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ABOUT COVER

Peer Reviewer of *World Journal of Psychiatry*, Ravi N Shah, MD, MBA, Assistant Professor, Chief, Department of Psychiatry, Columbia University Irving Medical Center, New York, NY 10032, United States.
rns2142@cumc.columbia.edu

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

Nathalie Moise, Milton Wainberg, Ravi Navin Shah

ORCID number: Nathalie Moise 0000-0002-5660-5573; Milton Wainberg 0000-0002-9390-4652; Ravi Navin Shah 0000-0001-5611-1269.

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Nathalie Moise, Center for Behavioral Cardiovascular Health, Columbia University Medical Center, New York, NY 10032, United States

Milton Wainberg, Department of Psychiatry, New York State Psychiatric Institute, New York, NY 10032, United States

Milton Wainberg, Department of Psychiatry, Columbia University College of Physicians and Surgeons, New York, NY 10032, United States

Ravi Navin Shah, Department of Psychiatry, Columbia University Irving Medical Center, New York, NY 10019, United States

Corresponding author: Ravi Navin Shah, MD, Assistant Professor, Department of Psychiatry, Columbia University Irving Medical Center, 5 Columbus Circle, 7th Floor, New York, NY 10019, United States. rns2142@cumc.columbia.edu

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

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Core Tip: Primary care has been dubbed the “de facto” mental health system of the United States since the 1970s. Two psychiatrists and an internist at a major academic medical center review difficulties with implementation of collaborative care in academic primary care settings along with novel recommendations to improve dissemination of this evidence based practice.

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INTRODUCTION

Much of the evidence for integrating mental health treatment into primary care settings comes from collaborative care (CC) interventions for depression. While the effect of CC on clinical outcomes like glycemic control has been inconsistent[1], CC has proven effective in improving depressive symptoms, satisfaction, quality of life and costs[2,3], especially among racial and ethnic minorities[4]. Policymakers and researchers designed CC to optimize the care of psychiatric patients, the majority of whom receive mental health treatment in primary care. The last decade saw remarkable improvements in CC implementation and reimbursement[5]. However, the recent coronavirus disease 2019 (COVID-19) pandemic contributed to physical morbidity and mortality but also social isolation, loneliness, economic insecurity, and alarming rates of acute stress, anxiety, and depression among patients[6] and providers alike[7]. Depression for example increased 3-fold in the United States[8], and up to 7-fold according to recent meta-analysis of multiple countries[9]. Few if any recent articles have addressed how best to overcome barriers to CC implementation in the post-COVID era, however. In this perspective, we address emerging barriers and challenges to treating common mental health conditions. In addition, we propose systemic changes to improve the dissemination of mental health treatment in the telemedicine era.

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 of factors contributing 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[5], 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[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[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[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[26]. Patient-preference driven or precise, individualized algorithms (*e.g.*, machine learning) for targeting screening and treatment according to patient depression phenotypes or risk[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[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

Table 1 Recommendations to improve treatment of common mental health conditions in primary care settings**Recommendations**

(1) ACGME requirements should be amended to require dedicated time for primary care physicians to learn self-care/burnout prevention as well as basic problem-solving therapy and psychopharmacological care on outpatient psychiatry rotations or through internal medicine resident-run mental health clinics and for psychiatrists to learn how to supervise other clinicians, including but not limited to: social workers, psychologists, and primary care doctors who function as the primary prescribers; (2) Health systems should streamline communications systems (pagers, cellphones, telehealth) to create access to e-consultations for primary care doctors needing psychiatric expertise; (3) Financial models should align with the long-term need for indirect consultations as well as with new roles of primary care providers and psychiatrists within integrated care settings particularly in the post-COVID-19 financial milieu; (4) Integrated care models should leverage technology to fill administrative functions (such as tracking patient health questionnaire (PHQ-9 forms), develop guidelines for determining when and how to use smartphone treatment applications and self-care resources in primary care settings, and rapidly expand telemedicine to address workforce gaps particularly in socioeconomically disadvantaged groups who face technology-driven disparities; (5) Primary care practices must partner with psychiatry specialty services to create a robust process for referring appropriate patients to specialty mental health care; and (6) Real world effectiveness research should be conducted to elucidate the effectiveness of precisely and efficiently targeting screening and treatment recommendations according to patient phenotype, risk and preference

ACGME: Accreditation Council for Graduate Medical Education; COVID-19: Coronavirus disease 2019.

telehealth and telepsychiatry, 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.

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