides some inpatient training in collaboration, the outpatient environment is meaningfully different. Trainees need practice and supervision to know the limits of what can and cannot be done with a patient they have not directly interviewed, and how to teach colleagues clinical pearls in a digestible and helpful manner. These skills can and should be part and parcel to psychiatric training. In the interim, the American Psychiatric Association has developed trainings for psychiatrists already in practice to learn the skills needed to successfully operate in a CC setting. Systems should compensate psychiatrists not only for direct patient time but also indirect consultations and teaching primary care colleagues the nuances antidepressant titration strategies. These are the tools that will help scale an expertise-driven treatment of depression and anxiety much faster than having these patients wait to see a psychiatrist. Relatedly, financial models now compensate for telepsychiatry and tele-CC models but should also align with the long-term need for indirect e-consultations as well as with new roles of PCPs and psychiatrists within integrated care settings particularly in the post-COVID-19 financial milieu.

CONCLUSION

In conclusion, long-standing barriers to addressing mental health in primary care settings are underscored in today’s environment. COVID-19 propelled the use of
ACGME: Accreditation Council for Graduate Medical Education; COVID-19: Coronavirus disease 2019.

telehealth and telespsychiatry, offering multiple opportunities for improving the uptake of CC. Future success in these settings will require that primary care and mental health providers apply lessons learned during this period and consider innovations in training, technology, workforce, and treatment selection.

REFERENCES

1 van der Feltz-Cornelius CM, Nuyen J, Stoop C, Chan J, Jacobson AM, Katon W, Snoek F, Sartorius N. Effect of interventions for major depressive disorder and significant depressive symptoms in patients with diabetes mellitus: a systematic review and meta-analysis. *Gen Hosp Psychiatry* 2010; 32: 380-395 [PMID: 20633742 DOI: 10.1016/j.genhosppsych.2010.03.011]

2 Gilbody S, Bower P, Fletcher J, Richards D, Sutton AJ. Collaborative care for depression: a cumulative meta-analysis and review of longer-term outcomes. *Arch Intern Med* 2006; 166: 2314-2321 [PMID: 17130380 DOI: 10.1001/archinte.166.21.2314]

3 Thota AB, Sipe TA, Byard GJ, Zometa CS, Hahn RA, McKnight-Eily LR, Chapman DP, Abraido-Lanza AF, Pearson JL, Anderson CW, Gelenberg AJ, Hennessy KD, Duffy FF, Vernon-Smiley ME, Nease DE Jr, Williams SP. Community Preventive Services Task Force. Collaborative care to improve the management of depressive disorders: a community guide systematic review and meta-analysis. *Am J Prev Med* 2012; 42: 525-538 [PMID: 22516495 DOI: 10.1016/j.amepre.2012.01.019]

4 Areán PA, Ayalon L, Hunkeler E, Lin EH, Tang L, Harpole L, Hendrie H, Williams JW Jr, Unützer J, IMPACT Investigators. Improving depression care for older, minority patients in primary care. *Med Care* 2005; 43: 381-390 [PMID: 15778641 DOI: 10.1097/01.mlr.0000156852.09920.b1]

5 Sederer LI, Derman M, Carruthers J, Wall M. The New York State Collaborative Care Initiative: 2012-2014. *Psychiatr Q* 2016; 87: 1-23 [PMID: 26040961 DOI: 10.1007/s11126-015-9375-1]

6 Clay JM, Parker MO. Alcohol use and misuse during the COVID-19 pandemic: a potential public health crisis? *Lancet Public Health* 2020; 5: e259 [PMID: 32277874 DOI: 10.1016/S2468-2667(20)30088-8]

7 Shechter A, Diaz F, Moise N, Anstey DE, Ye S, Agarwal S, Birk JL, Brodie D, Cannone DE, Chang B, Claassen J, Cornelius T, Derby L, Dong M, Givens RC, Hochman B, Homma S, Kronish IM, Lee SAJ, Manzano W, Mayer LES, McMurray CL, Moira V, Pham P, Rabbani L, Rivera RR, Schwartz A, Schwartz JE, Shapiro PA, Shaw K, Sullivan AM, Vose C, Wasson L, Edmondson D, Abdalla M. Psychological distress, coping behaviors, and preferences for support among New York healthcare workers during the COVID-19 pandemic. *Gen Hosp Psychiatry* 2020; 66: 1-8 [PMID: 32590254 DOI: 10.1016/j.genhosppsych.2020.06.007]

8 Ettman CK, Abdalla SM, Cohen GH, Sampson L, Vivier PM, Galea S. Prevalence of Depression Symptoms in US Adults Before and During the COVID-19 Pandemic. *JAMA Netw Open* 2020; 3: e2019686 [PMID: 32876685 DOI: 10.1001/jamanetworkopen.2020.19686]

9 Bueno-Notivol J, Gracia-Garcia P, Olaya B, Lasheras I, Lopez-Anton R, Santabarbbara J. Prevalence of depression during the COVID-19 outbreak: A meta-analysis of community-based studies. *Int J Clin Health Psychol* 2021; 21: 100196 [PMID: 32904715 DOI: 10.1016/j.ijchp.2020.07.007]

10 Yao H, Chen JH, Xu YF. Patients with mental health disorders in the COVID-19 epidemic. *Lancet Psychiatry* 2020; 7: e21 [PMID: 32199510 DOI: 10.1016/S2215-0366(20)30090-0]

