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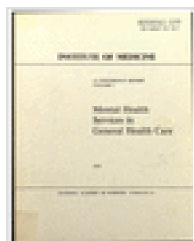

Mental Health Services in General Health Care: Summary of the Invitational Conference on the Provision of Mental Health Services in Primary Care Settings, April 2, 3, 1979, Washington, D.C. (1979)

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Abstract: Most modern mental health professionals agree that a major component of primary health care should be the attention to psychosocial needs. There is less agreement, however, about how to accomplish and maintain that goal over the long term without stretching the definition of health service, pushing the cost of health care too high, or further complicating government regulation of services. Questions of linking mental health and general health care were taken up at an 'nvitational conference April 2-3, 1979, conducted by the titute of Medicine in Washington, D.C. This volume is a ---not the full verbatim proceedings--of that conference. keynote presentation summaries, summaries nine ions, and full texts of five papers nce.

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MENTAL HEALTH SERVICES IN GENERAL HEALTH CARE: VOLUME 1

CONFERENCE REPORT

Summary of the Invitational
Conference on the Provision of
Mental Health Services in
Primary Care Settings,
April 2, 3, 1979, Washington, D.C.

Division of Mental Health and Behavioral Medicine
Institute of Medicine

Supported by the National Institute
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This conference summary was developed by the staff of the Division of Mental Health and Behavioral Medicine, Institute of Medicine, with the advice and assistance of the conference's principal speakers and workshop participants. Major themes, conclusions, and suggestions included in this summmary are reported to provide a full record of the conference deliberations. Their inclusion, however, does not represent policy statements by the Institute of Medicine.

The Institute of Medicine was chartered in 1970 by the National Academy of Sciences to enlist distinguished members of appropriate professions in the examination of policy matters pertaining to the health of the public. In this, the Institute acts under both the Academy's 1863 Congressional charter responsibility to be an advisor to the federal government, and its own initiative in identifying issues of medical care, research and education.

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I

INTRODUCTION

A Conference on Provision of Mental Health Services in Primary Care Settings was held April 2 and 3, 1979, at the National Academy of Sciences in Washington, D.C. The conference was organized by the Institute of Medicine, through its division of Mental Health and Behavioral Medicine. Support was provided by the Division of Mental Health Services Programs, National Institute of Mental Health, Department of Health, Education, and Welfare.

The meeting was designed to examine the benefits as well as the potential disadvantages and difficulties in linking mental health services and primary care in a coordinated approach to health care. Specific conference objectives were to:

- o consider how linkage can take place between primary care and mental health services without causing additional costs or regulatory burdens, and without compromising the autonomy of the mental health system
- o identify potential risks of linkages between health and mental health toward an end of assisting the federal government in developing realistic regulations, guidelines and evaluation procedures
- o develop an agenda for future studies in health and mental health services research.

The conference had both plenary and small group sessions, a structure that enabled presentation of major papers to all conference participants and discussion of particular issues in smaller invitational workshops. Appendix A lists the full conference agenda. David A. Hamburg, M.D., President, Institute of Medicine, National Academy of Sciences, chaired the plenary sessions. The first day presentations were keynoted by Herbert Pardes, M.D., Director, National Institute of Mental Health; Merle Cunningham, M.D., Bureau of Community Health Services, Health Services Administration, speaking on behalf of Edward Martin, M.D., Director, Bureau of Community Health Services; and Gerald L. Klerman, M.D., Administrator, Alcohol, Drug Abuse and Mental Health Administration. Michael Shepherd, M.D., Professor of Epidemiological Psychiatry, Institute of of Psychiatry, University of London, addressed the conferees at the plenary session opening the second

day of the meeting. His paper "Mental Health as an Integrant of Primary Care" highlighted some key issues that were considered in the smaller workshop sessions held following his presentation. The papers presented at the plenary sessions are summarized in Section IV. An integrated summary of the three invitational workshop discussions is contained in Section V. Appendix B lists the participants invited to attend the workshops. The afternoon of the second day concluded with a panel discussion, summarized in Section VI, on future directions in coordination of mental health services in primary care settings. Julius Richmond, M.D., Assistant Secretary for Health, Department of Health, Education and Welfare; George Lythcott, M.D., Administrator, Health Services Administration and Gerald Klerman, M.D., were the discussants.

Five papers were commissioned by the Institute of Medicine specifically for this conference. An abstract of each of these papers appears in Section IV where major presentations are summarized. The full text of each is contained in Section VII.

The design of this conference included an opportunity for paricipants to submit post-meeting comments on issues raised in the sessions, or on areas that, in the writer's opinion, need further examination. These "postscripts" are included as Appendix C of this conference summary.

Volume 2 consists entirely of a principal background paper for the conference, "Coordinated Mental Health Care in Neighborhood Health Centers," by Jonathan Borus, M.D. and colleagues. An earlier version of this monograph had been developed in 1977-78, for submission to the President's Commission on Mental Health.

II

BACKGROUND AND OVERVIEW

The recognition of benefits from a strengthening of the relationship between general medicine and psychiatry in hospitals has stimulated interest in extending the coordination of medical and mental health care to ambulatory primary care. Better coordination of mental health services with primary care holds a promise of better treatment for disturbed individuals in the general health care system who are not referred for specialized mental health care.

The potential benefit of the general health care system to the delivery of mental health care is illustrated by recent epidemiological findings: (1) at any one time, 15 percent of the American population suffers from some form of mental disorder; (2) 21 percent of identifiably disordered individuals receive specialty mental health services; (3) 54 percent of identifiably disordered individuals are seen only in the ambulatory general health care sector, 3 percent are in nursing homes or general hospitals, and 20 percent are in contact with no recognized health care providers of any kind. 1/

In addition to those with identifiable mental disorders, a great many patients seen in primary care settings have significant emotional or behavioral problems expressed as somatic symptoms or personal distress. The onset of physical illness often is precipitated by psychosocial stress or elicits maladaptive behavioral responses. Failure to recognize a correlation of physical and behavioral factors can impair the restoration of the patient to health. The limitations of specialty mental health resources, however, would make it difficult for the mental health sector to absorb high numbers of patients with mental disorders being seen in the primary care sector. To provide appropriate care to those who need it, closer ties between mental health services and general health care should be effected in the organization of health care delivery, the training of both health professionals and mental health professionals, and the financing of health care.

The 1966 Report of the Citizens Commission on Graduate Medical Education stated the shortage of physicians delivering general medical care was the leading deficiency of the U.S. medical care system. The Commission promoted the concept of the "primary physician" who would "serve as the primary medical resource and counselor to an individual or family." 2/ In the more than ten years since the publication of the report, training of more primary care physicians has been advanced by legislation and other health policy decisions. In 1976, the Health Professions Education Assistance Act (Public Law 94-484)

encouraged development of training programs for ambulatory care-based primary care physicians in order to increase their number and thereby accomplish certain improvements in health care for the American people. It was expected that elimination of certain deficiencies in the health care system (such as limited comprehensiveness of treatment, disrupted continuity of care, maldistribution of physicians, high costs, and overly technical focus of the medical profession) would be accomplished by the implementation of this legislation.

Other developments in medical education have indicated a growing appreciation of the need to train physicians to recognize the role of psychosocial factors in illness, and of the impossibility of separating the mental and physical aspects of health care. There are increased emphases on social and behavioral sciences in medical curricula, promotion of primary care residency training programs with psychiatrists and other mental health specialists helping in the design and collaborative teaching arrangements, and development of neighborhood health centers and pre-paid health plans with psychiatric components.

The President's Commission on Mental Health in its report submitted to the White House in April, 1978, emphasized a need to strengthen the working alliance between mental health and the general health care system:

> General health care settings represent an important resource for the mental health care in the community. There is ample evidence that emotional stress is often related to physical illness and that many physical disorders coexist with psychological disorders. While general health care settings frequently serve as an entry point to the mental health care system, many millions of persons with some level of mental disorder are never referred to mental health specialists. They are cared for by office-based practitioners, in industrial health care settings, in homes, in general hospital outpatient clinics and emergency rooms.
>
> While the interdependence of the mental health and general health system is evident, cooperative working arrangements between health care settings and community mental health service programs are rare. If we are to develop a truly comprehensive system of mental health services at the community level, greater attention must be paid to the relationship between health and mental health.

As initial steps toward coordinating the working alliance between the health and mental health systems, the Commission recommended

o Funding by the Department of Health, Education, and Welfare of a limited number of research projects to assess integrated general health care and mental health care services.

o Requiring community mental health centers and community mental health service programs, where appropriate, to establish cooperative working arrangements with health care settings.

These arrangements should allow for:

a) mental health personnel to provide direct care and treatment in the health care setting to patients with emotional disorders whose problems exceed the skills of non-psychiatric health care practitioners;
b) consultation directed toward altering behavioral patterns that increase the risk of physical illness;
c) collaborative treatment with non-psychiatric health care practitioners for those patients with combined physical and mental illness; and
d) training non-psychiatric physicians and other health care personnel to enhance their skills in the treatment of patients with relatively mild emotional disorders. 3/

Strategies for implementing these recommendations of the President's Commission on Mental Health have been developed on the agency policy level and at the legislative level. The Department of Health, Education, and Welfare has supported a number of activities to encourage linkages between health services and alcohol, drug abuse, and mental health services to promote a comprehensive health system. Notable among these is an agreement between the Alcohol, Drug Abuse, and Mental Health Administration and the Health Services Administration to spend $1.5 million of Community Health Center funds to provide on-site mental health personnel, and encourage linkages of community health centers with a nearby mental health center. Fifty-seven linkage grants were approved for funding in fiscal year 1979. The Mental Health Systems Act (S.1177) introduced in the Senate in May, 1979 is the Carter Administration's proposal for reform of the nation's mental health program. Title IV, Section 404, would authorize grants to assist ambulatory health care centers to participate in provision of mental health services to their patients.

An Institute of Medicine conference, which this report summarizes was convened to examine some of the underlying concepts and long range implications of these "linkage" efforts. Major themes of the

conference were developed by individual speakers and in workshop sessions. These themes are outlined briefly in the pages that follow.

Definitions of Primary Health Care and Mental Health Services

In the 1978 Institute of Medicine report, "A Manpower Policy for Primary Health Care," primary care is defined as "accessible, comprehensive, coordinated, and continual care provided by accountable providers of health services." 4/ The five essential attributes of primary care as it should and could be practiced in the United States today were described as follows:

(1) Accessibility of care refers to the provider's responsibility to assist patients or potential patients to overcome temporal, spatial, economic, and psychologic barriers to health care; i.e., to promote the availability, attainability, and acceptability of services provided.

(2) Comprehensiveness of care refers to the willingness and ability of providers to handle the great majority of health problems arising in the populations served (which may be limited to a given age group or sex). While the primary care practitioner may have an area of special medical interest, his or her services are not restricted by concentration on that specialty.

(3) Coordination of care denotes the primary care practitioner's role as ombudsman, coordinating the total care — including that provided by specialists — of his or her patients. This role presupposes awareness of patients' financial capabilities and personal desires.

(4) Continuity of care depends largely on the first three attributes of primary care, requiring active commitment on the practitioner's part to maintaining an ongoing relationship with each patient. Record-keeping is an important aspect of continuity.

(5) Accountability requires that primary care providers review regularly both the process and outcomes of care with attention to potential improvement, and also entails commitment to ensuring that patients are informed decision-makers. Providers also should respect their obligation to maintain appropriate financial accountability, including adequate professional liability coverage.

Primary care generally is recognized as the first level of personal health services, in which initial professional attention is paid to current or potential health problems. Primary care frequently is associated with care of the "whole person" as opposed to care for an

illness. Primary care is distinguished from other levels of personal health services by the scope, character, and integration of the services, and is not necessarily limited to provision by any particular type of practitioner or practice setting.

Mental health services (primary mental health services) are defined in terms of direct and indirect care to patients with mental disorders in ambulatory settings. 5/ Direct services consists of diagnostic and problem evaluation, crisis intervention, individual, group and family psychotherapies, supportive counselling, prescription of psychoactive medication, and post-hospital care for the chronically mentally ill in the community. Indirect and preventive services are provided through consultative and collaborative arrangements with schools, welfare agencies, police, and a wide range of other community organizations. In some settings the provision of these mental health services is almost exclusively in the domain of specialty mental health professionals: psychiatrists, psychiatric social workers, psychologists, or psychiatric nurses. In other settings, these services are provided by the primary health care provider trained in mental health skills.

Nature and Scope of Mental Health Problems in Primary Care

Epidemiologic and health services utilization studies suggest that the number of patients with psychiatric disorders seen in primary care settings is higher than indicated by current data. It cannot be determined, however, whether the majority of the mentally ill have always been treated by the general health practitioner or whether these patients have become more numerous in the past few years. In the absence of completely objective criteria, researchers have used a variety of techniques to identify the rates of psychiatric morbidity in primary care settings. The reported rates of mental disorder vary with its definition, with the method of case identification, and with the setting and the sampling method.

An increase in the medical treatment of mental disorders, specifically pharmacotherapy, and in outpatient treatment make it not surprising that the majority of the mentally ill already are being cared for by primary care practitioners. Several studies have suggested factors that act as barriers to the use of specialized mental health services, including 1) patient fear of stigma associated with psychiatric treatment; 2) the generally high cost of psychiatric treatment, limited private insurance coverage, and the major portion of public funds spent on inpatient care, particularly long-term institutionalization; and 3) the patient's lack of knowledge about the availability and nature of specialized mental health services. Advocates of integrated mental health and general health services in prepaid plans or community health centers contend that those arrangements improve access to mental health professionals. Such health care models, typically report relatively high utilization rates of mental health services.

The distribution of mental illness by health care models is important to note. Of research conducted to date, eighteen studies from fee-for-service settings indicate prevalence rates ranging from 4 to 39.6 percent; studies from prepaid practices indicate a range of prevalence for mental illness from 1.2 to 14.6 percent; and studies from community health centers indicate a range of 15.6 to 50 percent. Finding the lowest rates of disorder in prepaid practices may reflect particular incentives in such plans to under-diagnose.

Some data suggest that referral rates among health care delivery models are highest in prepaid settings, perhaps because of a physical proximity of health and mental health professionals in those and certain community health center settings. Proximity encourages close relationships, making referral more feasible and attractive both to the patient and the referring physician.

Models for Coordinated Mental Health and Primary Care Services

There is general agreement that implementing the linkage of the mental health system and the general health service system in the United States requires the development of many conceptual and organizational models for health care. There are at present three principal types of health care delivery in this country: fee-for-service, prepaid, and community health centers.

Fee-for-service health care is the predominant type of health care in the United States for both general medical services and mental health services. The distinguishing feature of fee-for-service health care is that physician services are purchased on an individual basis. Availability of non-specialty mental health care from a fee-for-service primary care practice appears to depend largely on the individual primary care physician's training, skills, personal interest, and individual practice style. Economic incentives or disincentives also are likely to have significant effect on the kind and extent of mental health service in this setting.

Prepaid health care, typified by health maintenance organizations (HMOs), is a system in which subscribers pay a prearranged amount for an established set of medical services, which may or may not include mental health care. Physicians delivering prepaid health care are usually salaried. Prepaid health care plans currently cover only about 3 percent of the American population, mostly middle-income families.

Federally-funded HMOs are required to provide enrollees with up to 20 visits per year to mental health clinicians, along with unlimited visits to primary physicians for treatment of emotional problems. In keeping with the traditional separation of health and mental health services in this country, HMOs typically have set up separate psychiatric clinics for referrals within their organizations

or have purchased specialized psychiatric services outside of the plan.

Community health centers are much like prepaid health plans in that a geographically defined population is provided a comprehensive set of medical services. Almost all employ salaried physicians. These centers are largely subsidized by public funds and provide free or low-cost services to disadvantaged persons.

Identification and Management of Mental Health Problems in Primary Care Settings

Although many patients with disorders that are both distressing and disabling seek primary care, it appears that primary care providers identify only a limited number of such patients who could benefit from specialty mental health care. A small segment of the adult primary care population may be utilizing medical services at high levels in an effort to remedy their undetected chronic psychiatric disorders.

Studies have shown that primary care case identification improved where mental health and primary care services are integrated professionally, administratively, and structurally — particularly when the physical setting is shared and when training takes place in the primary care setting. Formal hospital consultation liaison applied to ambulatory care settings may also improve case identification. However, case detection does not guarantee successful, or even feasible, treatment.

A lack of uniformly applied diagnostic criteria is documented by many surveys of mental disorders among patients attending primary care physicians. These studies have shown wide variations among individual practitioners' estimates of the frequency of such conditions, although psychiatric screening tests used during the surveys typically show less variation between various practice populations than indicated by the physician assessments. It has been suggested that differences in physician assessments may reside not in the patients but in the physicians' concepts of psychiatric disorder and the threshholds adopted for case identification.

There is general agreement that high priority needs to be given to developing more effective screening and evaluation of psychiatric illness in primary care settings. Further study is needed of the interaction of the three dimensions — syndromes, functional status, and socially unacceptable behavior — that furnish the basis for the widely used Research Diagnostic Criteria (RDC) evaluation. Improved detection of psychiatric illness by primary care providers could promote more appropriate therapeutic interventions and decrease the financial burden on the ambulatory medical care system.

Little is known of the treatments provided to patients with mental disorders or other emotional or behavioral problems who remain in the general health care sector. Referrals for mental health services usually are low; even when primary care physicians identify patients as emotionally disturbed, they are likely to make a referral for specialized mental health care for only one in 10 to 20 such patients.

In terms of treatments received by emotionally disturbed patients from family physicians, evidence suggests that drug therapy is more common than other psychotherapeutic help, including counseling and referral to specialists. Evidence on the appropriateness of drug prescriptions, however, is not encouraging, and suggests a need for further research on the utilization of psychotropic drugs in the management of emotionally ill patients by primary care physicians. Unresolved questions include: 1) When are such prescriptions appropriate? 2) Are psychotropic drugs efficacious when used alone, or should they always be combined with psychotherapy? 3) Is management of psychiatric patients with psychotropic drugs cost-effective relative to other alternatives? 4) What is the quality of psychotherapeutic prescribing by primary care physicians? 5) When should patients be referred to psychiatrists for drug therapy?

Although definitions of psychotherapy vary, 60 to 80 percent of patients with recognized mental disorder reportedly receive such therapy in some form from their primary care physicians. However, such therapy occurs in only 22 percent of the patient visits, and the difficulty of conducting formal psychotherapy due to time constraints in primary care settings are cited frequently. Although short-term life crisis therapy seems to be emphasized, with more than half of the patients receiving psychotherapy in one to four visits, there is little data on the intensity and nature of psychotherapy in general. Studies on psychotherapy outcomes among primary care patients are almost nonexistent.

Unanswered questions about psychotherapy by primary care physicians include: 1) For which patients is primary care psychotherapy indicated, rather than psychiatric referral? 2) Which psychotherapeutic techniques are most successful for a specific diagnosis? 3) Is psychotherapy cost-effective in this setting?

Education and Training

The relationship between general health and mental health has important implications for the training of both health professionals and mental health professionals. Given the substantial amount of mental illness identified and treated in general medical practice, there was agreement at this conference that general health professionals should receive adequate training in the psychological aspects of patient care, and should demonstrate competence in when and how

to treat patients, when and how to refer patients to mental health professionals, and how to collaborate with mental health professionals.

