Mental Health Care in Family Practice

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An important monograph was recently released reporting the proceedings of a national invitational conference organized by the National Institute of Medicine to examine the benefits, feasibility, and problems of linking the nation's mental health services more closely to primary care.[1] A number of serious problems were identified concerning the availability and quality of existing mental health services. These problems include the following:

1. There are major economic disincentives within present reimbursement policies of third party payers which work against the provision of needed mental health services (particularly ambulatory services).
2. Drug therapy, often used excessively and indiscriminately, is much more common than other psychotherapeutic help.
3. Partly due to time and reimbursement constraints, psychotherapy in some form (usually short-term crisis intervention) occurs in only about one fifth of the primary care visits of patients with mental health problems.
4. Primary care physicians underutilize referrals for specialized mental health care for emotionally disturbed patients.
5. There are still virtually no outcome studies of psychotherapy in primary care patients.
6. The prevalence of mental health problems is largely unknown because of the looseness of some diagnostic criteria and widespread underreporting of these problems in the primary care sector.
7. Cooperative working relationships between the mental health and general medical care systems are rare.

There is general consensus that the primary care physician has an essential role as a principal provider of mental health services, particularly in the areas of prevention, diagnosis, and management of common mental disorders. Studies sponsored by the National Institute of Mental Health have shown that in the United States over one half of all patients with mental health disorders are cared for solely by the primary care sector.[2] It is now well documented that patients with mental health disorders have a higher incidence of organic illness than others without such problems.[3] The utility of the psychobiomedical model of disease and health care is gaining increasing acceptance among primary care physicians in view of the important influence of psychosocial factors upon the occurrence and natural history of disease. Because of his/her long-term contact with all members of the family, the family physician has a special opportunity to prevent, recognize, and treat mental health problems.

From its onset as a clinical specialty, family practice has embraced the psychobiomedical model and the need for family physicians to be well trained in this area. The *Essentials* for family practice residency training[4] have stressed the importance of training in psychiatry and behavioral science. The Residency Assistance Program (RAP) has called for the following as *absolute* requirements for family practice residencies[5]:

> Training in the recognition, diagnosis, and management of emotional and mental disorders alone or as components of organic disease.
>
> Specific training in psychotherapy, psychopharmacology, and psychiatric counseling for a broad spectrum of mental illness, including alcoholism and other substance abuse.

After ten years of experience with family practice residencies, there are now sufficient graduates in practice to begin to assess the extent to which residency trained family physicians are prepared to care for mental health problems and the extent to which they integrate this care into their practices. Several studies have been done to date in this general area, and the results are mixed and somewhat disturbing. On the positive side, three recently reported statewide follow-up studies of

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Table 1. Residency Graduate Perceptions of Adequacy of Training in Psychiatry and Behavioral Science in Three Statewide Networks

Subject Area	Percent of Graduates Who Feel Adequately Prepared		
	University of Minnesota	Medical College of Virginia	University of Washington
Family structure and function	82.5	77.6	66
Psychosomatic problems	85.7	80.4	76
Psychosocial components of major medical illness	82.6	85.0	82
Stages of human development	75.3		67
Behavior disorders	79.6	71.7	67
Psychiatric disorders	80.4		74
Counseling skills	76.9		58

almost 400 graduates showed rather positive perceptions of their preparation in psychiatry and behavioral science (Table 1), but no information is yet available on their actual practice patterns and performance.[6]

Another study of the perceptions and practice patterns of family practice residency graduates is reported in the current issue of this journal and is discouraging with respect to mental health care. Cassata and Kirkman-Liff studied the mental health activities of 199 family physicians (116 residency graduates and 83 nongraduates). They found widespread perceptions of under-preparedness in behavioral science skills, together with extremely low volumes of mental health activities (eg, counseling sessions and referrals comprising only two to four percent of all patient encounters).[7]

In a second paper in this issue, Jones and his colleagues outline a comprehensive and realistic competency based curriculum for mental health knowledge and skills based upon the joint assessments of faculty in both family medicine and psychiatry in one medical school and its family practice residency graduates.[8] Continued reassessment of the content, methods, and outcomes of training in psychiatry and behavioral science is required if family practice is to make the contribution to mental health care which is called for in the community. Beyond the obvious importance of developing more effective teaching programs at all levels in this area, however, is the pressing need to develop and test practical diagnostic and management techniques which can be applied in busy primary care practices, together with revision of present third party reimbursement policies to remove the disincentives to provide time consuming mental health services.

References

1. National Institute of Mental Health: Mental Health Series in Primary Care Settings. Report of an Institute of Medicine Conference, Washington, DC, April 2-3, 1979. Series DN No. 2. DHHS publication No. (ADM) 80-995. Government Printing Office, 1980

2. Regier DA, Goldberg ID, Taube CA: The de facto US mental health services system. Arch Gen Psychiatry 35:685, 1978

3. Eastwood MR, Trevelyan MH: Relationships between physical and psychiatric disorders. Psychol Med 2:363, 1972

4. American Medical Association: Special requirements for residency training in family practice. In: Essentials of Approved Residencies. Chicago, American Medical Association, 1975

5. Family Practice Residency Assistance Program Criteria. Kansas City, Mo, Residency Assistance Program Project Board, 1979

6. Geyman JP (ed): Profile of the residency trained family physician in the United States 1970-1979. J Fam Pract 11:715, 1980

7. Cassata DM, Kirkman-Liff B: Mental health activities of family physicians. J Fam Pract 12:683, 1981

8. Jones LR, Knopke HJ, Parlour RR, et al: Shaping the mental health role of family physicians. J Fam Pract 12: 697, 1981