Mental Health Problems in Primary Care

A Research Agenda

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BACKGROUND. The North American Primary Care Research Group (NAPCRG) Task Force on Mental Health Problems was commissioned to explore critical research and policy issues in mental health and to develop a primary care research agenda for review and action by NAPCRG. This paper presents the key findings and recommendations of the task force.

METHODS. As co-chairpersons of the task force, we performed a comprehensive review of the primary care mental health literature using MEDLINE searches with manual follow-up and personal communications with many active researchers in the field. Task force members participated in the editing and refinement of this paper through electronic mail and a series of face-to-face meetings.

CONCLUSIONS. Rapid changes in the US health care environment threaten to undo the integration of mental and physical health that is at the heart of primary care. It will be necessary for the primary care leaders in the mental health field to step forward to guide policymakers, purchasers, and the public as primary care is reengineered for the next generation. Efforts to use episode of care and comorbidity recording within electronic medical record systems, particularly in cooperation with managed care corporations or primary care research networks, may represent the most effective strategy for promoting the integration of mental health services into primary care. The most promising area for original research may be the exploration of common mental health problems in the context of routine primary care practice.

KEY WORDS. Health services; primary health care; mental health; depressive disorder; health policy. *(J Fam Pract 1998; 47:379-384)*

In recent years, mental health issues have come to the foreground in primary health care. Published estimates of the prevalence of mental health problems in primary care patients continue to rise, as do the number of diagnostic entities contained in the *Diagnostic and Statistical Manual of Mental Disorders* (DSM-IV). Primary care physicians face mounting pressures to improve recognition and treatment of these disorders, despite considerable uncertainty about the epidemiology, severity, and natural history of these problems in the primary care setting and a health care environment that is in a state of rapid change.

The North American Primary Care Research Group (NAPCRG) Task Force on Mental Health Problems, a group of active mental health researchers from the fields of primary care and psychiatry, was commissioned to explore critical research and policy issues in mental health and to define and develop a primary care research agenda for review and action by NAPCRG. This paper reflects the contributions of task force members to date in reviewing published research in this area, describing potential effects of the current US health care environment on mental health research, and determining the areas of highest priority for primary care research efforts.

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THE MENTAL HEALTH RESEARCH ENVIRONMENT

Early Epidemiologic Research on Major Depression

Much of the empirical work examining mental health issues in primary care has focused on major depressive disorder (MDD), and a review of this body of literature provides a useful illustration of the central research and policy issues in the area. Several epidemiologic studies have documented the high prevalence of depression in the primary care setting,[1-7] revealed the considerable functional impairment associated with depressive disorders and subthreshold depressive symptoms,[8,9] and confirmed that a large proportion of all depressed persons receive treatment exclusively in the primary care setting.[10] Subsequent work focusing on detection and treatment of MDD in routine primary care practice showed that many depressed primary care patients were not formally detected by their primary care physicians,[11-14] but sug-

gested that routine feedback of scores on case-finding instruments before office visits could improve recognition rates and increase treatment rates.[15-17] The results of these early studies supported the common wisdom that depression was underdiagnosed and undertreated in primary care, and led to the "screen-detect-treat-improve" clinical paradigm embodied in the clinical guidelines of the National Institute of Mental Health/Agency for Health Care Policy and Research for primary care detection and treatment of depression,[18,19] as well as the recent National Depression and Manic-Depressive Association (NDMDA) Consensus Statement on the undertreatment of depression.[20]

Failure of the Screen-Detect-Treat-Improve Clinical Paradigm

A second wave of observational studies and clinical trials examining the relationships between screening, detection, treatment, and outcome for depressed primary care patients failed to confirm this paradigm. Several observational studies found no difference in short-term clinical outcomes between recognized and unrecognized depressed patients.[21,22] Clinical trials of enhanced detection and treatment protocols for depression[23-25] have largely failed to show improved patient outcomes; the sole exception, the Group Health Cooperative study of collaborative care, noted improved outcomes only for the subgroup of patients requiring medication adjustment.[26] Despite the development of improved primary care mental health screeners, such as the PRIME-MD[27,28] and SDDS-PC,[5,29,30] clinical trials have failed to demonstrate their utility in improving either treatment rates or clinical outcomes for depressed patients.[25] Finally, of the three clinical trials examining guideline-concordant care for MDD, two found no differences in outcome between usual care and guideline-concordant care,[31-33] while the third featured such severe patient selection that it became an efficacy trial.[34] The tenuous connections between detection, treatment, and outcome seen in this work highlight the difficulty of extrapolating specialty-derived clinical evidence and guidelines into the primary care setting.