Three broad categories of skills required by primary care physicians to work effectively in mental health are: 1) sensitivity skills, including physicians' awareness of their own reactions and the effects on treatment, understanding of a life cycle context, and understanding of both the psychosocial factors involved in illness and community resources for treatment; 2) therapeutic skills for counseling, based on a psychosomatic approach to history taking and interviewing, minor psychotherapy, and recognition and management of anxiety and depression related to illness; and 3) referral skills, which involve learning to recognize serious psychiatric disorders that can best be treated by mental health specialists.

Conversely, there is agreement that mental health professionals should be better trained to understand the relationships between medical and mental illness. They should be required to demonstrate competence in collaborating with health professionals. One educational opportunity that could benefit both professional groups is experience in integrative health care settings that could provide a model for future collaboration and sensitize professionals to the needs and issues of the other members of the health care team.

Issues of Financing and Cost-Offset

If efforts to link services are to be successful, the financing of health care must take into account the integral relationship between general health and mental health. Recent increases in insurance coverage notwithstanding, mental health services typically are covered to a lesser extent than general health services in private health insurance plans. Mental health insurance also more frequently includes deductible and co-insurance requirements than do plans for medical illness. Some evidence suggests that adequate coverage for treatment of mental disorders within primary care settings and by primary care physicians as well as mental health professionals may lead to increased utilization of mental health services and a decrease in the utilization of general medical services. Whether the change in the locus of care will be cost-saving is not yet clear. It may, however, be an important step toward assuring the quality and appropriateness of care.

There appear to be both conceptual and methodological problems in studying the effects of providing mental health services at the primary care level. It was suggested that the following conceptual issues be considered: 1) The assumption that the cost of mental health care should offset the cost of physical health care may be valid when physical health care has been misused as a substitute for needed mental health care. However, there are mentally ill patients, who, with treatment, should have utilization of general

medical services that increases to more optimal levels as they become less likely to neglect their overall health. 2) Cost-effectiveness may not be an appropriate indicator of effective mental health care. Other outcome indicators such as improved ability to function may be more reasonable. 3) The common assumption that mental health care and physical health care services can be evaluated separately may be inaccurate if they are as integrally related as are mental and physical illness in the individual. 4) Medical utilization is often used as an indicator of health status. Accordingly, persons discharged from the medical care system are assumed to have improved health. In fact, nothing may be known about their subsequent health status or utilization of other service.

There was consensus at the conference that methods should be developed to assure adequate reimbursement for consultation and collaboration between health and mental health professionals. These services, along with the cost of such preventive services as behavioral therapy for smoking or obesity are unlikely now to be covered by any private insurance plan or proposed models of national health insurance.

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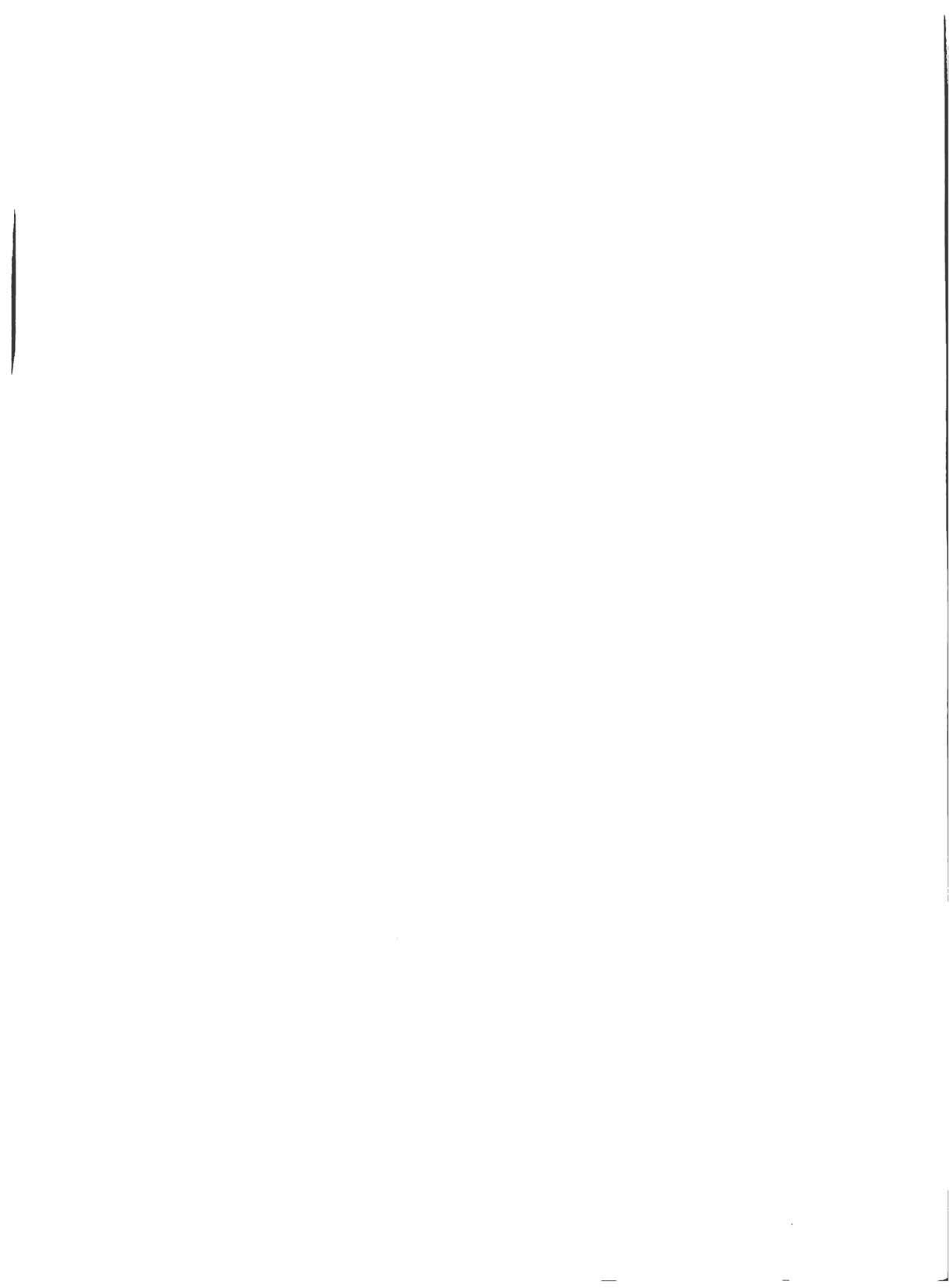

III

KEYNOTE PRESENTATIONS

David A. Hamburg, M.D.
President, Institute of Medicine

There has been a gradual increase of interest in primary health care in the United States, maybe I should say a revival, after some decades in the doldrums. That revival has been gradually building for a decade or more and has become rather intense in the past few years.

We as a nation seem to be groping for ways to develop a national network of primary health care providers. We are on the way toward that objective, but have some distance to go, and all of you, I am sure, are aware of the hauling and tugging and serious analytical work that is going on to try to ascertain how that can be done.

Concomitantly, we have been groping for ways to make mental health care more widely available. We have known for many years that a large percentage of the overtly mentally ill were cared for in the general health system, if they received care at all; and only a small percentage of the overtly mentally ill were cared for by mental health specialists. We have argued a bit about what these percentages might be. We have not had the kinds of epidemiological data we should have had to pin down a lot that is important. But it has been a kind of stark and brutal fact, overwhelmingly apparent to anyone reasonably familiar with the subject, that some gravely ill persons were receiving treatment of essentially unknown characteristics and there was reason to be concerned about finding ways to improve the care that they get within the general health system.

We have been aware, too, that beyond the overtly mentally ill, a much larger number — though we could not specifically say what the number is — have problems in living manifested by truly burdensome emotional distress; these individuals are thought to be almost entirely looked after in the general health care system. Again, we have known little about these patients. We knew that there was a certain amount of depreciation of such patients, reference to them as "crocks" and the like, but there was also a good deal of conscientious, decent and responsible care. But what remained largely unknown were the proportions of the different kinds of

care and the nature of the process in the general health care system by which these people suffering from formidable emotional distress were looked after.

In recent years we have had an additional factor entering the picture, and that is a growing awareness of the behavioral and environmental aspects of health. Some of that falls in the domain of this conference, as well. Some does not. There are major behavioral aspects of health that contribute to the burden of illness in this country — heavy cigarette smoking, abuse of alcohol, very risky driving, and the like. Those aspects of the burden of illness in this country which are pre-eminently behavioral in character have, so far as we know, been dealt with in a rather limited and faltering way, both in the general health care system and the mental health care system. These behavioral problems, whether recognized or not, whether treated or not, are present in the general health care system. Indeed they are coming to be seen as a major responsibility of the general health care system, most particularly within the framework of primary health care.

Presumably, then, the mental health component in primary health care -- and beyond that in the general health care system altogether — must now be a major focus for research. Wrong. It is not a major focus for research as far as we have been able to determine.

Well, at least it must surely be a major focus for medical education. Wrong. As far as we have been able to determine it is a marginal component of medical education. Surely, it must be a focus of excellent nationwide collaboration between mental health and general health professionals. Right? Wrong. As far as we can see, there are only promising models. There are some valuable efforts to be sure, but it has not been a high priority, high status activity in the health professions. It has been a kind of a lowbrow activity with some stigma attached to it.

Well, then, who is irrational? The patients or the professionals? I remember some years ago when a distinguished social scientist studied a health institution over a period of time. I asked him how the study was coming along and he said to me, "Well, the difference between the staff and the patients in that place is that the _patients_ get better."

Fortunately, there are notable exceptions. What I have said so far bears on the question why I think this conference is a decade late. We have dimly been aware of these issues for a long time and for a great variety of reasons have been reluctant to face them. But even in the context of this shortfall, there have nevertheless been pioneering people doing research in the area, conducting innovative education in the health professions, and innovative service.

These innovators and indeed authentic pioneers, are well represented at this conference: and so are those who have seriously undertaken research, education or service at various interfaces between mental health and general health care.

We have not tried to be comprehensive within the time frame available and the resources available. It was not feasible to do so. I am sorry that we have undoubtedly left out people who have done excellent work in this country and abroad, but we thought we could quickly get a reasonable sample of people and institutions who have made important advances in this area; and get a sense, above all, of what is possible in the future.

We wish now to be future-oriented. The problems are increasingly recognized and we are in a different context than we were even a few years ago. We hope that in this conference we can face some of the obstacles in an analytical way, not in a polemical way, in order to clarify the emerging opportunities to understand more about how lack of knowledge has interfered in this field. We will try to understand some of the major obstacles analytically, and how to deal with them more effectively in the future. We have deliberately included in the conference some people who are constructive, searching skeptics about this area of activity. There is no point in wishing away those difficulties. If it is important to move in the directions I have indicated, then we had better know what the difficulties are likely to be. The social context is in some respects distinctly encouraging with respect to the problems on which this conference is focused.

On the governmental side, the President's Commission on Mental Health, under Mrs. Carter's leadership, gave the coordination of mental health and primary health care services a distinct emphasis. That has been carried forward vigorously and dynamically by the new leadership in NIMH, Dr. Pardes and his colleagues; and by the new leadership in ADAMHA, Dr. Klerman and his colleages; indeed, in HEW altogether. Dr. Richmond, who is participating in the conference, Secretary Califano, Undersecretary Champion — these are all people who personally and in a determined way have taken cognizance of this issue and are moving ahead to the extent it is within their power to do so.

The level of Congressional interest, at least in the health-relevant committees, is reasonably high and encouraging also. In the private sector, there are hopeful stirrings in medical schools, in schools of public health, and in some professional societies. Altogether there is a kind of ferment in the country in reference to the interfaces between primary care and mental health care.

The Institute of Medicine has been active in these efforts. Briefly, these are some of the IOM activities pertinent to this topic.

In the primary health care study, 1/ mainly a manpower study, there was some consideration given to the interface with mental health. Emphasis was put upon the educational dimension, the need for more adequate training in behavioral sciences of those who are entering primary care. This subject deserves more extensive treatment than this report was able to give it.

We are in an era in which a fairly wide range of specialties wish to be identified with primary care. They have a new vision of what is possible in primary care. The internists want it built on internal medicine, the pediatricians want it built on pediatrics, and so on. These developments in specialty-based primary care must take account of the major mental health component that characterizes actual practice. Otherwise preparation for primary care would be unrealistic and impractical. This situation has been improving in the past few years. But there has been a tendency for this segment of the medical care population to be put in a marginal status, left with a certain amount of stigma.

The IOM's recently published study, Health Services Research, 2/ is significant to this issue. We need an upsurge of health services research in general, and particularly in relation to the issues of this conference.

In the papers the Institute of Medicine prepared for the President's Commisssion on Mental Health, 3/,4/,5/ much revolved around the various

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1/ A Manpower Policy for Primary Health Care: Report of a Study. Institute of Medicine. Washington, D.C.: National Academy of Sciences, 1975.

2/ Health Services Research: A Report of a Study. Institute of Medicine. Washington, D.C.: National Academy of Sciences, 1979.

3/ J. Borus, B. Burns, A. Jacobson, L. Macht, R. Merrill, E. Wilson. "Neighborhood Health Centers as Providers of Coordinated Mental Health Care," invited paper of the Institute of Medicine Advisory Committee on Mental Health submitted to the President's Commission on Mental Health, February 13, 1978.

4/ J. Houpt, C. Orleans, L. George, K. Brodie. "The Relationship of Mental Health Services to General Health Care," invited paper of the Institute of Medicine Advisory Committee on Mental Health submitted to the President's Commission on Mental Health, February 13, 1978.

5/ M. Parloff, B. Wolfe, S. Hadley, I. Waskow. "Assessment of Psychosocial Treatment of Mental Disorders: Current Status and Prospects," invited paper of the Institute of Medicine Advisory Committee on Mental Health submitted to the President's Commission on Mental Health, February 13, 1978.

interfaces between mental health and general health. There was examination of the research evidence regarding effective measures that could be taken, both psychobiological and psychosocial measures. There was also delineation of the practical arrangements by which interdisciplinary cooperation had been elicited and could be strengthened in the future.

The IOM will shortly be publishing a report called Sleeping Pills, Insomnia and Medical Practice 6/ addressing a large clinical problem. In the course of conducting that study, the internists, the pediatricians, and family practitioners who were consulted in our advisory panel, and the Steering Committee, emphasized not only insomnia, but other mental health problems, as a major part of medical practice. This provided a practical reaffirmation that a major portion of medical responsibility in virtually every field has to do with mental health problems.

The present conference is intended to clarify what is known about the interface between the mental health system and the primary care system and to delineate some promising approaches to improving the coordination of these systems. Our goal is not to reach firm conclusions as we do in IOM major studies. Our major studies typically make policy recommendations after analyzing various options. We do not generally see conferences as suitable for that kind of function, although sometimes there are recurrent themes that have almost the force of recommendations. Our intention here is that the major facts and options can be clarified in the conference.

The format for this meeting provides a very full schedule the first day, reflecting in part the intense interest in the subject. There will be only a little discussion time today. But please be patient, because tomorrow is arranged in such a way that there will be much more time for discussion. We will have three workshops in order to be sure that everyone present will have an ample opportunity to make what we here in Washington call "input" -- in any case, to say what you want to say and to have that on the record; and, more than that, we have adopted an additional mode for "input" -- the "record will be open" for 30 days after the conference to allow for flashes of insight that may occur to you, for visions of the future that may come in some moment after you have left the conference. We have made a decision that wisdom need not be confined to these two days in this great building. The final conference publication will reflect all of the input -- before, during, and after the conference.

6/ Sleeping Pills, Insomnia and Medical Practice. Report of a Study. Institute of Medicine. Washington, D.C.: National Academy of Sciences, 1979.

Finally, I want to welcome our guests from abroad. There is a great deal we can learn from their experience. Granted, there are important cultural differences, as Professor Shepherd will no doubt point out, which make a literal transfer difficult. I recall, not on this topic, but on a science policy topic, discussing with some friends in Sweden some activities I thought were highly constructive. I asked, "What do you think about the likelihood of our adopting those procedures?" The response was negative. I asked, "Why not?" "Well," they said, "we are a small country, we have 8 million people." "Well, so?" "And the other thing, we trust each other."

So, I am not proposing that we automatically or literally transfer what we learn from other cultures. But we have much to learn from experience in other countries. I think we are moving beyond parochialism to share information and ideas with colleagues from abroad. We are very fortunate that several people who can help us a great deal have been willing to make the journey and join with us in this important endeavor.

THE PROVISION OF MENTAL HEALTH SERVICES IN PRIMARY CARE SETTINGS

Opening Remarks

Herbert Pardes, M.D.
Director, National Institute of Mental Health

Typically, the task of an opening speaker is to articulate the significance of the conference theme. On some occasions, the dubious import of that theme or topic makes the task difficult, but today the assignment seems relatively easy. Its ease becomes apparent as one reflects on the many forces and developments that repeatedly and with increasing frequency draw our attention to the interaction of mental health and general health.

At the present time, increasing national attention is being given to the role of behavior in medicine. In the population at large, the notion that one may improve one's health by modifying behavior has given rise to everything from Weight Watchers and Smokenders to jogging and gymnastic centers for middle-aged adults, and attests to the broad concern about the interlocking nature of behavior and health.

Within the health establishment, the awareness is illustrated in such diverse areas as smoking, teenage pregnancy, alcoholism, diabetes, obesity, and treatment compliance. With regard to this last issue, there is increasing recognition of pervasive noncompliance on the part of anywhere from 15 to 50 percent of persons who receive medical advice, and this is emerging as a matter of some considerable concern.

In this context, complaints regarding the disappearance of the old style family doctor seem tied particularly to decline of the personal relationship and psychological sensitivity he supposedly offered. The re-energized family practice movement has emphasized its needs for a major mental health component, both in its training and its clinical work. Other elements, too, within the general medical sector are calling for more focus on psychosocial and behavioral issues.

Large segments of the mental health and psychiatric sectors are calling for an increasing alliance with medicine and general health. Data provided by the Division of Biometry and Epidemiology of the NIMH shows that in the course of a year, 54 percent of patients with mental health disorders are cared for solely by the primary or general outpatient health care system (Regier, et al, 1978).

The presence of this large number of patients who stay within the general health sector for mental health care is complemented by estimates that indicate a large proportion of people walking into a general health or primary health care office have some mental health or emotional problem.

In essence, we are dealing with a major issue within the health care system, as well as an issue of increasing priority among the broad range of society's concerns. Now, acknowledging the topic's significance, I would like to underline several points regarding the scope of the issue.

First, accurate reporting of mental health problems is complicated not only by factors typically involved in reporting, but also by factors somewhat more unique to the mental health field. The difficulty of precise diagnosis is well-known. There is, however, further, the problem introduced by the wide spectrum of reactions, both by provider and patient, to the fixing of a mental diagnosis to an individual.

Yet, again, there is a very broad range of difference in individual practitioners' sensitivity to and awareness of mental health problems. Mr. Goldberg, Dr. Regier, and others have noted that the recent National Ambulatory Medical Care Survey showed that a diagnosis of mental disorder as a primary or otherwise existing condition was made in about 2 percent of all visits to office-based pediatricians in the United States (Goldberg, et al, 1979).

On the other hand, in their study of outpatient pediatric service use conducted in Monroe County, New York, the authors found that two-and-a-half times that rate, or 5 percent, of the children visiting the sample of pediatricians in that locale had mental health problems.

