A Call to Action: The Need to Develop, Study, and Refine Integrated Care Models for the Severely Mentally-Ill Population in Primary Care

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The 2004 National Comorbidity Survey Replication found a 26.2% 12-month prevalence of mental disorders, 23.3% of which were classified as serious.\(^1\) Practice guidelines exist for the treatment of mental disorders, including depression\(^2\) and bipolar disorder\(^3\) using traditional hierarchical approaches, with mild to moderate cases treated in primary care and serious, complex, or refractory cases referred to specialty mental health practices. However, this is not the practice in many communities.\(^4\) This commentary reviews the current practice landscape, highlighting the fact that many people with serious mental illness are receiving mental health care from their primary care providers, how mental health practices in primary care settings can be structured to provide these services, the lack of a meaningful evidence base for these models, and a call to action to address this gap in research and practice.

Primary care providers are taking care of much more than mild to moderate anxiety and depression. A study by the CDC found there were 63,000 outpatient visits for schizophrenia in 2009-2010, 34,046 of which occurred in specialty mental health and 20,875 (38%) in primary care.\(^4\) Also concerning is that many patients who are referred to specialty mental health services fail to follow up there, or follow up too infrequently to receive adequate care.\(^5\) In one study looking at managed care referrals for depression, 22% of the patients who called looking for therapy did not make a single visit in the next 90 days; only 57% attended 2 or more sessions.\(^6\) Less severe depression at the time of the initial phone call was associated with higher attrition, but one-third with severe depression dropped out prior to the second visit.\(^6\) While the service use patterns for individuals with serious mental illness vary from study to study, in some studies, up to one-third of those suffering with schizophrenia, bipolar I, or schizoaffective disorder who have contact with specialty mental health practices will drop out of treatment.\(^5\) Also concerning is that in one study, 18%-67% (median 58%) of individuals who are hospitalized with a severe mental illness “no showed” for their first post-hospitalization outpatient appointment.\(^5\)

Why patients do not follow up with referrals to, or disengage from, specialty mental health services is not well understood. Many theories have been put forth: stigma, a positive relationship with a primary care provider and/or clinic, lack of transportation to specialty clinics, lack of resources to afford specialty care, a belief that they can take care of their mental health issues on their own, cultural beliefs, preference, and previous bad experience at a specialty clinic.\(^6,7,8\)

More detailed characterization of the population who seeks mental health care in primary care could serve as the basis for targeted integrated care interventions. One health center found that while 20.9% of their studied population reported psychotic symptoms, diagnostic evaluation revealed only 7.1% had a psychotic disorder.\(^9\) Most had typical forms of less severe mental illness, including major depressive disorder, panic disorder, generalized anxiety disorder, alcohol use disorder, and borderline personality disorder.\(^9\) Psychotic symptoms were associated with higher degrees of reported impairment in work, social, and family functioning, and were inversely related to income.\(^9\) This highlights several potential integrated care interventions: (1) the screening of all patients for psychotic symptoms, (2) the referral of those who screen positive to integrated behavioral health clinicians for differential diagnosis, and (3) the subsequent development of a team-based treatment plan that incorporates individual psychological, psychosocial, and medication needs.

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Factors including variable access to care, workforce shortages, and a growing population suggest that primary care providers will increasingly be asked to treat patients with serious mental illness. A national survey of physicians found that half of all psychiatrists do not accept Medicaid or Medicare, and a little less than half of psychiatrists do not accept private fee for service insurance, with some regional variability. Percentages of psychiatrists accepting insurance has been decreasing. Furthermore, the psychiatry workforce is aging; more than half of the psychiatrists currently practicing are 55 or older. Without significant changes, it is unclear how the mental health needs of our growing population will be met.

Clinical innovators, recognizing the need, developed the Collaborative Care Model (Impact Model) to improve the usual care of depression and anxiety in primary care demonstrating improved quality of treatment and decreased health care costs. The Impact Model team members include the primary care provider (PCP), an embedded Behavioral Health Consultant (BHC), and a consulting psychiatrist. Cases are referred to the BHC for diagnostic evaluation and brief treatment. The psychiatrist, working in a step-wise fashion, reviews cases with the BHC, prioritizing complex and refractory cases, providing medication and other treatment recommendations that are implemented and followed by the PCP and BHC. Patients who do not improve are seen by the psychiatrist. This model allows for the psychiatrist to manage more patients than they would otherwise be able to, and the team to manage the needs of their clinic population.