Although several conventional explanations for the failure of these clinical trials can be made (eg, failure to distinguish prevalent from incident cases, the use of crude outcome measures, and failure to account for independent mental health treatment or comorbid mental health problems),[35,36] it is important to note that these studies all examine a specific mental health problem in isolation from its biopsychosocial context. None of the trials adequately account for the "not otherwise specified" conditions or comorbidity issues that are at the heart of primary mental health care.[37] This oversimplification of the clinical epidemiology of mood disorders in primary care may be at the heart of the inconsistencies seen in clinical trials to date.

Research on Other Common Mental Health Problems

A growing body of work describes the clinical epidemiology of anxiety and panic disorders in primary care,[38-42] but has not yet progressed to clinical trials of screening protocols or enhanced detection and treatment. Published works on detection and treatment of substance abuse in the primary care setting have matured rapidly,[43] but we are only now beginning to explore comorbid mental health and substance abuse problems. A few primary care researchers have begun to study subthreshold conditions[37,44] and the interrelationships of physical and mental health comorbidity.[37,45,46] Comorbidity appears to be overwhelmingly common and crosses all diagnostic categories, obscuring many of the clinical distinctions between specific DSM-IV diagnostic entities.[45-47]

Re-examining the Epidemiology of Mental Health Problems in Primary Care

A few primary care researchers have begun to explore the complex clinical epidemiology of mental health problems in primary care. The works of Barrett et al,[4] Goldberg,[48,49] and Lamberts and Hofmans-Okkes[50] confirmed the inadequacy of the structured DSM-IV classification in capturing the spectrum of mental health problems seen in primary care and suggested alternative ways to classify such problems. Investigators have developed new conceptual frameworks for mental health problems[49-51] and refined the analytic framework of the episode of care.[52] A recent comparison of the domain, scope, and clinical content of 3 primary care mental health classifications (the International Classification of Diseases–Version 10, DSM-IV, and the International Classification of Primary Care [ICPC]) showed that compatibility between classifications is possible, but that differences in scope and clinical content of diagnostic entities make it difficult to move between classifications or to compare patients carrying the same diagnostic label from different classifications.[53] These results highlight the importance of determining a common theoretical framework for research on mental health problems in primary care.

Qualitative and descriptive studies of detection, classification, and treatment of depression in routine primary care practice have confirmed the importance of time spent and the physician-patient relationship[54-56] and highlighted the limited utility of formal diagnostic assessment.[55] Recent work has examined the consequences of "misclassification" of depression in primary care, finding that undetected patients with MDD have equal or better outcomes than detected patients,[21,22] that physicians appear to effectively use clinical cues to detect patients who are most severely impaired,[57,58] and that physicians provide psychosocial care for many patients without recording a formal diagnosis.[59] Crabtree and colleagues[60] have begun to explore the relationship between practice structure and provision of preventive services, an area with clear paral-

lels to the provision of mental health services. A "competing demands" model for detection and treatment of mental health problems in primary care has been developed on the basis of this exploratory work.[35]

This body of work offers a critical reappraisal of the clinical epidemiology of mental health problems and the process by which clinicians appear to recognize and manage these problems in routine primary care. The conceptual foundation of this work is that mental health problems are an integral part of primary care and are best studied within the milieu of everyday practice, using tools that enable symptom-level diagnoses and capture episodes of care.