These were defined as emotional or behavioral disorders, including school problems of adjustment or achievement. In the same paper, the authors, while noting methodological variations among studies, cited differences in two separate English studies of children.

One indicated that 5.7 percent of children aged 10 to 11 who were surveyed had a "clinically significant psychiatric disorder." A second study estimated that 19.4 percent of the sample of children were judged to be maladjusted. Aside from noting such differences in reporting data, one must also recognize that sensitizing and educating people in the general and primary health care sectors about mental health issues may result in significantly higher reporting and essentially greater case-finding.

In addition to taking note of these problems of precise epidemiological data and diagnosis, it is important, also, to recognize that behavioral and mental health components are not only critical in primary health care, but also in secondary and tertiary health care. For those of us in mental health, who are accustomed to meeting colleagues in general health who may have reservations if not outright

disinterest in the behavioral area, an extraordinary development is the phenomenon of highly specialized surgeons and internists actively seeking our mental health psychiatric consultation and involvement in their work. Frequently the settings for such requests are intensive care units, burn units, and units for kidney transplants or renal dialysis. Recognition of high suicide rates, for example, among people with chronic renal disorders, as well as significant family and sexual problems that these patients experience, highlights the need that we be aware that our renewed attention to the interface of behavioral and mental health issues with general health cannot be confined simply to the primary care setting.

Not only providers, but patients, as well, have recognized the important psychological issues arising in these settings. In a most eloquent article, Dr. Henry Kempe, one of the outstanding pediatricians in the country, has described his personal experience at the time of his own acute coronary. Noting the extraordinary psychological pressures it produced, he pointed to the sensitivity of the ICU staff who attended to him, and described the profound gratitude he felt when they reassured him about the variety of psychological and emotional experiences he endured (Kempe, 1979).

The burgeoning attention paid to the mental health-health interaction offers considerable potential for major contributions to the health and general welfare of society. Increased efforts on programs of prevention and promotion in general health presents the possibility of a healthier population.

Particular attention to such issues at the earliest stages of life is a significant part of the prevention strategy, inasmuch as identifying high risk children and families and attending to latent disorders as early as possible offers the possibility of early intervention, with resultant decreases in the severity of problems at the point where they finally receive attention.

Furthermore, we know now that people who come to primary care and general health care physicians with mental problems usually have a higher rate of organic illness and utilize health services more frequently than do people with other than mental health disorders (Eastwood and Trevelyan, 1972). These facts suggest that more effective treatment of this population would have important ramifications, both for health care utilization and incidence of organic difficulties.

This notion has been elaborated in a variety of so-called offset studies, which lead to the suggestion that appropriate attention to and provision for the mental health needs of a general population of patients coming for health care may be accompanied not only by better quality and more appropriate care, but also by an actual reduction in inappropriate service utilization and, as a result, possibly financial savings (Vischi and Jones, 1979).

Moreover, the problem of patients and their families' acknowledgment of mental illness and their reluctance to seek specialized help has dramatically influenced the mental health care system since its inception. Recent data suggest that perhaps larger numbers of people may be willing to seek mental health consultation and help (Taube et al, 1978).

Further, the notion that such help is sought primarily by the middle and upper classes of the society may be being modified, judging by early additional data that suggests some increasing readiness of people in the lower social classes to seek mental health consultation and treatment (Jacobson et al, 1978). Given these trends, it is apparent that increasing expertise on the part of general health care providers, accompanied by this readier acknowledgment of mental health problems by all classes in the society, can combine to enhance better care for larger numbers of people.

Now, while the trends may be important and have considerable potential, there are, however, major problems that require attention as we work at articulating the best way in which this system should function. Inevitably, questions of turf arise, with some people in the mental health sector feeling threatened by the notion that people in the general health care and primary health care sectors may appropriate some of their roles.

Also, there are questions of the appropriate role in mental health care of primary care physicians, given their training, orientation and temperament. The nature of many physicians and others in the general health care system is one of high activism, the need for immediate results, a preoccupation with the tangible and a fascination with technology.

The need to listen, the need to allow the patient to play an active role in his or her own treatment program, the need to avoid intruding one's own set of values and principles on one's patients, and the necessity of being comfortable when playing a necessarily passive role, do not come readily to everyone.

There were reasons that the mental health care system was sequestered, and in our enthusiasm for reintegrating it, we must be aware of those forces still playing critical roles at the present time. The story of separation of the mental health system, and why separation, is addressed, I believe, in one of the papers by Dr. Goldman (Goldman, 1979).

Suffice it to say that because many of the original forces are still active, they require recognition and attention as we focus on the mental health-health system. At a social gathering recently, a general psychiatrist lamented that at the hospital where he worked, he and

several psychiatrists had offered their services to the remainder of the medical staff for discussion or consultation about any psychiatric problems but few came to avail themselves of this service.

In this example, one senses the perhaps limited interest on the part of nonpsychiatric staff in securing such consultation and interaction. But one must also wonder about the nature of the product the psychiatrist was offering. Not infrequently, the mental health field has been justifiably criticized for responding to requests for consultations with irrelevant, unrealistically elaborate or highly personalized jargon, or with cryptic if not invisible responses.

Additionally, the notion of simply offering one's self up as available for consultation without the active outreach and involvement in the other medical and health care services long encouraged by those familiar with liaison work, is almost a certain ingredient for failure of the undertaking. As the health care provider must recognize the needs of his or her patient, the consultant must recognize the need of the person consulting him.

The problems of adequate training and its organization for people in primary and general health care are formidable. At the same time, the value of effective training and liaison is critical. It is commonly recognized, for example, that medical students who have not received instruction in the area of interviewing often become increasingly directive and less empathic as their medical training proceeds.

The need to educate actively medical students and general and primary health care students has been recognized by the Psychiatry Education Branch of the NIMH, which has placed increasing focus on and devoted a major portion of its budget to development of such programs. The need for such interaction at the service level, too, has been recognized by the Bureau of Community Health Services of the Health Services Administration, as well as by the Division of Mental Health Service Programs at NIMH. The two have collaborated on the development of projects in which mental health practitioners are brought right into general health care settings for active interaction, consultation, and mutual education.

The interaction of the mental health and health system is important. Its scope is considerable, it has enormous potential, and there are many obstacles that require attention. What, then, are some of the questions that we would put to this group and to conferences of this sort to help us address?

Let me suggest some of them. First, what is the appropriate balance between the primary health care system and the mental health care system and the rendering of mental health treatment? How does one discriminate that which the primary health care person should be able to treat, as opposed to that which should be the responsibility of the mental health specialist?

Dr. Sharfstein has asked how one enters the mainstream without drowning (Sharfstein, 1979). Perhaps the primary care physician or general health care practitioner is wondering, if he broadens his field of attention to include behavioral and psychosocial issues, will his mother and his medical society still think he is a real doctor?

Is the solution one of the general health sector handling both health and mental health care? Do we stay as we are? Should we consider one radical solution I had put to me by a psychologist colleague who suggested that, given the large number of people coming with mental health problems to general emergency rooms, for example, the mental health care people should be the first line people, and then simply refer on those problems which do have physical causes?

Second, in addition to these questions of balance, what kinds of studies, what kinds of research, what kinds of data should we be seeking to round out our understanding of the nature of the problem? Third, how can we best get a handle on the notion or the suggestion that appropriate attention to mental health care problems has an important impact on services, appropriate utilization, and, ultimately, costs of the health care system?

I attach substantial significance to this conference, to the work that has led up to it and also to the work that I anticipate will follow. Having come recently to the NIMH, I am concerned about looking broadly at the nation's mental health programs, and certainly the question of the health-mental health linkage is one of the preeminent issues.

I would, therefore, like to thank you all for offering your time, energy, and thinking in this process, and I look forward to hearing and learning from you and to a continuing dialogue and ferment around this issue. Thank you very much.

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OPENING REMARKS

Merle Cunningham, M.D.
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Health Services Administration

The Bureau of Community Health Services (BCHS) is committed to the provision of comprehensive, family-oriented primary health care services to Americans in urban and rural medically underserved areas. That commitment comprises three major types of programs: the primary care-oriented neighborhood and community health centers; the National Health Service Corps; and the maternal and child health and family planning programs.

BCHS efforts to promote the integration of mental health and primary care services reflect a concern originating with the strong mental health component included within the initial comprehensive maternal and child health programs in 1935. Similarly, in the 1960s OEO philosophy emphasized the importance of mental health services when the neighborhood health centers were established. During FY 1978, $1,500,000 in BCHS supplemental funds were spent to develop "linkages" between community-based health centers and community mental health services. Additional supplemental funds have been allocated for FY 1979 to increase the number of linkage grants from the current 57 sites to 120. Among the 57 sites that have received linkage monies thus far, a variety of linkage approaches have been taken. Those approaches are currently being evaluated jointly by BCHS and NIMH.

Dr. Cunningham's personal experience as a primary care physician in a community health setting suggests that the new BCHS funding essentially represents formal Federal recognition and support of an ongoing trend in individual communities, where mental health services and primary care services increasingly have been integrated through less formally defined linkages such as staff sharing.

POLICY ISSUES ON PROVISION OF MENTAL HEALTH SERVICES IN PRIMARY CARE SETTINGS: A FEDERAL VIEW

Gerald L. Klerman, M.D.
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Mental Health Administration

I would like to continue the discussion of mental health and primary care, and share with you some aspects of this issue as they are discussed at the policy level within Health, Education, and Welfare.

One interesting experience for a mental health person coming into the policy arena at HEW is the pleasant discovery of how accepted, particularly under the leadership of Secretary Califano and Hale Champion, are mental health concerns. If anything, they are impatient that we get on with them more quickly--they are impatient to have everything move more quickly in HEW.

And, contrary to my experience in other settings, I have not had to defend the importance of the topic or to re-cry the extent of the problem by quoting statistics in terms of the incidence, prevalence or economic burden. Within HEW, and particularly during the course of the President's Commission and interactions between HEW and the White House and the Commission, there is and was seldom any issue as to the importance of the matter or the impact it has where there are policy concerns as to the nature of the service and fiscal mechanisms to be employed in relating mental health to general health.

Now, I want to say a few things about both parts of the title of the conference. I want to identify those aspects of the relationship which have to do with general health as distinct from primary care, although recognizing that the majority of the papers and workshops will be on the primary care issue.

There are significant issues in policy that occur at levels of the health care delivery system other than primary care, and I will try to place those into context.

Psychiatrists and mental health professionals in general tend to shift unknowingly--I will not say unconsciously--from talking about mental health as, narrowly, mental illness to mental health as a field that includes alcoholism, drug abuse, developmental disabilities, retardation and other concerns that at various times have not been at the center of psychiatric thinking. This is a matter of particular concern to me in my current role because of the sensitivity

of the alcoholism field as to whether or not it wishes to be seen as part of the mental health field. Part of the response to this has been the establishment, largely with Federal support, of at least three parallel and somewhat isolated delivery systems--not only the mental health delivery system, but also a well-developed, often nonmedical delivery system for alcoholism and a very highly specialized delivery system for drug abuse, particularly for heroin, mostly supported by Federal monies. The interactions, let alone linkages, among these three systems have been, at most, minimal, let alone their interactions with the general health care system.

From a public health point of view, the problem is most pressing with regard to alcoholism, since it is likely that the majority of alcoholics are in the primary or general health care system, but are undiagnosed, misdiagnosed and certainly mistreated, particularly overtreated, with the inappropriate use of sedative, hypnotic and minor tranquilizing drugs.

This area represents, to my mind, one in which there is a tremendous opportunity for research to impact upon policy, because there are not clear answers and because the lack of not only knowledge, but also of adequate conceptualization, creates the opportunity for research to impact at a time when policy in this aspect of health care is in a very fluid state.

It is also of interest that the research areas that have the greatest potential for impact on policy are in the health sciences and behavioral sciences areas. Most important, of course, is epidemiology, which is well represented here by Darrel Regier and his colleagues. But health services research also ranks high, not only because the very conceptualization of primary care grew out of the work of people like Kerr White and others, but also because of the importance of cross-cultural studies. Now, we can, in effect, do a comparative analysis of experiments of administrative nature by comparing the consequences of our dissolution of general practice, an inadvertent experiment of administration, perhaps, with the British experience, where they not only did not allow that to happen, but purposely strengthened the general practice network as their major mode of contact with patients with mental illness.

I think it is significant that the organizers of this conference have invited Michael Shepherd, and that David Goldberg is here in the United States on sabbatical from England, continuing this work.

Three other types of sciences with potential relevance for policy are not represented here, but might be the focus of future conferences. They are medical anthropology, medical sociology, and economics, both macroeconomics and microeconomics.

Now let me put the policy issues into a certain context.

One of the main contributions of recent epidemiologic work, highlighted by the papers prepared for the President's Commission, is a fairly clear definition of the quantitative extent of the problem, as presented by Darrel Regier of the National Institute of Mental Health. A rough consensus of epidemiologic evidence indicates a yearly prevalence of discernible disorder in about 15 percent of the population.

It is not to be presumed from this that all the remaining 85 percent are without symptoms. One of the important things that also has emerged from the epidemiologic research is that in addition to those individuals with such definable disorders as neurotic depression or clear-cut alcoholism, who constitute this 15 percent, there are significant additional numbers, perhaps as many, with transient symptoms, perhaps stress reactions, periods of insomnia, weight change, and backaches, and the people experiencing these use the health care system to a great extent.

While people may argue whether or not it is legitimate to do so, one of the main functions of the health care system, in the United States or in any other country, is to provide a buffer and a means of auxiliary coping for these stressful responses, these symptom states, which may not reach the level of the DSM-3, the St. Louis Criteria, or the Research Diagnostic Criteria, but nevertheless cause misery and distress, and promote individuals to come into the system. One of the unmet diagnostic and epidemiologic needs is to get a better handle on the extent of this matter and to define the prevalence of this group without disorder, but with distress.

Next, we have attempted a quantitative compilation of the main disorders within the 15 percent. (Figure 1) Although one can make very crude estimates about children and about the aged, the status of clinical epidemiology for those two important populations is, by my estimate, crude. The absence of good data for the nature of children's disorders, particularly in the community, and the overlap with developmental disabilities hinder policy and planning, particularly on the interface with education.

Similarly, in the aged, the lack of good data as to the number of demented individuals or the overlap between dementia and depression, once again hinders planning for the extent to which nursing home care is really required, and for alternatives.

The best data are for those people in the adult age range, and here, as I read the data from the epidemiologic studies, there is fair convergence, again. Almost all the prevalence is accounted for by three disorders: 1) depression and the affective disorders, up to 8 percent of the population within one year; 2) alcoholism, between 2.5 for alcoholic dependence and up to 8 percent for people with alcohol problems, such as intoxication episodes and accident involvement, domestic violence, child abuse, homicide, suicide; and 3) anxiety, phobia, and other neuroses, about the same amount.

Figure 1
ESTIMATED PREVALENCE OF SELECTED
ALCOHOL, DRUG AND
MENTAL DISORDERS

Disorders by Age Category	Point Prevalence (rate per 100 persons)
Children (under 18)	8-10%
Adults (18-65)	10-15%
Depression and Affective Disorders	4.5-8%
Anxiety, Phobia, and Other Neuroses	4.0-7%
Alcoholism and Alcohol Problems	2.5-8%
Drug Dependence	0.5-1%
Schizophrenia	0.5-1%
Aged (over 65)	10%

These three groups of disorders are widely prevalent in the general health care system, particularly in the primary care component, often unrecognized and probably poorly treated. Two disorders which get much attention from psychiatrists and the public are actually of low prevalence, but high social cost. They are drug dependence, particularly heroin, which seldom goes above one percent, and schizophrenia, whose prevalence at best is one percent and lifetime prevalence, with the most broad definition, three percent. Yet it is this disorder with low prevalence, but with such high social cost, that eats up the resources of the long-term care system.

I will not dwell on this, except to acknowledge the softness of the data, but also to note that even with better data from more elaborate studies now underway in this country, or others such as the Camberwell Registry and the registry in Iceland, the trend seems to be that almost all the adult prevalence is accounted for by depressions, anxiety states and alcoholism.

Now, to return to the Regier analysis. Fifteen percent of the population comes to 31 million. That might seem like a staggering amount, but, again from the point of view of current thinking, it is not an insurmountable problem. Let me point out to you that hypertension has about the same prevalence throughout the population, and yet the Public Health Service has seen fit to mount a nationwide campaign on the detection and treatment of hypertension with discernible results on the death rate from cardiovascular disease.

We may not yet have the technology as well-established for diagnosis and treatment as in the hypertension field, and I am not advocating as comprehensive a program for mental illness as for hypertension, but I use the hypertension comparison to indicate that the magnitude of the problem, 20 to 30 million people, is not in itself one which need deter the development of a public health approach. In fact, while it may frighten some of those who are doing national health insurance planning, the existence of such a large prevalence is not in itself a deterrent to a public health approach.

The other contribution from health services research, and again I mention Regier, is the awareness that the delivery system can be divided into two sectors, the general health care sector, which accounts for about 60 percent of this 30 million, and the specialty sector. As I will show, the specialty sector is itself capable of being subdivided into the three somewhat fragmented components for alcoholism, drug abuse, and mental health. Although this conference has focused in its planning on the mental health component, I would hope that at times you would pay attention to the existence of comparable but not identical problems in the recognition and treatment of persons suffering from various alcoholism and drug abuse disorders.

I made mention earlier that one of the advances in policy has come from the field of health services research, and particularly from the conceptualization of primary, secondary and tertiary care. With the assistance of Gail Schecter, my research assistant, we undertook an attempt at a historical review of this conceptualization.

Surprisingly, although primary care is a catchword in today's parlance, the term is less than 15 years old. The division of the health care system into primary, secondary and tertiary levels is a relatively new conceptualization—an analytic conceptualization brought to bear on the field by people like Kerr White, Alberta Parker and others, in response to the awareness about 15 years ago that this country had allowed its general practice network to dissolve and had overdeveloped its specialty network. Again, the contrast to Britain is illuminating.

This had resulted in the disappearance of physicians, particularly from rural areas and from inner city poverty areas, and in a rapid expansion of costs, particularly at the tertiary level, of high technology. Again, it is worth making the comparison with Britain, where the percentage of the gross national product allotted to health is about 40 percent less than in this country. One reason for that is probably their having sustained and nurtured and, as a matter of public policy, continued to support a vigorous general practice component.

Now, to attempt to link the conceptualizations previously cited. One is the primary, secondary and tertiary care conceptualization with the distinction between the general health care sector and the specialty sector that Regier and Goldberg identified in their paper in the Archives in June of last year. Some of the characteristics of primary care are its relevanee to relatively small populations at the neighborhood or small city level. As one goes up to levels of tertiary care, one gets to larger population bases, so that the tertiary care network is usually regional hospitals or university hospitals, where highly specialized facilities with often high cost technology and often highly specialized personnel are concentrated.

I propose for discussion that, in addition to primary, secondary and tertiary concepts, long-term care be brought into that conceptualization, perhaps as a fourth level of endeavor, because one of the policy issues is that of determining the extent to which those patients now in the long-term care system can be shifted in reasonable ways into either the secondary or primary care networks.

We have attempted to combine in a single concept or matrix the two systems or analytic concepts that I think have been most useful from a policy point of view in understanding the growth or nongrowth and the changes in the American health care system since World War II.