11 Wang C, Pan R, Wan X, Tan Y, Xu L, Ho CS, Ho RC. Immediate Psychological Responses and Associated Factors during the Initial Stage of the 2019 Coronavirus Disease (COVID-19) Epidemic among the General Population in China. *Int J Environ Res Public Health* 2020; 17 [PMID: 32155789 DOI: 10.3390/ijerph17051279]
stress and COVID-19-related anxiety in the UK general population during the COVID-19 pandemic. Biomed Psychiatry Open 2020; 6: e125 [PMID: 33070797 DOI: 10.1192/bjpc.2020.109]

13 Salarl N, Khazaie H, Hosseinian-Far A, Khaleedi-Paveh B, Kazemini M, Mohammadi M, Shohaimi S, Daneshkhah A, Eskandari S. The prevalence of stress, anxiety and depression within front-line healthcare workers caring for COVID-19 patients: a systematic review and meta-regression. Hum Resour Health 2020; 18: 100 [PMID: 33334335 DOI: 10.1186/s12992-020-00544-1]

14 Salarl N, Hosseinian-Far A, Jalali R, Vaisi-Raygani A, Rasoulpoor S, Mohammadi M, Khaleedi-Paveh B. Prevalence of stress, anxiety, depression among the general population during the COVID-19 pandemic: a systematic review and meta-analysis. Global Health 2020; 16: 57 [PMID: 32631403 DOI: 10.1186/s12992-020-00589-w]

15 Ran L, Wang W, Ai M, Kong Y, Chen J, Kuang L. Psychological resilience, depression, anxiety, and somatization symptoms in response to COVID-19: A study of the general population in China at the peak of its epidemic. Soc Sci Med 2020; 262: 113261 [PMID: 32758794 DOI: 10.1016/j.socscimed.2020.113261]

16 Gao J, Zheng P, Jia Y, Chen H, Mao Y, Chen S, Wang Y, Fu H, Dai J. Mental health problems and social media exposure during COVID-19 outbreak. PLoS One 2020; 15: e0231924 [PMID: 32298385 DOI: 10.1371/journal.pone.0231924]

17 Deng J, Zhou F, Hou W, Silver Z, Wong CY, Chang O, Huang E, Zuo QK. The prevalence of depression, anxiety, and sleep disturbances in COVID-19 patients: a meta-analysis. Ann NY Acad Sci 2021; 1486: 90-111 [PMID: 33096968 DOI: 10.1111/nyas.14506]

18 Moise N, Shah RN, Essock S, Jones A, Carruthers J, Handley MA, Peccoralo L, Sederer L. Sustainability of collaborative care management for depression in primary care settings with academic affiliations across New York State. Implement Sci 2018; 13: 128 [PMID: 30314522 DOI: 10.1186/s13012-018-0818-6]

19 Fleishon HB, Itri JN, Boland GW, Duszak R Jr. Academic Medical Centers and Community Hospitals Integration: Trends and Strategies. J Am Coll Radiol 2017; 14: 45-51 [PMID: 27815052 DOI: 10.1016/j.jacr.2016.07.006]

20 Overbeck G, Davidsen AS, Kougaard MB. Enablers and barriers to implementing collaborative care for anxiety and depression: a systematic qualitative review. Implement Sci 2016; 11: 165 [PMID: 28031028 DOI: 10.1186/s13012-016-0519-y]

21 Kates N. Sharing mental health care. Training psychiatry residents to work with primary care physicians. Psychosomatics 2000; 41: 53-57 [PMID: 10665268 DOI: 10.1016/s0033-3182(00)71173-x]

22 Solberg LI, Crain AL, Jaeckels N, Ohnsorg KA, Margolis KL, Beck A, Whitebird RR, Rossum RC, Crabtree BF, Van de Ven AH. The DIAMOND initiative: implementing collaborative care for depression in 75 primary care clinics. Implement Sci 2013; 8: 135 [PMID: 24238225 DOI: 10.1186/1748-5908-8-135]

23 Dong M, Salamanca LF, Medina V, Firpo-Greenwood JY, Carter EJ, Malhotra S, Ortiz Y, Moise N. Patient-level barriers and facilitators to sustaining collaborative care programs for underserved minorities: A qualitative study. Gen Hosp Psychiatry 2020; 67: 169-170 [PMID: 32843204 DOI: 10.1016/j.genhospitality.2020.06.016]

24 Calderone J, Lopez A, Schwenk S, Yager J, Shore JH. Telepsychiatry and integrated primary care: setting expectations and creating an effective process for success. Mhealth 2020; 6: 29 [PMID: 32632367 DOI: 10.21037/mhealth.2020.02.01]

25 Fortney JC, Pyne JM, Mouden SB, Mittal D, Hudson TJ, Schroeder GW, Williams DK, Bynum CA, Mattos R, Rost KM. Practice-based vs. telemedicine-based collaborative care for depression in rural federally qualified health centers: a pragmatic randomized comparative effectiveness trial. Am J Psychiatry 2013; 170: 414-425 [PMID: 23429924 DOI: 10.1176/appi.ajp.2012.12050696]

26 Ramanuj P, Ferenchick EK, Pincus HA. Depression in primary care: part 2-management. BMJ 2019; 365: 1835 [PMID: 30962249 DOI: 10.1136/bmj.3835]

27 Chekroud AM, Zotti RJ, Shehzad Z, Gueorguieva R, Johnson MK, Trivedi MH, Cannon TD, Krystal JH, Corlett PR. Cross-trial prediction of treatment outcome in depression: a machine learning approach. Lancet Psychiatry 2016; 3: 243-250 [PMID: 26803397 DOI: 10.1016/S2215-0366(15)00471-X]

28 Chapman E, Chung H, Pincus HA. Using a Continuum-Based Framework for Behavioral Health Integration Into Primary Care in New York State. Psychiatr Serv 2017; 68: 756-758 [PMID: 28712354 DOI: 10.1176/appi.ps.20170085]