THE MENTAL HEALTH POLICY ENVIRONMENT: CARVE-OUTS AND FRAGMENTATION

During the past decade, increasing competition in the health care environment has led to growing conflict over the interface between primary and specialty care. The issue has now emerged in the area of mental health services. Published results from the Medical Outcomes Study (MOS) suggested that care provided by primary care clinicians for depressed patients was less cost-effective than that provided by mental health specialists.[61] Although this study contained serious methodologic limitations, it has had a great deal of influence on mental health policy, as seen in the recent NDMDA Consensus Statement on the undertreatment of depression.[20]

With only the MOS results to guide policy, many insurers have taken a narrow approach to mental health problems and treatment, defining mental health problems strictly in terms of DSM-IV diagnostic criteria and moving them into the jurisdiction of mental health specialist providers. Some carriers continue to deny reimbursement for mental health treatment by primary care physicians.[55-62] Commercial managed health care vendors have developed subcontracted, capitated mental health service benefit packages for enrollees; more than half of all managed care patients in the United States are now covered by these carve-outs or carve-ins.[63] State Medicaid programs are increasingly turning to managed health care to solve the problem of rapidly escalating cost,[64] with mental health care carve-outs now commonplace in Medicaid managed care plans.[65,66] These arrangements create a separate system of mental health care operating in parallel to primary health care and marginalize the role of primary care physicians in the detection and treatment of mental health problems. Although the public health consequences of carve-outs are not yet known, the fragmentation of care resulting from their implementation may have profound implications for higher-risk populations.[67]

Health policy leaders have just begun to address this issue. The publication of the Institute of Medicine (IOM) report, *Primary Care: America's Health in a New Era*,[68] provided tangible support to the concept that mental health problems are an integral part of primary care. One of the report's recommendations explicitly addresses primary care and mental health:

> The committee recommends the reduction of financial and organizational disincentives for the expanded role of primary care in the provision of mental health services. It further recommends the development and evaluation of collaborative care models that integrate primary care and mental health services more effectively. These models should involve both primary care clinicians and mental health professionals.

At present, the health care marketplace is changing so rapidly that it is difficult to study, and there is almost no information available to guide those responsible for making decisions about the structure of primary care services. It is not yet known whether the IOM report will have sufficient influence to counteract market forces that appear to favor fragmentation of care.

RESEARCH PRIORITIES FOR PRIMARY CARE

The need for primary care research on mental health issues has never been more acute. There is growing awareness of the shortcomings of the top-down, DSM-IV diagnosis–driven approach to mental health care in the complex world of primary care, but we have not yet clearly articulated a bottom-up approach that can provide a more accurate view of mental health problems as they exist in primary care. Primary care researchers have an unprecedented opportunity to influence the development of health policy in this area, and there are several factors that suggest that we are on the threshold of a new era of productive and influential mental health research.

First, as emphasized in the IOM report, care for mental health problems is an integral part of optimal primary care. Research on mental health problems should therefore be an integral part of primary care's academic foundation. Second, the conceptual framework and tools required for research in this area have been developed and refined by primary care researchers. These include ICPC and episode-based recording, the crosswalk between ICPC and specialty diagnostic classifications, new conceptual frameworks that accurately capture the process of primary care, and the growth and maturation of primary care research networks such as The Ambulatory Sentinel Practice Network (ASPN), which can serve as our health services laboratories. Third, there is an emerging critical mass of primary care researchers with expertise in this area, as seen in the work of the investigators cited in the previous section.

However, there are significant barriers to overcome in developing a meaningful presence in the mental health

research community. One major barrier is the development of consistent sources of funding. Traditional funding sources such as the National Institute of Mental Health have maintained a narrow focus on community-based epidemiologic surveys, outcome-based studies limited to threshold DSM-IV diagnoses, and a preference for those with track records; this has largely precluded funding for studies exploring the epidemiology and management of mental health problems in the context of routine primary care practice. Private foundations have provided only scattered support for basic descriptive research or methodologic development in this area, with the recent MacArthur Foundation Depression in Primary Care Initiative a notable exception. The current health care environment presents other barriers: mental health carve-outs in an expanding managed care market and "turf" battles with specialists that threaten to Balkanize the core clinical content of primary care. The environment is changing so rapidly that an orderly progression of scholarly inquiry in this area may be an unaffordable luxury.