Figure 2

FOUR LEVELS OF HEALTH — ADM HEALTH CARE

Level of Intensity of Care	General Facilities and Services	Alcohol Abuse Facilities and Services	Drug Abuse Facilities and Services	Mental Health Facilities and Services
Primary	Neighborhood Health Centers	Primary Care Practitioners	Primary Care Practitioners	Primary Care Practitioners
Secondary	Community Hospital	Alcohol Treatment Centers	Drug Treatment Centers	CMHCs
Tertiary	Specialized Hospitals	Alcohol Treatment Hospitals		Residential Treatment Centers for Children and Adolescents
Long-term	Home Care Services Nursing Homes	State Hospitals		Community Support Programs; State Hospitals

The concept makes use of the primary, secondary and tertiary care distinction, adds to it at a fourth level considerations of long-term care, whether provided in institutions or in ambulatory programs, and explicitly identifies the reality that Federal support has created at least three sectors of a semi-specialized delivery system for mental health. The most important of these are the community mental health centers, followed by the large growth of psychiatric units in general hospitals, the network of Federally supported methadone clinics and State and local supported programs, not only for methadone, but also for residential treatment units, and a similiar, less well-defined, but still important network and sector for alcoholism.

Now, what is the larger context from the policy point of view? The awareness in the late sixties and early seventies that this country had allowed its general practice network to disappear and that there had been a tremendous growth in the secondary and tertiary levels of care with high technology and high cost has led to a Federal policy of previous Administrations, continued into this Administration. It is 1) to purposely strengthen primary care, 2) to limit the further development of specialty care, particularly at the tertiary care level, and 3) to attempt to transfer long-term care from institutional to ambulatory settings. This so-called deinstitutionalization policy, while perhaps most controversial in the case of mental illness, has corresponding issues for arthritis, alcoholism, and cardiovascular disease. The policy within the primary care setting is to facilitate--with government support and legal encouragement--the development of organized modes of delivery of primary care, among them the Federally supported network of urban health centers, migrant programs, and rural health centers, and the use of Federal monies to create a new form for delivery of primary care through organized, if not operated, Federally supported programs.

However, at best, it is unlikely that these will ever reach more than 5 to 10 million individuals. The other development of interest in the primary care sector, again with purposeful Federal policy, is to support HMOs, another new organizational mechanism for the delivery of primary care.

Still another policy dimension has been categorical support for training programs for a new class of practitioners, family practitioners, and the Federal definition of three other classes of practitioners as primary care practitioners who receive Federal support, namely internists, pediatricians and obstetricians-gynecologists.

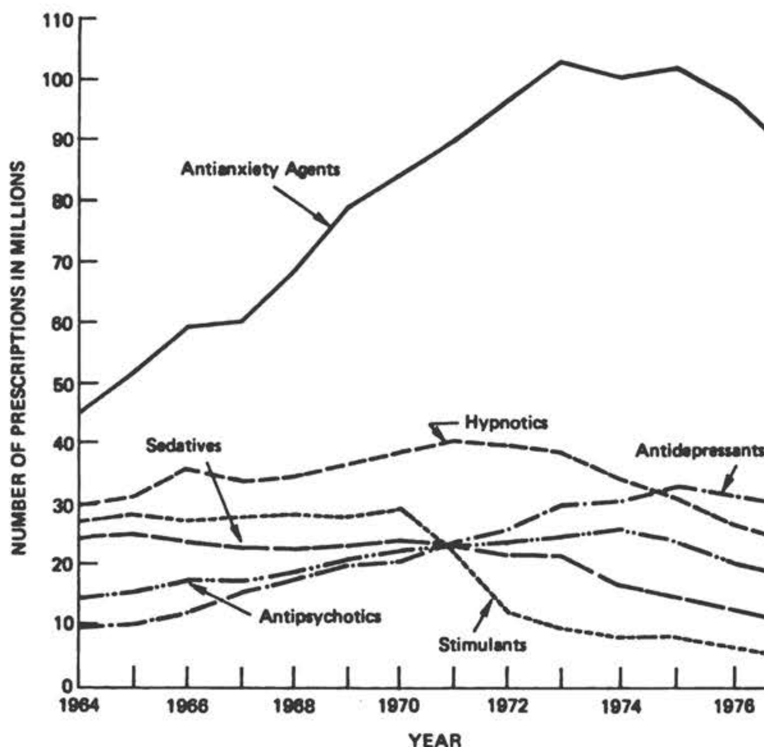
With regard to Federal policy, it is important, once again, to recognize that at the present time there are only two classes of medical practitioners who receive categorical support at residency training--psychiatrists, through the NIMH program, and family practitioners, supported by Health Resources Administration.

This is yet another indication of Federal policy to reinforce, in one case the sector of primary care, to hold back the continued erosion of the general health care sector; and in the case of psychiatry, to recognize the continued unmet needs with regard to clinical manpower.

Again, I should like to direct your attention to the fact that, at least transiently, these considerations and the linkage between general health and mental health are part of the larger complex framework of interactions and linkages between mental health, alcoholism, drug abuse at both secondary and tertiary levels, as well as to the important issues around long-term care and particularly the extent to which the long-term care patient, for the most part previously treated in long-term custodial institutions, can, in fact, be treated with humanity and with quality of life in ambulatory settings, hence the controversy around deinstitutionalization.

This brings me to another related policy issue, and that is the place of psychotropic drugs in treatment programs. (Figure 3) A survey of CNS psychoactive drug prescriptions indicates a downturn in the number of prescriptions for hypnotics and sedatives in the past five years, and especially rapid decrease in the number of prescriptions for stimulants in the 1970s.

Figure 3



Although the number of prescriptions for antipsychotics generally increased during the period from 1964 to 1974, it has leveled off in recent years. Prescriptions for antidepressants have shown consistent growth up to the past few years. The most dramatic increase has been in the number of prescriptions for anti-anxiety drugs, primarily chlordiazepoxide, diazepam, and meprobamate. In 1973, these accounted for over 100 million prescriptions, but more recent data indicate a leveling-off and even a slight decline. Valium is the single most prescribed drug in the world, as well as in the United States. The three most prescribed drugs in the United States are 1) Valium, 2) Darvon, and 3) Librium.

The importance of this is a matter of great policy debate. Are we an overmedicated society? Is this use of psychoactive drugs inappropriate? Are physicians in general and psychiatrists in particular using these drugs inappropriately in persons without mental disorder and, in particular, are women being prescribed these drugs out of cultural bias and sexism, as is claimed by some of the feminist critics of the health care system?

From the point of view of the topic of your conference, a fact that emerges from recent research, that of Balter and his associates, of Rickles of the Philadelphia group, and I think also confirmed by studies in Britain, is that the majority of prescriptions for these drugs are not written by psychiatrists. Psychiatrists account for only about 15 percent of all the psychoactive drug prescriptions written. All the others are written by general health care physicians, particularly the primary health care physicians.

In fact, if one looks at what evidence we have for the mode of treatment for 60 percent of the 30 million patients with mental disorders identified by Regier and his colleagues in the health care system, the evidence seems to be that the majority are treated with what I call a combination of a pat on the back, a kick in the pants, and a of bottle Valium.

I am not advocating this as the ideal mode to deal with these problems; in fact, I have some serious doubts as a clinician about its utility. But the fact is that for the most part, from the evidence that I have seen, this is the level of treatment for 60 percent of the 30 million now in the health care system.

The question from the policy point of view is whether the Federal government should make any attempt to influence this curve and its future development. Do we have any responsibility for the education of the public in general or the medical profession in particular with respect to the appropriate use of psychoactive drugs and, if so, through what mechanisms? And if there is evidence that this is an inappropriate mode of treatment, what alternatives exist for the large numbers of patients with anxiety states, depression, or alcoholism, who are, in fact, in the general health care system?

How good is the evidence for the efficacy of psychotherapy of any kind vis a vis that of drugs alone or in combination for these conditions? Are the psychotherapies which may be proven to be efficacious capable of being applied in the primary care sector? And, if so, should they be applied by the primary care physicians per se or by mental health personnel working in concert with them? Here, again, I think of the British experience, particularly the quasi-controlled trial of locating social workers in general practitioners' centers as reported by Cooper and Shepherd, which is, I think, an important experiment for us.

I have attempted to convey to you a sense of what are the types of policy issues that get discussed within HEW. They are not, to my surprise, a concern for the magnitude of the problem or for the extent of human misery.

The issues are what sectors of the health care system are most appropriate for dealing with these problems; what forms of technology available to us are, in fact, efficacious, whether they be drug or psychotherapeutic; and which types of personnel are most useful currently or in some hypothetical future. And, assuming there can be some agreement as to the goals, what is the role of the Federal government through reimbursement programs like health insurance, through categorical programs like funding of mental health care centers or linkage grants, or through training efforts, to move the system to a more rational integrated basis, instead of the avowedly fragmented basis we have now.

THE NATURE AND SCOPE OF MENTAL HEALTH PROBLEMS IN PRIMARY CARE: VARIABILITY AND METHODOLOGY

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The current and future role of primary care providers and settings is an issue of considerable health policy interest. Realistic policy and program development concerning this role must be based, in part, on accurate understanding of the scope and nature of mental disorder within the primary care sector. This fact has not been lost on the research community. As demonstrated by the recent literature review by Hankin and Oktay, a striking array of prevalence data is available. 1/ But what is a planner or policy maker or educator to make of mental disorder prevalence rates ranging from below 1 percent to over 50 percent of the population in primary care settings? Adding to the potential confusion are health services research data in primary care settings which are often focused on visits or volume of services rather than on the number of persons using services. Useful though they may be, visit-based utilization data and person-based epidemiologic data are difficult to interrelate meaningfully.

At present, we can give only a general rather than a definitive estimate of the rate of mental disorder in U.S. primary care settings. But we know that much of the variance in reported rates is directly related to differences in research methodology. We will examine some of the effects of methodology on prevalence rates, citing study results from the literature in which single prevalence measures are usually used, as well as results from some recent NIMH-sponsored studies in which multiple measures were used within and across sites. Results from the latter studies, which permit person-based and visit-based rates to be compared, will also be reviewed. We hope that this exercise will serve both as a guide to understanding the current state of knowledge and a goal to more systematic study.

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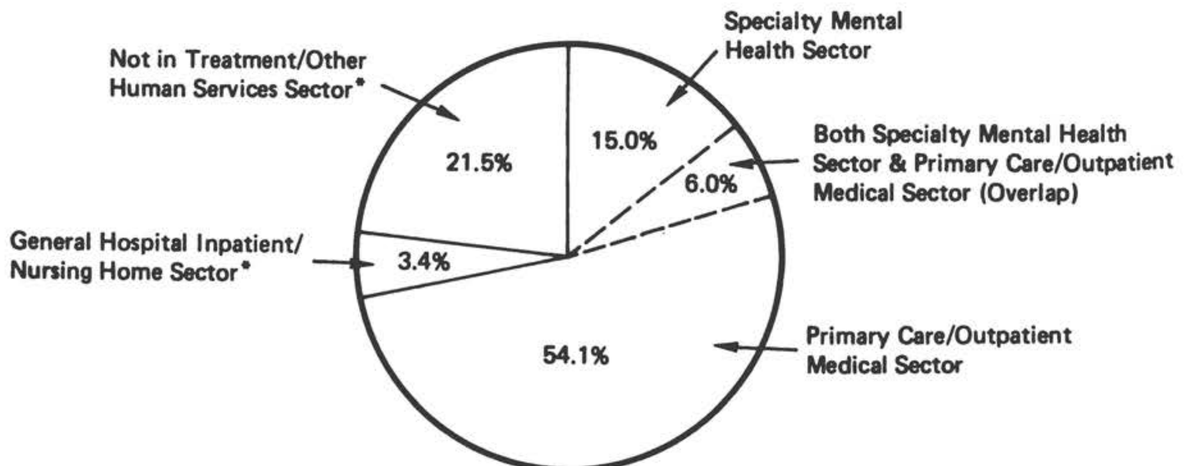
As background to this discussion, let us first sketch in the overall prevalence of mental disorders in the population at large and the distribution of persons with mental disorders among major sectors of the health care system. In the recent review(s) prepared by the NIMH Division of Biometry and Epidemiology for the President's Commission on Mental Health, we estimated that about 15 percent of the general population could be diagnosed as having an ICD Section V-defined mental disorder in a given year. 2/ While this estimate is relatively crude, it does provide a general framework for understanding the scope of the problem.

Regarding the division of responsibility in the current service system for the care of those with mental disorders, as shown in Figure 1, we have identified some 21 percent in the specialty mental health sector, another 54 percent as being seen only in the outpatient primary care sector (with 6 percent specialty overlap), 3 percent in the general hospital-nursing home sector, and 22 percent for whom we cannot account. Thus, in discussing the mental health care role of primary practice, we are addressing the health care sector used exclusively by better than half of those with mental disorders in a given year.

Figure 1



*Excludes overlap of an unknown percent of persons also seen in other sectors.
NOTE: Data relating to sectors other than the specialty mental health sector reflect the number of patients with mental disorder seen in those sectors without regard to the amount or adequacy of treatment provided.

Shifting perspective now to the primary care sector, we might expect the prevalence rate for mental disorder to match the overall population rate of approximately 15 percent. Indeed, reported rates are predominantly in the 10-20 percent range. 1/ But, as we have noted, the variation in reported rates is considerable. Let us look more closely at its methodologic sources.

Major differences in reported rates can stem from the choice of population base (total registered, total users, or consecutive users) from the time period (one point in time, several months, one year, or a lifetime), and from the principal unit of analysis (number of persons, number of visits, or allocation of resources and costs for the treatment of persons with mental disorders). Further, differences can stem from the choice of case identification method. Let us take, as an example, the effect of five methods of case identification on reported rates.

Figure 2 shows some of the prevalence rate ranges in primary care settings, grouped by case identification method. Starting with the person-based, more epidemiologically oriented studies, the first method of case identification is routine reporting of mental disorder diagnoses on clinical records of general practitioners. Using this method of case identification, Fink, et al, found that about 5 percent of the Health Insurance Plan of New York (HIP) population in a given year had a diagnosis of mental disorder routinely recorded on their clinical records. 3/ (We have recently repeated this approach on studies of four different health programs, demonstrating a range between 1.3 and 6.3 percent across programs. 4/ These rates increase to a range of 1.5 to 8.2 percent when the population base is utilizing patients rather than the total population potentially using services; when only patients are used as the population base, the denominator is smaller and prevalence rates correspondingly increase.)

The second case identification method is the routine recording of diagnoses, symptoms, treatments, and referrals. Hoeper, et al, have recently completed a study, using a chart review of adult patients in a prepaid group practice at Marshfield, Wisconsin, which revealed a three-month prevalence rate of some 5 percent. 5/ This rate was somewhat higher than the 2.6 percent rate for the same setting found by routinely recorded Section V diagnosis of mental disorder. 4/

The third method of case identification, which has received the most attention within epidemiological circles, is the use of survey report form for recording mental disorder diagnoses by general medical physicians. In the classic study of this type, Dr. Michael Shepherd reported that some 14 percent of the patients in 46 general medical practices in London were identified by GP's as having mental disorders. 6/ In this country, Locke, Goldberg, Rosen and others of the

Figure 2

CASE IDENTIFICATION METHODS IN PRIMARY CARE SETTINGS

Person-Based Studies

Routine recording of mental disorder diagnoses on clinical records
- --Fink R, et al: 4.8%
- --Regier DA, et al: 1.3-6.3% (1.5-8.2%)

Routine recording of diagnoses, symptoms, treatments, and referrals
- --Hoeper EW, et al: 5.0%

Survey report form used for recording mental disorder diagnoses
- --Shepherd M, et al: 14.0%
- --Locke BZ, et al: 16.9%

Standardized psychiatric interview with general practice patients
- --Rawnsley K: 22%
- --Hoeper EW, et al: 26.7%

Patient self-report on psychiatric symptom questionnaire
- --Shepherd, M, et al: 20-36%
- --Pedder JR and Goldberg DP: 30%
- --Hoeper EW, et al: 30%

Visit-Based Studies

Routine recording of mental disorder diagnoses on clinical records
- --NAMCS(1975): 2.1%
- --Regier DA, et al: 0.4-4.0%

Routine recording of mental health treatments
- --Balter MB, et al: 12% of visits receive psychotropic drugs 18/

Division of Biometry and Epidemiology of NIMH have identified rather comparable rates. 7,8,9/ (However, since a patient population base and not a general population base was used, the rates are somewhat higher.)

The fourth case identification method is a standardized psychiatric interview with general practice patients. There have been several interviews of this type. The interview developed in the University of London, Institute of Psychiatry general practice unit by Drs. David Goldberg, Michael Shepherd, and others, 10/ has been used by Rawnsley to identify some 22 percent as having a mental disorder diagnosis in a primary care practice. 11/ Similarly, in their recently completed study in Marshfield, Wisconsin, Hoeper, et al, using the SADS-L standardized psychiatric interview, reported some 26.7 percent of patients identified with an RDC diagnosis of mental disorder. 5/

The final method of case identification is patient self-report on psychiatric symptom questionnaires. The Cornell Medical Index (CMI) was used in the original Shepherd study in which a range of 20-36 percent

scored positive on the MR section of the CMI. 6/ Other studies, using the General Health Questionnaire (GHQ) developed by David Goldberg, 12/ have found rates in the range of 30 percent. 13/ Hoeper and his colleagues found the same range when they used this instrument in the Marshfield area. 5/

In reviewing Figure 2, then, it is important to recognize that the rates tend to be higher with each successive case identification method. Elevated rates are also found when consecutive patients are used, and when only the patient population is counted in the denominator.

Shifting now to health services research data on the volume (and cost) of services, these tend to use visits as the unit of analysis. The most common utilization data available are from routine reporting systems on medical records. However, visit-based physician practice surveys are also used.

The National Ambulatory Medical Care Survey (NAMCS) of U.S. office-based physicians identified a primary diagnosis of mental disorder in only 2.1 percent of visits to all nonpsychiatrist physicians. General practitioners had a slightly higher rate of 3 percent, internists 3.6 percent, and pediatricians a lower rate of 1 percent. 13/

A similar type of diagnostic reporting was also examined in four organized health care programs, in three settings under contract with NIMH. These settings included the Bunker Hill Health Center in Boston, the Columbia Health Plan in Columbia, Maryland, and the Marshfield Clinic, which has both a fee-for-service and prepaid practice program. The rates across settings ranged from .4 to 4 percent of visits. 14,15,16/

Because multiple measures were used in these settings, it is possible to compare the relationship between visit-based and person-based rates. In all cases, the percent of patients identified with mental disorder in one year is higher than the percent of visits for such diagnoses -- indeed, on the average, about two times greater (see Table 1). This finding seems somewhat counterintuitive, considering that patients with diagnoses of mental disorder have much higher total visits to their physicians than those without such disorders. (In fact, in the four plans that we studied, patients with mental disorder averaged from 1.4 to 2 times as many visits per patient per year as patients without mental disorder diagnoses.) (See Table 2) However, although patients with mental disorder diagnoses visit more frequently, most of their visits are for diagnoses of other medical illnesses, a fact consistent with the finding that patients with mental disorders have higher morbidity rates for all other categories of medical illness. 17/

The interaction among different case identification methods and their relationship with utilization indices may be illustrated by a case example involving the Marshfield Clinic, in Marshfield, Wisconsin. In this large clinic, where multiple measures of primary care practice activities were used, it was found that 2.7 percent of the visits had

Table 1. Percent of Visits and Patients, in Non-Mental Health Departments with Diagnoses of Mental Disorder, By Setting, 1975

Setting	Associated With Mental Disorder Diagnosis		Ratio of Patients/Visits
	Percent Visits	Percent Patients	
Columbia Medical Plan	0.4	1.5	3.8
Marshfield Clinic			
Prepaid	2.7	3.7	1.4
Fee for Service	2.3	4.0	1.7
Bunker Hill Health Center	4.0	8.2	2.1

Table 2. Mean Visits to Non-Mental Health Departments Per Patient With and Without Diagnosed Mental Disorder, By Setting, 1975

Setting	Mental Disorder Diagnosis		Ratio of Means: Present/Absent
	Present	Absent	
Columbia Medical Plan	7.1	5.0	1.4
Marshfield Clinic			
Prepaid	7.7	4.2	1.8
Fee For Service	6.5	3.6	1.8
Bunker Hill Health Center	6.4	3.2	2.0

a principal diagnosis of mental disorder. This represented 3.7 percent of patients aged 0 to 65. Patients with mental disorder diagnoses averaged almost twice as many visits per year as patients without such disorders, accounting for 7 percent of the total visits. However, only slightly more than one-third of their visits were for a diagnosis of mental disorder.