Integrated care has continued to evolve. In some models, like the Primary Care Behavioral Health Model (PCBH), the BHC accepts all referrals, optimally in conjunction with a PCP appointment. The PCBH model, compared to the Impact Model, has the potential to intervene on more patients, but does not utilize a registry to track individual patients or to manage the population. In integrated care practices that do not restrict access by diagnosis, clinicians end up treating the seriously mentally ill.

Yet, there is a gap in the literature regarding clearly-defined models for the treatment of the severely mentally-ill population in primary care. There are no guidelines describing the treatment of the seriously mentally ill in primary care practices. A Cochrane review of approximately 330 articles found only 1 randomized-controlled trial. They concluded that there was no evidence to support the use of collaborative care (here a generalized term) in schizophrenia, and there was only 1 low or very low quality study addressing the use of collaborative care to treat bipolar disorder, the findings of which could not be generalized to the seriously mentally-ill population. These findings are disheartening and counterintuitive, given what we know about where people with seriously mental illness obtain treatment. More recently, patients with bipolar disorder who were treated in a primary care clinic using the Impact Model were studied. Patients with bipolar disorder, on average, had more housing concerns and were more likely to lack dependable transportation than seen in a prior study of depressed patients at the same site. They also tended to receive more intensive services, possibly related to the high number of comorbidities and a high rate of suicidal ideation. Interestingly, only 26% were referred to specialty mental health care. While the authors did not assess the reasons for the lack of referrals, they noted limited resources and patient preference as possible explanations.

This author co-designed a proposed model for the treatment of Schizophrenia Spectrum and Other Psychotic Disorders in integrated care that will be published in Psychiatry, Primary Care & Medical Specialties: Pathways for Integrated Care. The proposed model incorporates existing fundamental integrated care practices, the clinical integrated care experience of the authors at the Denver Health Medical Center, and current specialty-focused guidelines. The proposed team is an enhanced one and includes the PCP, the BHC, the psychiatrist, as well as clinic navigators/care coordinators, health coaches, social workers, and clinical pharmacists. The team coordinates care and prioritizes patient needs via monthly team meetings and weekly meetings between the BHC and the psychiatrist (involving others as needed). Key components include the identification of patients with psychotic symptoms, initial evaluation (including assessing for medical and psychiatric emergencies), a full bio-psycho-social evaluation, and treatment via multiple modalities (medication, supportive psychotherapy, social skills training, cognitive behavioral therapy, group therapy, vocational rehabilitation, and substance abuse treatment) occurring in the community or in the clinic. In addition to treating a patient’s primary psychiatric disorder, the team screens for and
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treats co-occurring medical conditions, co-occurring psychiatric conditions (eg, substance abuse, and trauma), all of which are tracked in a registry. Special attention is paid to the identification and management of emergencies (psychiatric and medical), to transitions of care (emergency room and hospital), and the potential to identify and offer targeted interventions to high utilizers is described. Emphasizing a team approach, the treatment intensity and team members involved vary, responding in real time to changes in clinical presentation. In this way, the model is very flexible, more closely resembling existing integrated-care models at some times and traditional specialty-care models at others.

With limited access and barriers to specialty mental health care, and patient factors such as preference, those with severe mental illness are increasingly treated by primary care providers. As psychiatrists age and opt out of insurance plans, the burden on primary care systems will only increase. While this may seem like a daunting task, as collaborative care models are not fully developed, there is a historic opportunity upon us. The call to action is as follows: psychiatrists and psychologists, and master’s-level clinicians, united with their primary care partners, need to further develop, study, and refine integrated care models to treat the seriously mentally ill. Those models that take into account clinic population and resources, community resources, and specialty provider availability are a priority. Clinicians may need to use multiple models, applying different types and levels of intervention based on the patient need. Further, clinicians need to describe in the literature what is and is not working. Outcome studies are essential for the needs of both patients and providers in the primary care setting and the efficacy of these enhanced integrated care models. Given the present and likely future systemic realities, there is no time to lose.

References