Dissemination of Current Knowledge

For research results to influence the current policy debate, it will be necessary to aggressively disseminate current knowledge as well as create new knowledge. Dissemination can be aimed at purchasers of research (funding agencies) as well as purchasers of primary care (health insurers, managed health care organizations) and could include: (1) collecting, collating, and promoting the contributions to this field made by primary care researchers, particularly in the areas of mood disorders and substance abuse; (2) influencing funding priorities for agencies and foundations by promoting and critiquing existing work; (3) collaborating with managed health care corporations to promote integration of mental health and biomedical care and to develop methods for assessing the cost-effectiveness of integrated care; and (4) moving research directly into the community by belonging to community groups interested in mental health issues and participating in medical center or state initiatives regarding mental health services, such as state Medicaid managed care initiatives. The NAPCRG task force has collected examples of current activities in each of these areas.

Creation of New Knowledge

The most pressing need by far is for descriptive studies that accurately capture the clinical epidemiology of common mental health problems as they occur in the primary care setting, including their development over time and the presence and impact of medical and mental health comorbidities. These studies will provide the data necessary to construct the bottom-up approach to mental health problems as they will allow researchers to determine whether the subthreshold and undifferentiated mental health problems so common in primary care can be categorized into distinct groups with meaningful implications for treatment. For example, a cohort of patients presenting with subthreshold depressive symptoms may be tracked to observe patterns of comorbidity, functional and health status, and the emergence or regression of other mental health problems or disorders over time.

Another area in which research is clearly needed is the exploration of the interaction among physician, patient, and practice environment in detecting, managing, or preventing psychosocial and mental health problems. Examples of this type of work include: describing and measuring the physician-patient interactions that ultimately determine the outcome of detection and treatment; exploring the effects of the practice environment on mental health care; assessing the impact of competing demands on the provision of psychosocial care; and identifying and characterizing exemplary practices.

A third area of high priority lies in exploring the interface between primary care physicians and mental health professionals by identifying optimal models of collaborative care and determining the most effective ways to structure the delivery of mental health care to defined primary care populations.

To carry out this work, it will be necessary to structure data in a way that allows examination of episodes of care and captures the medical and mental health comorbidity that defines the context of primary care practice. The Dutch Transition project [52] provides the best current example of this structured approach to primary care data collection, with project investigators now moving forward to put into practice their conceptual model in an electronic medical record (H. Lamberts, personal communication). Efforts to develop similar data collection capacity in the United States should receive the highest priority, and may be the natural place for investigators to build alliances with managed health care corporations.

A high priority should also be given to developing primary care research networks capable of longitudinal, episode-based data collection on mental health problems and the clinical context in which they occur. These might be existing networks or dedicated new mental health research networks. Network-based studies can achieve levels of power and generalizability not attainable by studies from single locales and they offer great promise for research that can influence health policy.

CONCLUSIONS

Primary care researchers have made major contributions to our growing understanding of mental health problems as they exist in the real world of primary care. Rapid changes in the US health care environment threaten to undo the integration of mental and physical health that is at the heart of primary care. It will be necessary for the primary care leaders in this field to step forward to guide policymakers, purchasers, and the public as primary care is reengineered for the next generation. Efforts to put into

practice episode of care and comorbidity recording within electronic medical record systems, particularly in cooperation with managed care vendors and primary care research networks, may represent the most effective strategy for promoting the integration of mental health services into primary care as recommended by the IOM. The most promising area for research in the immediate future may be descriptive studies that explore the clinical epidemiology of common mental health problems as they occur in routine family practice.

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Editor's Note: This article by Klinkman and Okkes and the accompanying editorial by Lebowitz raise a number of interesting questions and suggest important opportunities for research on mental health and primary care. These two pieces will also be published in the *International Journal of Psychiatry and Medicine* and are posted on *The Journal of Family Practice* Web site. The Web site offers the opportunity for readers from both the family practice and mental health communities to respond to the issues and challenges raised. To join this discussion, go to www.jfp.denver.co.us and select "Mental Health Research Agenda" from the main menu. Your comments will posted as part of the ongoing discussion, and may be edited for space.