In a recent three-month survey of adult members of this same population, it was found that 5 percent of consecutive patients could be diagnosed as having a mental health problem if prescriptions for psychotropic drugs and recorded emotional symptoms are included. Although no survey per se of the Marshfield GP's was performed, such as has been done by Shepherd, Locke, and others, the GHQ was administered as a patient self-report form, and a standardized psychiatric interview (SADS-L) was conducted with a sample of patients. Preliminary findings indicate that 30 percent of the patients scored positive on the GHQ and approximately 27 percent received diagnoses of specific mental disorder on a standardized psychiatric interview with mental health specialists.

Thus, results from the Marshfield study, in which multiple case identification techniques were used in one site, confirm the method-dependent effects noted earlier across many studies and sites: relatively low rates when GP reporting is used, and relatively high rates when self-reports of standardized psychiatric interviews are used.

Elucidating precisely the prevalence of mental disorders in primary care practice is but one of the important research tasks required to guide future policy and program development. It is also important to determine the diagnostic and treatment needs of persons identified by different methodological approaches. Likewise, it is necessary to determine both the effectiveness and cost-effectiveness of services provided to such patients in either the primary care or the specialty mental health referred settings.

If we are to integrate health and mental health services further, or simply to pay more attention to the role of primary care practitioners in treating persons with mental disorder, we will need, first, to have more data on the specific types of disorders they tend to identify, misidentify, treat, decide not to treat, or decide to refer. Second, we need to link the data on specific disorders with service utilization, cost, specific treatments, and outcome. Third, the effect of training methods on improving accurate identification and effective treatment also needs further study.

If the primary care sector is to be a full partner in the treatment of patients with mental disorder, primary care physicians will need all of the tools of the specialty sector, in somewhat modified form, to function effectively. These include: a classification system for psychosocial problems and mental disorders oriented to the level of specificity expected of a primary care provider; a method of case

identification which includes elements of symptom questionnaires in routine history taking; and more detailed structured interviews which can be used when there is doubt about diagnosis or treatment.

In short, a combination of descriptive, analytic, and methodologically oriented studies is needed to improve understanding of the mental health service role of primary care providers, to aid them in carrying out that role, and to guide the informed development of services policy related to that role. We have a good initial effort; it must be sustained.

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A NEIGHBORHOOD HEALTH CENTER MODEL OF INTEGRATED AND LINKED HEALTH AND MENTAL HEALTH SERVICES

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Efforts to provide more closely integrated health and mental health services particularly within primary care settings have taken a number of forms in community and neighborhood health centers and health maintenance organizations. A current Federal emphasis encourages closer ties between existing neighborhood or community health centers (CHCs) and community mental health centers (CMHCs). A description is provided of one organized primary care setting, a neighborhood health center (NHC), with integrated mental health services from its inception which are linked to a community mental health center. Despite its unique features, this particular example can serve as one model for the delivery of mental health services in a general health care context while maintaining a close working relationship with the specialty mental health sector. A brief description of the organization will be followed by reported patient benefits and provider issues experienced in this setting.

THE MODEL

The focal point of this report is the Bunker Hill Health Center (BHHC) of the Massachusetts General Hospital, a NHC serving a primarily low-income Irish-American community of about 17,000 persons who live in Charlestown, Massachusetts, a relatively isolated section of the city of Boston. Following assessment of the community's health and mental health needs, BHHC was opened in 1968 under the strong leadership of an Irish pediatrician. The Center is a satellite of the Massachusetts General Hospital (MGH), a teaching hospital in Boston. Its stated goals were to provide comprehensive, coordinated, continuous, personalized, non-fragmented, family-centered health care at a reasonable cost. As a physical extension of the MGH, the Center offered

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medical, pediatric, mental health, social service, dental, nutritional and other specialist services on a scheduled appointment and walk-in basis, with back-up from the MGH emergency room and inpatient services. The mental health services included evaluation, individual and group therapy, day treatment, emergency services, pre-school screening, consultation to community agencies, and community-based prevention programs. In 1975, the mental health staff made up 44 percent of total staff. A more extensive description of the services offered can be found elsewhere. 1/, 2/

The community mental health services were originally designed, and have been continuously delivered, as an integral and essential component of this comprehensive health program. Since 1971, when the catchment area CMHC (the Erich Lindemann Mental Health Center) was founded, BHHC was designated as the provider of outpatient mental health services for Charlestown. Such a model has been characterized by Borus as a "joint endeavor model" in which a health center's mental health program is supported by both the NHC and the CMHC. 3/ Specifically, the CMHC provided the NHC with staff for specialized day care programs for chronic patients and a child psychiatrist consultant to the Center's child mental health program. Affiliation with the CMHC also increased the center's access to other sources of program funds.

Organizationally, although there was no interlocking directorate between the NHC and the CMHC (a potential disadvantage to consumer groups), there was considerable administrative and staff interaction among the directors of the CMHC, BHHC, and the BHHC Mental Health Unit. The organizational linkages between the NHC and the CMHC fostered many types of interaction around the provision of secondary and tertiary mental health services by the CMHC for patients seen by the NHC. Frequent communication between the BHHC and the CMHC developed around coordination of specialized services including those for CMHC inpatients, and the mental retardation and children's programs.

Within the neighborhood health center, there was active interaction between general health and mental health providers. Consistent with the stated BHHC goals to provide comprehensive and coordinated care, staff were recruited with a strong commitment to and capacity for interdisciplinary teamwork. The single medical record and multi-disciplinary health care teams were instituted from the beginning. A number of vehicles for communication developed somewhat sequentially with the growth of the program and understanding of the community, e.g., consultation, inservice education, and collaborative programs. These appraoches, undertaken to facilitate health/mental health provider communication, were intended to strengthen the mental health skills of health providers and to facilitate appropriate referral of patients to mental health specialists.

FIGURE 1. APPROACHES FOR HEALTH/MENTAL HEALTH INTERACTION AT THE PROVIDER LEVEL

	Vehicles for Health/Mental Health Coordination	Examples of Applications
1.	Single Medical Record	Formal communication among providers
2.	Multi-discipline health care team	Multi-problem families with health and mental health problems are frequently presented
3.	Ease of referral to mental health services	Open intake system by mental health service
4.	Case-centered consultation	Health provider requests for advice on managment of patients
5.	Center Committees	Medical records, various task forces
6.	Inservice education	Series on alcoholism, child development, infant-parent relationships
7.	Joint patient interview	Modeling assessment approaches for health providers
8.	Collaborative program	Pre-school screening, obesity group, medication clinic
9.	Client - centered consultation	Pediatric nurses counseling adolescent mothers meet with psychiatrist regularly
10.	Liaison to units	A pediatrician attends the child mental health intake meeting
11.	Collaborative research	A study of internists' patterns for prescribing tranquilizers

BENEFITS OF THE MODEL

Through an NIMH contract, it was possible to study the utilization of health and mental health services at Bunker Hill Health Center for persons with and without diagnosed mental disorder for the year 1975. 4/ That study permitted us to document some of the advantages to patients, 9,233 of whom used the Center in 1975 for a total of over 53,000 visits. First, accessibility and acceptability of mental health services delivered by both health providers and specialty mental health providers within BHHC were demonstrated. During 1975, 15.7 percent of Health Center patients received a provider-reported diagnosis of mental disorder, a high rate as compared with other studies of routine recording of mental disorder by providers. 5/, 6/ Health providers identified about half of these patients while mental health providers diagnosed two-thirds (the overlap is accounted for by patients seen and diagnosed by both provider types).

Second, comprehensive health care was provided for persons with mental disorder in the sense that 86 percent of such persons received some health services at the Center during the year. The availability and use of health services are particularly important for this affected population since relatively higher medical morbidity was found among persons with mental disorder than those without mental disorder (also reported in the literature 7/, 8/).

Third, specified target groups, namely children and parents, received a high level of specialty mental health services. Among the 1975 Health Center patients from Charlestown, high rates of utilization were seen, e.g., 17 percent of the boys in the 5-14 year age group and 23 percent of women in the 25-44 year age group (many of whom were single parents) were seen in one year in the Mental Health Services.

Fourth, patients with chronic severe mental illnesses were served extensively. Persons diagnosed with schizophrenia, affective psychoses and other psychoses comprised 19 percent of those seen by the mental health providers for mental disorder diagnoses, and accounted for 29 percent of the visits to the Mental Health Unit. The latter finding, which is unusually high for a health center, is largely a function of the affiliation with the CMHC and participation by these patients in chronic care programs at BHHC. The linkage with the CMHC also offered these patients numerous other advantages including easy access to inpatient care, sheltered workshops and other specialized mental health programs.

Fifth, that specialty mental health outpatient services were delivered at a reasonable cost (an average of $345 per patient per year, which is appreciably less than the $500 required Massachusetts

outpatient mental health insurance) tends to give support to the economy of this form of organization. Indeed, 80 percent of the patients seen had their mental health services fully covered at a cost below the $500 limit.

ISSUES ASSOCIATED WITH THE MODEL

Despite the long heritage of ideological and other barriers separating the health and mental health service systems and their personnel, 9/ it was possible in the BHHC experience to develop a staff that viewed mental health as integral to general health. Nonetheless, certain tensions and differences along discipline lines became manifest as the organization grew and had to undergo financial and management changes.

The initial teamwork served to develop trust and differentiate expertise among the various types of health and mental health providers. Initial limited emphasis on specialist departments or units resulted in close working relationships with minimal boundaries among the various provider types. Yet, working side by side, health and mental health provider differences in pace, role and approach were revealed. For example, health providers tended to see two or three times as many patients a day as mental health providers while the latter spent more time in the community in outreach and agency consultation activities. Although the objectives of both provider groups were to improve the overall health of the community, the approaches varied considerably. Frustrated with the length of mental health treatment for chronic mental illness and long-term psychosocial problems, some health providers felt that mental health providers should spend less time with patients and be more authoritative and directive.

In later years, as a result of both organizational growth and decreased grant support, other issues developed. The multi-disciplinary team became too large to function as an efficient vehicle for case coordination. Although other communication vehicles emerged, increased pressures to generate fees reduced the time available for health and mental health provider interaction. These factors contributed to isolation of health and mental health providers until a combination of raising fees and generating further grants and contracts occurred.

Other issues arose associated with the special relationship that the Mental Health Unit had to the CMHC. In some respects the mental health services were able to grow more rapidly due to the potential to expand programs through CMHC resources. However, the short-term nature of such staffing or funding created a source of anxiety within the Health Center. Further nonreimbursed activities associated with the mental health unit's involvement with the CMHC (e.g., attending policy and planning meetings concerning the catchment area program),

became an issue. In general there was some feeling that the availability of CMHC resources was not entirely predictable (precipitated by several long-term budget freezes), and that the Center involvement was costly in staff time.

CONCLUSIONS AND IMPLICATIONS

Despite the special organizational problems associated with integration and linkage of health and mental health services, the potential to resolve them was facilitated by the physical proximity of health and mental health providers who were by necessity forced to work together around clinical, training and research matters within a relatively small integrated organization. The pressures created by bringing the health and mental health service delivery systems closer together require continuous attention in order to derive benefits for patients. After more than ten years the delivery of mental health services has continued to increase and the health/mental health provider interface to diversify creatively.

Although the Bunker Hill Health Center may not be typical of community or neighborhood health centers with respect to the extensive integration of its outpatient health and mental health services, or the level and complexity of linkages influencing the health/mental health interface, at least some of the following recommendations which emerged for this experience should be applicable to other settings and populations:

> A scarcity of mental health resources, a high level of need for mental health services within a general medical population, and the <u>availability of new resources</u> combine to make a health/mental health effort feasible.
>
> As in all organizational or programmatic innovations, the support of <u>strong leadership</u>, and sanction by the boards (of directors or trustees) are a minimum essential.
>
> Building intra-agency and interagency linkages is a difficult process which demands great <u>political skill</u> and can best be approached on an incremental basis. 10/
>
> Specification of a limited set of <u>health/mental health service objectives</u> that can be measured or examined can serve to initiate and continue the dialogue between health and mental health forces.
>
> The selection of health and mental health staff with a holistic approach to medicine which for <u>both</u> types of providers includes a <u>biopsychosocial orientation</u> can contribute to minimizing

initial conflict and contribute to perceiving a joint mission in behalf of patients. A view of mental health as integral to health is an important philosophical basis.

The development of active and systematic communication at the board, administrative, program, and provider levels can serve to cement the joint endeavor and facilitate cooperation. Shared authority between systems and among sub-systems requires considerable good will, education and effort to reduce conflict and keep the focus on service to patients instead of process.

Initial clarity of the agreements for fiscal support of the mental health services can provide some "assurance" that as the health center mission evolves, mechanisms for supporting mental health services in a health care system will also continue to evolve.

Physical proximity alone (co-location) is not sufficient to change attitudes or practice; diligent and responsive attention to the critical health/mental health interface activities around clinical, training and evaluation/research functions is necessary to sustain healthy interaction and to promote growth.

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DELIVERY OF MENTAL HEALTH SERVICES IN A FEE-FOR-SERVICE PEDIATRIC PRACTICE

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I am a board certified pediatrician, the senior pediatrician in a group of three who practice as a fee-for-service group. We have a strong orientation toward behavioral pediatrics. The practice provides well child care, acute illness care--both in the office and in the hospital-- and what we call consultation care. Consultation care involves spending from one-half to two hours with a family, child, school, or other pertinent organization. Charges for the service are based primarily on time spent and services rendered. The requirements necessary for the provision of adequate mental health services in a primary care setting are adequate training for the provider, allotment of significant time to provide the service, and appropriate remuneration for the time spent and the quality of service offered.

In my case, the subsequent training after pediatrics residency and my Air Force tour of duty consisted of a one-year fellowship, entitled "The Psychiatric Aspects of Pediatrics," with Dr. Leon Eisenberg at the Children's Psychiatric Service at Johns Hopkins. It was literally the only place that I could find in 1962 that would allow a pediatrician to work fulltime without two years of prior adult psychiatry training and at least an implied commitment to complete child psychiatry training. It should be remembered that 15 years ago pediatricians, general practitioners, and internists were not supposed to need this training and were even discouraged from pursuing it. Each of my associates has been a fellow for one year in the Child Psychiatry program, receiving similar training following pediatric residency.

In addition, I have been involved actively in teaching programs in the Department of Pediatrics and the Children's Psychiatric Service at Johns Hopkins and as a consultant in Special Schools of the Board of Education of Baltimore County. In each of these situations I have been identified as a provider of primary care who is interested in and capable of providing mental health services in addition to pediatric services. This has further served to make our patients aware of our complete range of services and interests. We are not participants in any insurance plan, including Blue Shield of Maryland.

To help control costs, we each now generally schedule consultations at a time when at least one other physician is in the office. This serves to relieve some of the economic pressures on the office. It also serves to eliminate the pressures of answering the telephone and handling acute problems that many primary care physicians complain interfere with their delivering mental health services.

Initial screening of the consultation request may be done by either the nurse or the physician. All requests for consultations, however, are discussed with the family by the physician prior to the arrangement of the appointment. This allows for more appropriate scheduling, and increases the likelihood that all pertinent parties and material will be available at the time of the meeting. The entire session may be devoted, as is appropriate, to history taking, discussion and interpretation, and even physical and neurological examination in some cases. In addition, when appropriate, relatively simple screening tools such as the Peabody Picture Vocabulary IQ Test, Goodenough Draw-A-Man Test, and Gray Oral Reading Test are utilized. Often a disposition can be made after the initial interview. In my case, typically the initial interview lasts an hour-and-a-half. Appropriate follow-up by us also usually is arranged at that time.

We do not employ or have formal arrangements or association with any psychiatrist, psychologist, social workers, or other mental health specialists. We have done this to avoid the appearance of conflict of interest and to take advantage of the variety of both public and private services available in the community. For example, for school age children, the services of the Division of Psychological Services of the Board of Education of Baltimore County might be utilized. In the near future, we may consider hiring a psychiatric social worker who has considerable experience in medical and school settings as an addition to our staff.

An active approach to mental health delivery in the primary care setting begins with the first well child visits. Interpretation of parental concerns and observation by the physician is an integral part of the program. When we feel it is appropriate, we do ask families to spend additional time and money in consultation with us. Acceptance of this approach, we believe, is based both on the willingness of the physicians to discuss this type of information openly and on the parents' belief in the competence of the medical care being offered. Because of the way the practice is structured, we undoubtedly have attracted and lost some patients primarily because they are sympathetic or unsympathetic to this approach.

It should also be noted that each physician has a calling hour in the morning at home beginning at 7:15 a.m., during which any subject may be discussed.

Some typical areas of concern brought to us in our consultation times and other settings have included:

(1) Adjustment of family members to pregnancy and birth, including sibling rivalry and postpartum depression;

(2) effects of children on marital relationships;

(3) divorce and other marital problems as they affect children emotionally and physically;

(4) school problems;

(5) parental problems such as illness, death, alcoholism, separation, and unemployment; and

(6) anorexia nervosa as a medical and psychiatric problem.

We typically have referred patients to other professionals under a limited variety of circumstances. The primary reason for referral has been unusual severity and/or chronicity of the problem. On some occasions, however, it has been deemed advisable to refer to a mental health professional in order to maintain effectively our role as primary care physicians. We often have done rather extensive workups prior to referral—sometimes out of necessity, when the family was unwilling to accept such a workup in any other setting. The feedback to us is that, in comparison with the typical referrals from primary care settings where such screening is omitted, the patients we refer appear to be more appropriate cases, are better motivated, and are more likely to follow through on recommended therapies. Our impression is that this system of pre-evaluation represents an improved investment in time and money, with results that usually are satisfactory from all viewpoints.

The patient with significant underlying medical problems usually seems to need referral, if warranted, either to a psychiatrist with pediatric and/or adolescent training or to someone with ready access to specialized medical support or an unusual willingness and ability to maintain a close follow-up relationship with us. Failure to find such qualified referral resources generally leads to early termination of treatment, unsatisfactory outcome, and decay in the relationship between the primary care physician and the patient. We have found that non-medically oriented or related health agencies find it difficult to handle patients with underlying medical problems. The inability to understand the possible interaction of the disease process and mental health concerns, combined with their fear of having unfavorable effects on the medical aspects of such cases, leads to impotence or at least to lowered effectiveness. Community mental health clinics have not provided a consistent, reasonable or practical referral source for patients from private practice fee-for-service

settings in our experience. Despite the screening of patients, family motivation, and physician intervention, there tend to be long delays and a lack of ongoing professional, personal involvement. The limited treatment schedules apparently often are predetermined by administrative concerns.

Financing care for these services does present a problem for the less well motivated, less interested, and less financially able families. However, we find that those with some of the most severe financial limitations are at least willing to spend both the time and money for the initial evaluation, if they believe that it is beneficial to them and their children and that real help will be offered in overcoming their problems. This is true even in cases where families feel that they could not continue with more extensive consultations.

Most parents, when presented with the need for this type of care and the possibility that their health insurance will pay for at least part of it, report ignorance of the coverage and even ignorance about how to obtain appropriate information. Unfortunately, these results seem to vary only slightly when the family itself or an employer is responsible for the premiums. Again, insurance coverage does not seem to be the determinant to us in initial use of consultation time but does seem to affect long-term use of such services.

The Task Force on Pediatric Education reports that insurance coverage on children has improved, and that 90% of families have some hospital insurance for their children. But 65% of families still have no insurance covering office visits to a physician. Since policies are generally procedure oriented, counseling and psychological services are usually excluded.

Eighty percent of pediatricians report that they offer services somewhat similar to ours, to at least some extent; however, less than half of that 80% report reimbursement for the time spent, and only 5% were always reimbursed in proportion to their time. The parent or guardian was the most common source of the payment.

We unfortunately have not carefully kept statistics on the patients for whom we have provided consultative services. However, we believe that a least 80 to 90% of our patients complete the need for consultative services with us in a formal way, during 3 to 5 visits at most. The majority, in fact, require only one extensive visit. Problems requiring more time probably would include persistent school management problems, particularly those involving the use of medications; divorce and the ongoing effects of visitation, custody and other disputes, and their role in physical and mental health; and psychosomatic illness or physical illness with major emotional components.

Although there are several problems associated with this type of practice, I must reemphasize that it is possible for even the solo practitioner to adapt this type of service to his practice. However, unless time is allowed by the primary care provider and he or she acknowledges the value of and the reponsibility for such services and also receives adequate remuneration, consultation care will not be offered. Even in a group situation, it may not be possible to offer these services. Unless there are other primary care providers either offering similar services or spending time in some other relatively time consuming aspect of care, i.e., specialty care of some type, the atmosphere may be hostile to offering this service to patients. The cry often is: "I am seeing all of the patients while you see 'those people'." Usually the offer to share patients is passed up. Young pediatricians who have spent an extra period of time in training in the behavioral aspects of pediatrics and wish to add this option to their practice indicate that they have found themselves unwelcome in groups where the idea of setting aside extra time is not practiced. I have had an opportunity to compare notes with practitioners in a variety of circumstances, including HMOs; this is a common experience even there. We have had only limited experience competing with an HMO. There are several now in our areas and we have had some families join them. However, some of these families for whom we provided consultation care in the past have returned for such care from us, with fees paid directly by the families. We do not have any statistics concerning this situation. We often find out about families joining HMOs through requests for transfer of records.

It has been our impression that mental health services are most appropriately offered in a primary care setting. The requirements to make this a viable option are attitude and training of the provider, appropriate scheduling, and adequate remuneration. Awareness of these needs and requirements should extend down to the levels of medical students and house officers. There are other added advantages for the primary care provider. This system allows for the delivery of more complete, appropriate care and makes primary care a more rewarding and fulfilling profession. Mental health care cannot be solely the responsibility of psychiatrists, psychologists, and mental health counselors. It is an integral part of reasonable, even minimal, primary care. It must be recognized as such.

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TREATMENT OF EMOTIONAL PROBLEMS BY PRIMARY PHYSICIANS IN AN HMO

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The Community Health Care Center Plan of Greater New Haven (CHCP) provides the mental health services required of a federally qualified HMO to its enrolled membership of about 25,000. These include up to 20 visits to a mental health clinician and unlimited visits to a primary physician each year for the treatment of emotional complaints. The mental health services are incorporated in the primary care delivery system which is without limits on the number of total visits available to the enrollee and which can draw on the secondary or tertiary specialty services by referral. The provision of primary health care at CHCP is organized around small primary care teams, each including two physicians, a physician assistant or nurse practitioner, two medical assistants, a non-medical mental health clinician and a receptionist. 1/

Team mental health workers are psychiatric social workers, a clinical psychologist or a psychiatric nurse practitioner. They are trained psychotherapists. With the Plan psychiatrists, who provide essential back-up support to primary care and mental health clinicians, they constitute the mental health service at CHCP. There is no separate psychiatric clinic. One way to visualize the program is to think of it as analogous to a community clinic, with the enrollees constituting the community, and the clinic functioning simultaneously in two interdigitated fields of operation, primary care and mental health, each providing necessary contributions to the other for optimum patient care.

We have found that 72% of our patients with emotional problems are cared for by primary physicians alone, and are not seen by mental health personnel. The organizational model for mental health services at CHCP recognizes and supports the key role of primary physicians as mental health providers by including mental health clinicians as members of the primary care team. 2/

Psychiatric services have traditionally developed in separate care systems, such as the public and private mental hospitals, general hospital psychiatric services, child guidance clinics and community mental health centers. HMO's have followed this tradition and set up

separate psychiatric clinics as referral resources within their organizations, or purchased specialized psychiatric services out of plan. The program at CHCP breaks with this tradition. It follows a basic principle of community psychiatry, that mental health services be integrated within an organization in such a way that they further its functional goals. It subscribes to a concept of psychiatric collaboration with health, welfare or education organizations which themselves serve ego-integrative and illness-preventive functions in addition to their specific human services. The CHCP program in psychiatry is thus oriented to the human problems of patients under the care of primary physicians, as well as to patients referred to mental health clinicians for specialized care.

Mental health problems require the resources of many professional groups within the health field as well as in other social support agencies. However, most non-medical resources are utilized in a haphazard way by selected population groups. The medical establishment is the only social resource potentially available for the care of health needs of all segments of society, including all age groups, all social classes, and all ethnic groups. In our view, the inclusion of mental health services as an integral component of primary health care offers the only feasible means of substantially improving the distribution of mental health services for the population as a whole. Separation of psychiatry from the mainstream of primary medicine has resulted in the exclusion of large sectors of the population at risk and in need of mental health care. 3/

In our national health care program, primary care physicians occupy a strategic and central position in the delivery of all health services, including psychiatric. Psychiatric liaison services in general hospitals are now firmly established; similar services for patients in ambulatory health settings, although less developed, are rapidly expanding. The present challenge is to explore methods of psychiatric liaison with primary physicians which will be helpful to ambulatory patients with emotional disorders.

Given the accessibility of primary physicians to patients with a broad range of emotional disturbances and life problems, it is inevitable that the largest share of responsibility for their care now rests with these physicians, and must continue to do so. For most patients, the decision to seek help for emotional problems in a primary care setting is acceptable when referral to a psychiatric facility is not.

All health delivery systems rest on a primary care foundation. Despite the great emphasis on specialization in this country since World War II and the decline in the number of general practitioners, a primary care system has been retained in the practice of general internists and pediatricians -- with or without general practitioners as family physicians. In the further development of our national

health program, a first principle must be integration of all medical services in relation to primary care, since the fragmentation of medical care can be avoided in no other way.

The development of prepaid, group medical practices creates a large number of natural laboratories for the study of approaches using mental health clinicians as extenders of primary health care. At CHCP, most of the non-medical mental health clinicians are psychiatric social workers, but we have included a clinical psychologist on one team in medicine and a psychiatric nurse practitioner on another. We have found that professional differences become less important than the functional similarities shaped by similar job demands. The enlarged manpower pool thus provided is important if the collaborative model becomes widely accepted.

CHCP studies of the role of primary physicians in mental health care. Prevalence studies of patients with emotional problems at CHCP have paralleled the findings of other studies elsewhere. We found that in a recent period 15.7% of patients presented such problems. However, we also found that patients with emotional problems made 27.6% of all visits of CHCP for all medical and mental health reasons. We found that patients with emotional problems made three to four times as many visits to the Plan as patients without emotional problems. 5/ It was also noted that 9% of all prescriptions filled by the CHCP pharmacy were for psychoactive drugs, which 25% of all patients received.

One might assume that mental health clinicians saw patients with more serious psychiatric diagnoses or more severe symptoms. Overall this was not the case. Primary physicians alone saw a greater percentage of patients in almost every diagnostic category, including the psychoses. Whether a patient was referred to a mental health clinician was not dependent on the diagnosis but on special circumstances such as unusual pressure or time demands patients put on the primary physician; complicated personal, marital and family situations requiring the psychosocial skills of the mental health clinician; the failure of a patient to improve; legal requirements that a patient be seen by a psychiatrist, and so on. It might be noted that mental health clinicians saw 4.4% of all patients who visited the Plan, and 28% of patients with emotional problems. We should note that in a separate study of patients with chronic emotional problems, we found that mental health clinicians saw a greater number, 53.8% compared to the 46.2% seen by primary physicians alone. 6/

Very few patients with emotional problems of any kind were seen by mental health clinicians alone. They continued to be carried by their primary doctors for physical complaints, and in general made twice as many visits to the Plan for medical as for mental health reasons. An important aspect of the mental health work

of an HMO is the lack of limitation on long-term general health care. At CHCP, primary and mental health clinicians are partners in such care. The opportunity to consult with mental health clinicians formally, informally, day or night, with continuity of care assured the patient and his family as long as they are members of the Plan, provides the primary physician with a built-in structure of institutional support in dealing with the emotional problems of his patients. We regard the treatment of emotional problems as a process which unfolds over a period of years, with multiple care-givers providing patients with a gradually secured base of personal stability.

Some problems and issues in the integrated program. We see a number of organizational and management problems. Whatever mental health program is adopted at the start of a health care plan tends to become institutionally entrenched, with resistance to change. If change is to occur, it would require incentives offered to administrators and practitioners. In this connection, small demonstration programs might be helpful.

Another issue is how much responsibility the primary physician takes for patients with severe or demanding problems. This gets worked on over time with the development of mutual understanding between primary care and mental health providers of each other's capabilities and limitations, and understanding which may get sorely tried in unusual cases, and which is constantly retested and renewed.

The ratio between primary care and mental health caseloads is important. The number of mental health clinicians and the amount of time they spent in seeing patients affected how much primary care treatment of troubled patients was undertaken. Continuing health-mental health collaboration was also a factor. We conclude that staffing patterns, caseloads, physician interest, and overall program arrangements were important for the demonstrated increases in primary care treatment of emotional problems.

Staffing patterns and staff-patient ratios have remained fairly constant at CHCP over the years. This is reflected in expenditures for mental health personnel per patient per month. The in-Center cost for mental health services for the fiscal year 1974-1975, exclusive of the cost associated with primary care clinician treatment, was $.55 per enrollee per month. 2/ The cost in the current fiscal year is $.71 per enrollee per month, but this includes costs for all out-of-Plan psychiatric services, such as hospital emergency room charges and physician charges to hospitalized patients, but not direct hospital charges. The latter were $.55 in 1974-1975 and $.51 in this fiscal year. Expenditures have thus not changed appreciably.

There is an artifical separation between the mental health practice of primary physicians and psychiatrists. It is assumed that a patient may be regarded as a psychiatric case only if he

sees a psychiatrist. We have demonstrated that the diagnostic categories of patients seen by primary physicians do not differ from those seen by psychiatrists. The mental health program at CHCP attempts to bridge the gap between the two approaches to the care of patients with emotional problems.

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QUESTIONS AND COMMENTS ON TREATMENT OF EMOTIONAL PROBLEMS BY PRIMARY PHYSICIANS IN AN HMO

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My questions and comments will deal not only with Dr. Coleman's presentation, but also with issues he raises in his full paper which time did not allow him to cover.

My response is in the nature of concerns I have about first some of the priorities which influence HMO practice and second about some of the assumptions that define or justify the HMO organization we heard described.

In the first category is the extent to which the HMO incentive system implicitly rewards the false negative, in contrast to the fee-for-service system which has been criticized for rewarding the false positive. General medical practice has begun to take active steps to control the extent of false positives, e.g., PSRO, second opinions before surgery, etc. But at the same time, in fact, medicine as a healing art and science prefers the false positive to the false negative in terms of not missing a treatable illness. How then, does the HMO system, particularly emphasizing an early detection and prevention model, protect against the false negative diagnosis and treatment?

In regard to the second, these assumptions need to be identified so that they may be examined, as follows:

1. Mental health professionals are largely interchangeable, even as backup to the primary care physician, so you provide the lowest common denominator in the mental health disciplines. Are they really interchangeable?

2. When given a choice, patients prefer not to be referred to specialized mental health and specifically psychiatric services, even within the HMO system. The danger of this assumption is that it may be a self-fulfilling prophecy and a money-saving advantage. How are patients presented with the choice, and which choice is in their best interest? It seems a curious finding about HMO patients, at a time when the national experience is that the population as a whole is increasingly accepting of emotional illness as psychiatric care.

3. The assumption that children have individual resources by which they grow out of their problems, and that the one to two year follow-up data support benign neglect as an effective if not the best intervention. Dr. Coleman's own data in support of this assertion are both inadequate and also paradoxical, in that, e.g., with intervention children diagnosed as having moderate to severe disturbance did better on follow-up than those with mild to moderate disturbance. I am concerned here that the assumptions and the usage of the data justify the commitment of less than adequate resources to meet the special needs of children, in which case the HMO would be duplicating the problems children have in receiving adequate care in other delivery systems.

The HMO seems quite satisfied with the organization of mental health services described by Dr. Coleman, but I am concerned that the assumptions that underlie that organization have not been tested, perhaps because they satisfy economic considerations. The economic considerations are necessary, but alone are not sufficient to establish the guidelines by which the most efficient and efficacious mental health services may be provided to subscribers.

TRAINING OF FAMILY PHYSICIANS IN MENTAL HEALTH SKILLS: IMPLICATIONS OF RECENT RESEARCH

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Dr. Goldberg's paper reported the data from his recent study based on a psychiatrist's observations of over 2000 interviews by 56 family physicians cited three important variables accounting for much of the variance: interest and concern; psychiatric focus, similar to psychosomatic score; and age -- older doctors tending to have higher rates of identification. A number of other studies examined correlation coefficients of patient symptom levels, measured by screening tests, relative to physician ratings of degree of disturbance. While not accounting for the threshhold scores of either physicians or screening tests, the studies did suggest that over 2/3 of the coefficient variance could be accounted for by: interest and concern; and conservatism, a broad personality dimension reflecting inflexibility, resistance to change, and authoritarianism -- less conservative physicians making more accurate assessments. Thus, the ability to make accurate psychological assessments is related both to attitudinal and personality factors and to interviewing skills. The latter clearly provides more promise in terms of improving family practice training.

(The full text of Dr. Goldberg's paper appears in Section VII.)

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OBSERVATIONS ON THE IMPACT OF PSYCHIATRIC DISORDER UPON PRIMARY MEDICAL CARE

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INTRODUCTION

Houpt, et al., 1/ recommended to the Institute of Medicine that "general medical services cannot be adequately delivered in isolation from mental health services." They point out that behavorial specialists need to be concerned with: the prevalence of psychiatric disorder in general medical practice, life-style patterns of behavior which place people at greater risk, and medical disorders complicated by psychiatric disorder or life-style patterns of behavior. This report on a recent study conducted in Marshfield, Wisconsin documents the prevalence of psychiatric disorder in an adult Primary Care Provider (PCP) patient population, and the extent to which the PCP records recognition of mental disorder. In addition, psychiatric illness is related to patient distress, functional level, and overall medical utilization.

SETTING

The study was conducted in Marshfield, a central Wisconsin town of 17,000. The Marshfield Clinic, a 170 physician multispecialty group practice, provides primary care to the residents of Marshfield and the surrounding rural area as well as providing secondary and tertiary referral care to a large segment of central and northern Wisconsin. The responsibility for primary care at the Clinic is divided between the general internal medicine section (8 M.D.'s) and the immediate care section which consists of 4 family practitioners and 3 immediate care physicians. The next closest physician practice is approximately 20 miles from Marshfield.

Prepared in Collaboration with Gregory R. Nycz, B.S., Researcher, Marshfield Medical Foundation, 510 North St. Joseph Avenue, Marshfield, Wisconsin and Paul D. Cleary, M.S., Researcher, Center for Medical Sociology and Health Services, University of Wisconsin, Madison, Wisconsin.

The base population for the study consisted of the adult residents of the Marshfield zip code area who utilized services of the primary care providers from January through March, 1978.

METHODS

Previous methodological problems in prior studies dealing with these issues have been addressed in this study by: (1) Measuring prevalence of psychiatric disorder utilizing Research Diagnostic Criteria (RDC) 2/ in a standardized psychiatric interview, The Schedule for Affective Disorder -- Schizophrenia (SADS-L) 3/ to control for reliability and validity of psychiatric diagnosis; (2) Weighting to control for biases due to oversampling of high PCP utilizers and seasonality of the sample; 4/ (3) Comparing sensitivity and specificity of PCP diagnosis with RDC psychiatric diagnoses; (4) Conducting a detailed nonparticipation analysis, 4/ and (5) Obtaining an overall functional level with the Global Assessment Scale (GAS). 5/ Further details of the study design are available. 4/

RESULTS

Table 1 displays the prevalence of psychiatric disorder as measured by three different criteria. Utilizing the SADS-L as the criteria for mental disorder, the weighted estimate of the prevalence of RDC psychiatric disorder in the adult primary care population was 26.7%. The RDC lifetime prevalence in this group was 49.5%. The prevalence of PCP point diagnosis (within one month of study entry) of psychiatric disorder was 1.8%. When the determination of the presence of psychiatric disorder was broadened to include PCP nondiagnostic recorded recognition (psychiatric symptomatology, psychotropic drug abuse, referral to a mental health specialist, counseling), the resulting point prevalence was estimated to be 5.1%.

Table 2 presents the weighted estimates of the prevalence of the more frequent specific RDC diagnoses in the adult primary care patient population. These are not mutually exclusive categories; in fact, 25% of those with RDC diagnoses had two or more such diagnoses. Major depression and phobic disorder were the most prevalent (5.8%). The GHQ 6/ score was derived from a 30 item symptom screening device which seems to be a measure of distress. 7/ Persons with RDC diagnoses have mean GHQ scores that are greater than the general adult primary care population (mean = 4). The data on mean GAS scores by RDC diagnoses demonstrated that these psychiatric syndromes also adversely affect functional level. The schizophrenic disorders, not shown here, demonstrate even greater distress and dysfunction.

TABLE 1. RECOGNITION OF PSYCHIATRIC DISORDER BY RDC CURRENT, RDC EVER, PCP DIAGNOSIS, AND PCP RECORDED RECOGNITION IN WEIGHTED SAMPLE

Type of Recognition	Percent of Adult Primary Care Provider Users
RDC Current Diagnosis Present	26.7
RDC Diagnosis Ever Present	49.5
Primary Care Provider Psychiatric Diagnosis Present Within One Month of Study Entry	1.8
Primary Care Provider Recorded Recognition of Psychiatric Disorder Present Within One Month of Study Entry	5.1

TABLE 2. FREQUENCY, AVERAGE GHQ, AND AVERAGE GAS BY THE MOST PREVALENT RDC DIAGNOSIS IN THE WEIGHTED SAMPLE

RDC Diagnosis	Frequency*	Percent	Mean GHQ	Mean GAS
Major Depression	14	5.8	11.9	62.3
Minor Depression	8	3.4	6.0	73.4
Intermittent Depression	12	5.0	5.1	71.8
Generalized Anxiety Disorder	4	1.6	12.3	67.9
Cyclothymic Personality	5	2.0	9.9	70.0
Labile Personality	9	3.7	9.4	70.8
Phobic Disorder	13	5.8	6.5	76.4

*Number rounded to integers

Table 3 presents the overall medical utilization of patients with and without RDC psychiatric illness for 12 months before study entry and six months after study entry. Patients with a RDC diagnosis have a higher level of medical utilization (4.05 vs. 3.25 for the 12 month period before study entry). For the six months after study entry the comparable rates were 7.77 and 5.49.

TABLE 3. AVERAGE ANNUAL VISIT RATES BY PRESENCE OR ABSENCE OF A RDC DIAGNOSIS AT STUDY ENTRY FOR THE PERIODS 12 MONTHS BEFORE AND 6 MONTHS AFTER STUDY ENTRY

	Weighted Sample	
Time Period	Annualized Visit Rate for 62 RDC Positive Patients	Annualized Visit Rate for 171 RDC Negative Patients
12 Months Before Study Entry	4.05	3.25
6 Months After Study Entry	7.77	5.49

DISCUSSION

The results indicate that there are three problem areas:

1. A significant number of patients seek primary medical care who have a RDC psychiatric disorder which is distressing and affecting functional level.

2. PCP's identify very few of these patients (3 out of 100 true cases).

3. There is an overall increase of medical utilization in the adult primary care population who have a RDC psychiatric illness.

With approximately 25% of the adults seeking care in the primary care sector having a dysfunctional and distressing RDC psychiatric disorder, and only approximately 2% currently having a recorded psychiatric diagnosis, better case identification would appear to be a valuable goal to improve quality of medical and mental health care. Two studies 8/, 9/ have shown that if mental health and primary care services are integrated professionally, administratively and structually, there is an improved case identification, in that a

greater proportion of the population served is seen by mental health care providers than in non-integrated mental health settings. One of these studies 9/ demonstrated that when mental health workers are physically located in the primary care setting, this identification improves even more. Goldberg 10/ has shown that utilizing a screening device in a primary care setting can also improve this case identification. The hospital formal consultation-liaison service model applied to the ambulatory care setting would in all likelihood improve case identification. Review of the charts of the RDC identified patients in our study indicated that as Houpt, et al, 1/ described, some had psychiatric disorder only, some had a coexistent medical and psychiatric illness, and some had life-style patterns of behavior which either related to the onset of the illness or complicated treatment; that is, non-compliance with therapeutic regimens. Many were also experiencing social and environmental stressors 11/ at study entry.

Increased detection per se is of limited utility if problems exist in obtaining adequate treatment for detected cases. Therapeutic behavioral and psychopharmacological techniques have proven value, but both depend on high levels of patient compliance and therapeutic expertise. As one physician colleague has stated, "I don't want to detect something I can't do much about." The physicians' past psychiatric education has been didactic or caring for severe psychiatric patients; therefore, they have little observational knowledge of how psychotherapists treat or detect the ambulatory psychiatrically ill. From our findings it appears that the PCP is more likely to identify the chronically high utilizing, more dysfunctional, psychiatrically ill patient correctly. 4/ This would reinforce their attitudes about the chronicity of the psychiatrically ill. Conversely, they are less likely to detect the less disturbed acutely psychiatrically ill who are more likely to get better.

The PCP may also be aware of a psychiatric problem without making a notation of that problem because of the stigma associated with the label, and may not consider such information appropriate for inclusion in the medical record; a behavior modeled after psychotherapists.

Psychophysiologic complaints and mild symptoms of dysphoria viewed by the PCP as problematic are not adequately described by RDC or other DSM-III 11/ criteria. This accounted for most of the PCP misidentification in this study. RDC psychiatric illness is based on combinations along three dimensions: (1) symptom complexes or syndromes, (2) functional status, and (3) socially unacceptable behavior. Although some behaviors and feelings may fit a particular RDC diagnosis, they may not be perceived as problematic by either patients or their physicians. Such discrepancies emphasize the differences among the PCP's orientation (primarily symptomatic and bio-medical), the patients' orientation (subjective discomfort or

dysfunction), and the RDC (detection of syndromes, dysfunction and deviant behaviors). Future studies are needed to understand the complex interactions of these three dimensions so that providers can offer an integrated therapeutic approach.

Densen et al. 12/ in 1959 found that 4% of prepaid plan members of the Health Insurance Plan of New York utilized 25% of ambulatory care visits. In Marshfield, Wisconsin in 1977, these findings were replicated in a prepaid plan population with widely divergent socio-demographic characteristics. 13/ In the Marshfield population, persons diagnosed psychiatrically ill were disproportionately represented among the highest medical utilizers, especially in the chronically high utilizing population during a three year period. 14/ Kogan's 15/ results supported this finding. Our present study indicates that physician psychiatric diagnoses when made are accurate in the Marshfield setting, suggesting that the psychiatric labelling in the previous study 13/,14/ is valid. Since 1965 numerous English 16/,17/ and United States 9/,15/,17/,18/,19/ studies have demonstrated the consistency of the finding of greater ambulatory medical utilization by persons with diagnosed psychiatric disorder than persons without diagnosed psychiatric disorder. In this study, when identification by RDC for psychiatric illness is utilized, this differential in medical utilization holds true. The evidence remains strong that the more chronic, dysfunctional psychiatrically ill population place a heavy burden on the primary health care system. A high priority should be placed on developing screening and evaluation programs in primary care settings for psychiatric illness. To accomplish improved PCP case identification, present PCP's need to be reeducated to appreciate the value of the psychiatric diagnostic process coupled with the effect these syndromes have on the three dimensions of distress, dysfunction, and deviant behavior. Caution must be used since identification of high medical care utilizers who are experiencing psychological distress may only encourage further utilization by reinforcing help seeking behavior.

One way of accomplishing these goals would be to establish formalized ambulatory psychiatric consultation-liaison programs in integrated health and mental health care settings. This might encourage the establishment of linkages between PCP's and specialized mental health providers. Such programs should be temporary since PCP's would probably learn through consultation appropriate techniques for case identification, therapeutic intervention, and specialty referral. The PCP would also learn how to establish and maintain linkages with the specialty mental health care providers and no longer need a consultation-liaison person to do this for him.

These programs would need an evaluative component to answer questions about the effectiveness of case finding of psychiatric illness in primary care. Should acute psychiatric illness be identified since it appears most patients improve without inter-

vention and there may be a risk of actually reinforcing medical utilization by focusing on psychological distress? Which providers are most effective and efficient in the treatment of various chronic and acute psychiatric illnesses? Should providers focus their therapeutic efforts on distress or dysfunction or a combination of the two? Finally, evaluation procedures need to use scales which measure functional level, distress, and deviant behavior so that therapeutic outcomes can be measured.

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LITERATURE REVIEW ON MANAGEMENT OF EMOTIONALLY DISTURBED PATIENTS IN PRIMARY CARE SETTINGS

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To examine the management of emotionally-disturbed patients in primary care settings, Dr. Hankin and her colleague Dr. Julianne Oktay reviewed the literature published from 1958 through 1978. The review focused only on patients actually identified by primary care providers in North American settings, using the broadest definition of mental disorder. While referral to a mental health specialist is a treatment option, this review was limited to consideration of psychoactive drug therapy and psychotherapy administered by primary care providers.

(The full text of Dr. Hankin's paper appears in Section VII.)

Mental Health Services in General Health Care: Summary of the Invitational Conference on the Provision of Mental Health Services in Primary Care Settings, April 2
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SUICIDE PREVENTION BY FAMILY PHYSICIANS: OPPORTUNITIES AND LIMITATIONS

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I think that I have, in fact, very little to tell you that will be new to you about the epidemiology of suicide or the need for a preventive role on the part of the primary care physician.

Our interest was not that of research per se but arose from the need to inform ourselves about the problem and how better to tackle it. About the context of our subject: First, in terms of the size of the problem, it is said that at a conservative estimate, in the United States there are 225,000 attempts a year, actions intended to or capable of resulting in death by the individual's own hand. Rather more than one in 10 of these are successful. Suicide is 13th among the leading causes of death. The figures are for 1977. Having said that, for the primary care doctor, the problem will always remain an individual one. Large studies may show differences in profile between the failed and the essentially never intended death, but I do not think that these will greatly help the primary care doctor.

Second, there is a recognized connection between the problem of death by one's own hand and that of personal isolation.

Looking at these SMRs for the year 1965 to 1967 (Registrar General statistics), those on the extreme right may cause you to reflect how lucky you are if you have been successful in pairing for life at an appropriate age. They also reflect other very complex factors, and the implications of the table extend far beyond this particular topic: to the planning services, to the primary care work load. Looking at suicide, there was a great deal of literature from sociological and psychiatric sources over a century or more but the paper which most attracted us was Peter Sainsbury's first Maudsley monograph (1955), which he described as 'an ecological study.' He looked at 409 consectuve suicides over a three-year period in a north London Coroner's Office. I would like you to take note of Sainsbury's definition of bereavement, not simply that of a death in the family, but a wider definition, which has implications for our own work. I am also indebted to him for this quotation from Bacon: "For little do men perceive what solitude is and how far it extendeth. The Latin adage

Table 1:

	1965-1967			
	Married	Single	Widowed	Divorced
Males:				
(Ages 15-84)				
Resp. Tuberculosis	79	203	147	212
Cirrhosis of liver	88	142	138	220
Accidental poisoning	64	157	225	346
Suicide	68	152	125	184

Hospital "utilization" shows similar variation. Commentary - Registrar General, 1967

meeteth with it a little, magna civitas, magna solitudo, because in a great town friends are scattered, so that there is not that fellowship, for the most part, which is in less neighborhoods." The association between size of community and suicide is well-documented in the United States: the smaller the community, the rarer the occurrence. Other important associations are brought out in Sainsbury's work: with poverty, with lack of work, with alcoholism, with broken marriage or divorce, with a broken home in childhood, and with inner city residence.

If you were to ask where all such things come together, they do so precisely in such an area as that where I practiced, an old borough in the center of the metropolis at a time of unsettlement in the population, a process which is called 'urban renewal.' With the consent of the local coroner, we looked at 250 consecutive suicides presenting in the records of the Coroner's Court, Southwark, covering the area served by Guy's, King's College and St. Thomas' Hospitals, essentially that of our own practice area. The principal author, Dr. W.C. Lettington, was my partner. The third author, Ian Cross, was a medical student then studying in the practice.

We examined marital status at the time of death. Note the figures for the widowed, the only column in which there is a female over male preponderance. I have said nothing of age and class, although we looked at these. Recently bereaved females had a mean age of 54, but there was an interesting bimodal distribution with an older group in the 60 to 75 year age range. We classified those of "stable marital status," whether single or married, and those

TABLE 2.

Marital Status (at the time of death)	
Married	98 (55 M, 43 F)
Separated	30 (20 M, 10 F)
Divorced	10 (6 M, 4 F)
Single	74 (47 M, 27 F)
Unknown status	3
Widowed	35 (12 M, 23 F)

of "altered marital status" to see whether this gave any help. In fact, it did not. We could not determine from the records how long previously the second group had been separated, divorced, or widowed.

We went on therefore to look at a group across both the above who were "recently bereaved." Nineteen of the first group, those of stable status, and 33 of the those of altered marital status, 52 deaths in all, were recently bereaved; out of our total of 250, one-fifth of all.

If you look at the causes given, less than half were associated with bereavement by death. In terms of Sainsbury's wider definition, deaths were associated with marital breakdown, a lovers' quarrel, the admission of a loved one to hospital, an adolescent leaving home, and so on.

TABLE 3.

GROUP C

19 of group A (stable marital status)	(13 M, 6 F)
33 of group B (altered marital status)	(19 M, 14 F)

52 deaths, one fifth of the total were recently bereaved.

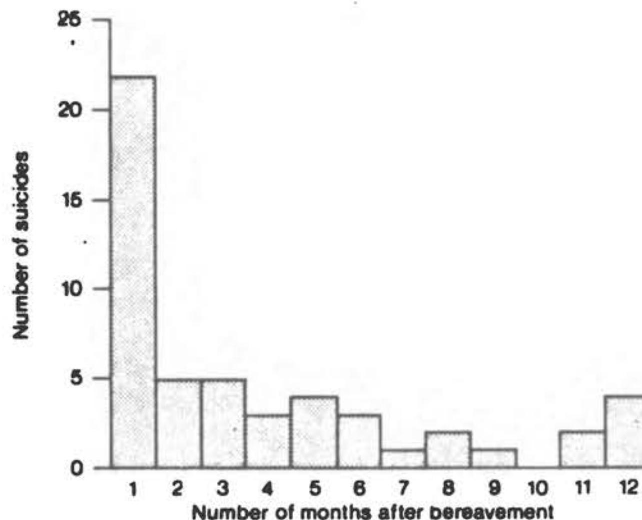
23 (44% of Group C, 9% of all deaths) had experienced the death of a loved one within the preceding 12 months. 29 (56% of Group C, 12% of all deaths) had experienced marital breakdown, a lovers' quarrel, the admission of a loved one to a hospital, an adolescent leaving home. Of these, marital breakdown affected 16 (M : F - 3 : 1).

As to the manner of death, there emerged one profile of a person compliant, biddable, responsive to family, to friends' or neighbors' suggestions to see a doctor, willing to see the doctor frequently. These persons died from self-administered drugs. There were others whose deaths display anger, protest, violence, perhaps punishment of another.

We looked at events leading up to death as to whether these might help to predict outcome. The recently bereaved did not differ from other groups in relation either to suicidal threat or suicidal attempt, although suicidal threat occurred three times more frequently.

Lastly, we looked at the existence of contact with the psychiatric services in this group. When we looked at the first two groups, we had found that 40 percent overall had formed some psychiatric contact; in the recently bereaved group only about half that number had formed such a contact.

Figure 1. Relationship between duration of bereavement and suicide among 52 suicides (Group C)



This stresses the vital role of the primary care physician, the only person likely to be able to make a contact at that time; a resume of something that you all know, pointing to the crisis situation that may exist after recent bereavement. What can we say about the role of the primary care doctor in prevention? Certainly young doctors and nurses in emergency rooms do a great deal to prevent, the change to the utilization of natural gas from carbon monoxide prevents, the change in the prescribing of drugs from barbiturates to benzodiazepines prevents. What it comes down to is always a question of measuring risk against resources, and people are very prone to score risks without being aware of the

importance we should attach to resources. You can tell me exactly what the Holmes & Rahe Scale says of somebody who is bereaved, who has also been ill, but you cannot score for all the part played by the patient's coping resources in avoiding this fate. Such coping resources may be money in the bank, may be previously learned skills in dealing with hardships; but most often they are people, members of the family, friends, neighbors, the local community, local authority services. Those life events which convey risk are much less than half the story.

(1) I think the family doctor needs to be aware of the patient's situation as a crisis. In practice, nothing will distinguish the failed overdose from the accomplished suicide, but if life continues, there is chance of adjustment.

(2) There is the duty to inquire directly into feeling of self-destruction, self-blame, unworthiness, and to take the appropriate steps, including, if necessary, admission to a psychiatric unit.

(3) There is a need to provide continuous and committed support, if necessary, daily. This is very demanding of the primary care physician.

(4) The doctor must have the ability to deal with the patient's or relatives' expectation of drug therapy.

(5) We need to know the patient's place in the social network, of other resources that could be invoked on the patient's behalf.

For example, we matched two recently bereaved men who supported each other until their need of company was no longer acute, and although they had enjoyed their association, they did not continue with it. In this context, too, I want to mention the work of the primary care team, from secretaries through practice nurses, social workers, and so on.

(6) We need to learn skillfully to deal with grief and anger, with despair, and to encourage mourning. In this instance, we were only able to help a mother who had a stillbirth when we insisted with the local hospital that she be allowed to see and to touch the stillborn child, which had been denied her.

(7) Finally, we need to know more of the dynamics of family life. I would like to give two illustrations. One is that classic of the daughter who has stayed on through middle life to look after elderly parents, a tower of strength to everybody, including the family doctor, right through the funeral and who then, with intense deprivation of role, becomes not the person who makes the most noise, but the person in the greatest need.

In another direction, expectation of role is a major problem: a recently bereaved father is typical. He is widely invited, he is well supported, he is fine everywhere except with his daughter. He believed, until it was made clear to him that this was not so, that, to display to her how much he had loved her mother, he needed constantly to show himself in the grieving position that he occupies exclusively with her. Thus, there is much in family dynamics that we have to be aware of. Lastly, I would like to say that it is always a human sum, the youngest person in our study being a girl of 15, the oldest a man of 86.

Thus, if you asked me to sum up the role of the family doctor, I would refer to Polonius, who telling Hamlet about the actors, said they were the best in the world, either for . . . . pastoral-comical, historical-pastoral, tragical-historical, tragical-comical-historical-pastoral, scene individual or scene unlimited.

In the case of the family doctor, I think there is no doubt but that the role is diagnostical-therapeutical-pastoral, and this not in the sense of Shakespeare, but in the sense of "feed my lambs" and "feed my sheep."

THE PRIMARY CARE PHYSICIAN: MENTAL HEALTH SKILLS

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Primary care practice provides special opportunities for the prevention, diagnosis, and treatment of mental disorders, through decreased stigma associated with the patient's mental illness, greater likelihood of familiarity with the patient's social context, and greater potential for long-term followup. However, studies traditionally have shown that most general practitioners, while they may recognize the emotional situations of their patients, are not qualified to treat mental health problems -- despite characteristics of the primary care therapeutic relationship that should enable physicians to treat many mental disorders more effectively than can specialists. Even when physicians are adept at helping their patients through normal life crisis, they generally lack skills to deal adequately with mental problems such as neurotic disorders, psychophysiological disorders, behavioral disturbances of childhood, character disorders, and more severe depressive and schizophrenic psychotic reactions. Dr. Lawrence suggests integration of mental health skills into primary care training programs as a mechanism for eliminating these deficiencies and enhancing the primary care physician's ability to ameliorate both physical and mental health problems.

(The full text of Dr. Lawrence's paper appears in Section VII.)

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THE ROLE OF THE PSYCHIATRIST IN PRIMARY CARE SETTINGS: ISSUES AND PROBLEMS

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My task today is to describe some of the challenges and problems for the psychiatrist working in primary care settings. This discussion is based upon my experience in two very different settings, a neighborhood health center and a large multispecialty group practice. The focus of this presentation will be on problems rather than on the benefits of this form of practice which have been so well described by other speakers.

The work of the psychiatrist in a primary care setting combines central features of practice from three other settings: (1) the outpatient or office practice; (2) the psychiatric liaison service; and (3) the community mental health center. The primary care psychiatrist must be able to use the kinds of diagnostic and therapeutic skills of the outpatient therapist, for this will be an important feature of what the clinical service offers the patient and the referring physician. Secondly, like the liaison psychiatrist he is called upon to help manage patients with medical illness and help staff cope with their responses to medically ill and chronically disabled patients. The primary care psychiatrist will also require the skills of a translator of psychiatric concepts and views for the non-psychiatric practitioners in the general practice. The ability to move across and between disciplines requires an ability to explain the complex and sometimes confusing concepts of psychiatry in non-technical language. Being at the interface of psychiatry and medicine means the psychiatrist must also have some interest in the medical problems of his colleagues' patients in order to experience the setting as relevant to his professional interest.

This task of translator is a difficult one, for psychiatry is frequently misunderstood by outsiders. The recent _Time_ magazine cover story on "Psychiatry's Depression" reflects this, for this story, while probably inaccurate in its presentation of the way psychiatrists view themselves, reflects accurately the way others view us. Those others include physicians and nurses. They find our concepts fuzzy, our suggestions confusing and imprecise and our jargon impenetrable. Yet they need us for they have a large group of patients who have major psychosocial issues interfering with

their lives and leading them to these general practitioners. Thus, the practitioners keep returning for advice only to find again, as exemplified by one physician who was unusually sensitive to the psychologic problems of his patients, that when we discuss it often sounds more like "gossip" than clinical case discussion.

Third, the primary care psychiatrist must recognize that the patients of a general practice are a population at risk for mental illness and thus provide an opportunity for the establishment of programs for early intervention or at least alternative intervention, using the relatively acceptable medical setting. Examples of this are the development of the adolescent clinic with psychiatric consultation regarding the psychosocial problems of these patients. A population-based focus may also have an impact on direct patient care in that recognition of patients who may be able to use psychiatric services but are ambivalent may lead to use of outreach techniques like home visits. In addition, the psychiatrist in primary care who sees all the patients of the medical practice as potential clients must be flexible in making therapeutic contracts which reflect the patient's ambivalence. This may lead to extensive contact over years but with only a few visits at a time. This type of intervention, in fact, closely imitates the model of the general practitioner's lifetime involvement with patients where actual interventions occur with long lapses of inactivity. For the generalist and the patient, however, these lapses do not mean termination or dropping out; they are simply an inactive phase of the relationship. The application of this approach, which I term extensive therapy, is a direct reflection of a population-based focus in which the psychiatrist attempts to engage all patients with psychosocial disturbance -- not just those who are willing to call their disturbance psychiatric or those who are "appropriate" for psychotherapy. Thus the primary care psychiatrist is also a community psychiatrist with the community defined by the medical practice.

The problems for the psychiatrist are multiple. He must be able to carry out very different types of tasks; he must fight the temptation to interpret the problems of translation as reflections of personal ineptitude or a demonstration that psychiatry must be reduced to a few hard facts. It would be nice if we had lab tests, but we do not; a return to our medical roots by giving up the complex, sometimes fuzzy concepts which we are still building will be a temptation for the psychiatrist practicing in a medical facility. Ironically, the generalist will be an ally in this particular fight, for as much as he'd like us to be precise he also recognizes that he wants us to join him in managing chronically disabled patients. Besides the danger of loss of identity by being in a non-psychiatric setting, the psychiatrist faces the problem of losing funding. The separation of psychiatric funding for research, training and services since World War II has lead to major growth in the field of psychiatry. By linking psychiatry to medicine the

loss of identity at a personal level may lead to a loss of identity at an institutional and national level. Psychiatric studies often seem soft and services are difficult to measure in terms of clear outcome; thus, the push towards linkage must be tempered by a realization that the unique identity and goals of psychiatry should not be lost by a simple reductionism.

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REIMBURSEMENT FOR MENTAL HEALTH SERVICES IN PRIMARY CARE SETTINGS

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It has been generally acknowledged that the experiences of other industrialized countries who have had some form of universal health insurance coverage should be studied as the U.S. seeks to initiate such a program. Dr. Richman describes elements of the Canadian health insurance system that have implications for the kinds of benefits that could lead to provision of truly comprehensive health/mental health services for the U.S. population.

The Royal Commission of Health Services recommended in 1964 medical services benefits covering the full range of diagnosis and treatment for all physical and psychiatric conditions. The Canadian National Health Plan -- "medicare" -- with this benefit package went into effect in 1969. Under the Canadian medicare program, reimbursement covers 50% of medical costs for those provinces in which health systems feature comprehensive and universally available services, accessibility to users to all income levels, and portability of benefits between provinces. The fee-for-services plan allows patients to choose their physicians, who in turn submit reimbursement claims to provincial agencies of the national system.

Throughout Canada during 1977-78, 3.8 million psychiatric services (170 services per 1000 population) were reimbursed at $91 million ($4042 per 1000 population); 43% of those services were provided by general practitioners.

Data for Saskatchewan during 1977-78 show the following trends: 1) Overall, 13.3% of the total Saskatchewan population received psychiatric services — 18,400 from specialized mental health hospitals or clinics, 10,100 from general hospitals, and 94,600 from private practitioners. 2) Of the total population diagnosed with mental disorder, functional psychoses accounted for 30% of inpatient psychiatric services, 9% of mental health clinic services, 7% of general hospital ward services, and 4% of services from private practice physicians. Neuroses and psychosomatic disorders accounted for 25% of psychiatric inpatients and 73% of private practice patients. 3) Of all patients who saw physicians, 88%

were seen by general practitioners and 12% were seen by psychiatrists; 6% were seen by both. 4) In terms of utilization, 77% of the patients who saw physicians received 28.1% of all medical services, while 4% utilized 39% of all services. 5) About 10% of patients seen by general practitioners used 50% of the mental health services provided, and 20% of patients seen by psychiatrists used 50% of those mental health services. Thus, the disproportionate use of mental health services was greatest among patients of general practitioners.

The data suggest a number of issues to be considered as more physicians become providers of reimbursable psychiatric services: 1) How can epidemiologic methods and classification systems be standardized to decrease variability among practitioners? 2) How can quality of care be guaranteed? Quality assurance in ambulatory mental health care will depend on more reliable definitions of diagnostic and therapeutic criteria and goals, distinguishing mental disorders from psychological reactions and emotional responses. In addition, it should be made clear that diagnosis of mental disorder does not necessarily justify treatment. 3) Does reimbursement for psychotherapy under national health insurance represent economic subsidy to the rich from the poor? and 4) How can psychiatric skills in clinical care appropriately be matched with mental health problems?

(The full text of Dr. Richman's paper appears in Section VII.)

PROBLEMS OF ANALYZING THE COST OFFSET OF INCLUDING A MENTAL HEALTH COMPONENT IN PRIMARY CARE*

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To assess whether there is cost-offset attributable to including a mental health component in primary health care would seem to be a straightforward research problem. Instead it is encumbered with difficulties from several sources, some conceptual and methodological, others practical and statistical.

First, one of the hopes of those who propose including significant mental health coverage in primary care settings is that it will serve to reduce medical utilization and hence reduce costs. But the very assumption that mental health services should reduce the utilization of other medical services needs to be examined closely.

Certainly mental health care should be required to demonstrate that it is effective and even that it is cost-effective, which is to say efficient. But should it have to justify itself by displacing other medical services? There are certain circumstances when such an offset might be expected, chiefly when physical health services are misutilized and overutilized, that is, substituted for unavailable, inaccessible, or inconceivable mental health care.

The reasoning underlying this expectation is that people will seek help for emotional problems whether or not a proper channel is provided. Emotional problems frequently have somatic components and it is easier for many people to ask for medical attention for sleeplessness, "tension," low back pain or G.I. disturbance rather than for "depression."

Reducing misutilization must be part of any attempt to improve health service systems. But misutilization may coincide with either <u>under</u>utilization or <u>over</u>utilization. Self-neglect or abuse is

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common among the emotionally ill, a factor which may contribute to the excess morbidity and mortality from physical disease noted among psychiatric patients (Goldberg, et al., 1979). One effect of successful mental health intervention for such persons should be to increase medical utilization (Borus, et al., 1979). For example, services are misutilized and underutilized by parents who fail to bring a child to medical care even though a reversible disease process has been identified through an expensive screening program. Services are misutilized and eventually overutilized when preventive services are not used and avoidable illness results in hospitalization. Misutilization also occurs when neglect of prenatal care contributes to unneccessary complications at delivery or to the birth of a defective child. Recognizing the paradox that failure to use medical services can result in overuse and misuse of health services is central to many preventive efforts and health education campaigns. The time, money and health potential wasted when medical advice is sought but ignored is the subject of a burgeoning literature on "compliance" with medical advice (Barofsky, 1977; Sackett and Haynes, 1976).

Excessive utilization directly raises costs of medical service. But it is also of great concern to physicians since it may reflect inappropriate utilization and hence lower quality of medical care, ironically at higher expense. Physicians, patients and third-party payers share an interest in realizing an optimal level of medical utilization that results in improved functioning with a minimum of unnecessary procedures, visits and hospitalizations.

A second conceptual problem is the supposed distinction between mental health care and physical health care. While conceptually distinguishable, emotional and physical distress are so inextricably intertwined that it can be counterproductive to encourage treatment of physical malfunction while discouraging treatment of emotional malfunction. Furthermore, the strategies that would be required to assign patients to services treating only psychological disorders or only physical disorders boggle the mind in light of the many studies that demonstrate the coexistence of both kinds of problems.

A third conceptual problem has to do with the very nature of the major variables of interest. Health itself, which is the prime outcome variable, is largely represented in research by medical utilization, a presumed negative indicator. Often the definition of health and whether an emotional problem is "a problem in living," a religious problem, an ethical problem, a social problem, or a medical problem seems to depend on whose purse is being gored. Medical utilization is often chosen as the indicator of convenience. It is not a simple variable, but rather a congeries of hospital days, doctor visits, procedures done and medicine prescribed. Since it is expressible in dollars spent, it is a convenient way to refer to the output of a health services system.

But there are other "hard," or easy to measure, indicators, and any number of "soft" ones that could be considered. "Soft" indicators generally refer to subjective issues, feeling well or ill, satisfied with medical services or not. While more difficult to measure, they may be equally or even more important as are the "hard" ones to the persons who are the patients of these studies, as well as to society.

Not withstanding all these caveats, it is important for planning health care systems to know if providing mental health services has any effect on the utilization of other medical services. While we will focus on the influence of psychotherapeutic intervention, medical utilization is also influenced by a wide range of psychosocial, economic, geographic and financial factors (Engel, 1977; Lipowski, 1977, 1975; Glass, 1977; Fabrega, 1975; Kaplan, 1975; Mechanic, 1976). We list some of these in order to warn the reader about the complexity of the field. Among the factors to which medical utilization is sensitive are the following:

1. The tendency in our society to "medicalize" life problems; the "selling of medicine" as holding the key to health, happiness, sexual success and social popularity (Aday and Andersen, 1978; Eisenberg, 1977).

2. Perceptions of health--emotional and physical--and the place of health in hierarchies of values (Kaminsky and Slavney, 1976; Lesse, 1974).

3. Perceptions of "rights"--to care, concern, treatment equality, attention--all expressible as "the right to treatment" (Mumford, 1977).

4. Secondary gain--the use of the experience of complaint of illness and medical attention to legitimatize a wish to be cared for, to be excused from fulfilling obligations and responsibilities, to fulfill a desire for "compensation" either for actual disability or for a sense of being treated unfairly by life (Mechanic, 1976; Dohrenwend and Dohrenwend, 1969).

5. Economic conditions--it has been observed that visits to physicians and rates of hospitalization increase in times of economic decline (Brenner, 1973).

6. Availability of health services--including geographic factors, clinic and office hours, presence of emergency services or walk-in services, financial conditions, and social and cultural expectations and patterns of help-seeking of the "patient" population (Mechanic, 1976; Clancy and Gove, 1974; Webb, et al., 1977).

7. Stress and "life events" may lead to emotional distress presenting as physical disease. Emotional distress, etc., may also affect existing disease, exacerbating symptoms or affecting the body directly or indirectly. Emotional factors, etc., may also trigger visits to physicians for a previously ignored physical illness (Mechanic, 1972; Clayton, 1973; Fontana, et al, 1976; Roghmann and Haggerty, 1972).

8. Physical illness may itself lead to social and/or psychological problems, including family disruption, which in turn may lead to emotional distress further aggravating the physical illness and leaving the patient dependent on medical facilities (Rappaport, 1975; Engel, 1977; Gersten, et al., 1977).

9. Patterns of response to medical advice resulting from the nature of care given and the setting in which it is given as well as cultural factors and personal idiosyncracies (Barofsky, 1977; Becker and Maiman, 1975; Sacket and Haynes, 1976; Rosenberg and Raynes, 1976; Stimson and Webb, 1975).

10. Professional convictions of health care providers about the appropriate "treatment" of complaints presented to them (e.g., surgeons tend to recommend surgery) (Lawson and Jick, 1976; Sedgewick, 1974; Vayda, 1973; Bunker, 1970).

11. Economic motives of health care providers (Fuchs, 1974).

12. Iatrogenic illness (Bercel, 1968; Fuchs, 1974; Reidenberg, 1968; Ogilvie and Reudy, 1967).

13. Risk-taking behavior--smoking, overeating, lack of exercise, careless driving, etc. (Pomerleau, et al., 1975; Singer, et al., 1976).

14. Environmental conditons--pollution, unsafe industrial conditions, traffic hazards, etc. (Fuchs, 1974).

15. The nature and effectiveness of social controls over availability of health care and its utilization (Goshen, 1963; McCarthy and Widmer, 1974).

This list is not exhaustive and many of the factors can be further sub-divided. Since medical utilization is sensitive to so many factors it would be all the more noteworthy if the availability and use of

psychotherapy or other forms of "mental health," or psychologically informed, intervention can be shown to influence it.

Psychotherapy is also a complex variable subject to multiple influences. To summarize, one must consider:

1. The kind of psychotherapy offered. Psychotherapies are classifiable in terms of the unit treated, e.g., individual or group, couples or family, in terms of the theory that inspires the effort, defines the presumed mechanisms or process and explains the results.

2. The time dimension of psychotherapy. How frequently is the patient seen for sessions of what length and over what period, intermittently or continuously? Long duration of treatment and high frequency of sessions are sometimes considered to guarantee "intensivity" while a brief episode of infrequent visits of psychotherapy may be dismissed as "superficial." These appellations may not be justified.

3. Therapies are not always conducted in a "pure" form but may be combined with each other as well as with other means of providing social support, and with medication.

4. The quality of the psychotherapy given. Even more difficult than knowing precisely what occurs between therapist and patient is knowing how representative the therapy is of what it was supposed to be, and how well it was done. In addition to the barrier of patient privacy, the conceptual tools for evaluating diverse therapies directly are rudimentary.

Again, since psychotherapy and medical utilization are each complex and messy variables, these complexities, if they could be assumed to vary randomly, might be expected to wash out any true relationships that more refined studies might reveal. Thus, if studies conducted at the present state of the art do reliably show a relationship, they would argue for remarkably robust effects.

In addition to conceptual and philosophical issues there are methodological problems besetting utilization research that make it difficult to estimate cost offsets precisely. First, most of the research is clinical. Patients are seen in naturalistic settings where treatment conditions cannot generally be manipulated to achieve experimental cleanliness. In clinical research we know that "the intervention" is not the only variable at work. A multifactorial approach is needed but rarely are there sufficient patients and sufficiently controlled conditions. More importantly, all the factors

that operate in the field have not yet clearly been identified. Second, much of the research in the field has been archival, or retrospective, making use of existing data gathered for purposes other than research.

A third issue, the problem of selecting appropriate control groups, has flawed many studies in the field, in ways we shall indicate. A fourth issue is the time when one should assess the outcome of psychological intervention. Should it be directly at the end of treatment, or a month or a year or a decade later?

While these multiple difficulties could lead one to conclude that research in this field is all but impossible, much work has actually been done. The following is a summary of findings presented elsewhere in greater detail (Mumford, Schlesinger and Glass, 1978).

REVIEW OF STUDIES OF THE EFFECTS OF PSYCHOTHERAPY ON MEDICAL UTILIZATION

We will discuss two types of research evidence on the effects of psychotherapy on medical utilization: 1) archival, time-series studies; and 2) controlled clinical experiments. For all of the shortcomings of the archival approach, it has the advantage of "naturalness" and some major sources of bias from intrusive research interventions are avoided. Although controlled clinical experiments may suffer in varying degrees from "reactive" (Campbell and Stanley, 1966) influences resulting from patient and doctor awareness of the research, they may compensate with superior experimental controls.

Archival Time-Series Studies of the Impact of Psychotherapy on Medical Utilization

Sixteen studies that examined patients' medical records for a period of time before and after entry into psychotherapy were located in the published and unpublished literature through April, 1979. They differ in whether they use control groups, in duration of observation and in frequency of pre- and post-therapy observation points. In general, the use of well matched control groups, longer duration of observations and higher frequency of observation imply higher quality of experimental design.

One important feature of design, however, critically affects interpretation of findings. The distinction between relative and absolute time base is crucial in assessing the validity of the evidence. Observations on a "relative" time base are accumulated at points before or after the date when each patient entered therapy. Thus, "one month pre-therapy" might be June 1975 for one person but August 1976 for another. "Absolute time," in contrast, is the same

for all persons in the group under observation; e.g., in absolute time, one month pre-therapy is April 1977 for each person in the group.

The importance of this distinction derives from the susceptibility of relative time series to invalidation from the effect of regression to the mean. This "regression effect" causes mischief in time-series quasi-experiments in the following manner: in reaction to the extreme deviation of the curve, the experimenter is prompted to take some action to bring the curve back to some more typical value. In these circumstances, the experimenter is likely to mistake the expected regression effect, i.e., the tendency in a series for extreme values to be followed by values closer to the mean, for the effect of his own actions. Hence, the fallacy of "reactive intervention" (Glass, Willson, Gottman, 1975). In regard to the present analysis, suppose an individual monitors his states across time. When discomfort reaches an extremely high level, he might be prompted to seek psychotherapy. The start of therapy might coincide with the expected decline of the discomfort curve and would likely be interpreted by patient and therapist alike as an ameliorative effect of treatment. An alternative explanation of this quick "improvement" is statistical regression; a movement toward the typical level of the series will reliably follow the high or low points in a time-series. If a control group is not matched for the "discomfort" variable with observations accumulated on a relative time base, there would be no comparable expectation for its values to regress toward the mean. The methodological issue of relative versus absolute time looms especially large in view of possible spurts of high utilization around personal crises such as a death in the family (Parkes, 1970).

"Statistical regression" is of course not in itself an explanation. It is an all-purpose, mathematical name for the movement of data values. There is nothing logically inconsistent with the claim that a person's scores regressed statistically and the claim that all the reasons for the change in those scores are known. Typically, however, the many and varied causes of the probabilistic fluctuations of a time-series are unknown and can be regarded as "error."

Table I summarizes the finding of all 15 studies in comparable terms: Three studies (Goldberg, McHugh, and Kessler) did not employ control groups. Their entries in the final column are the difference between pretest and post-test observations, the best estimate of effect in the absence of a control group. Since the most of the pre/post differences for the psychotherapy groups are confounded by the regression (or "reactive intervention") problem, it might be wise to forebear drawing conclusions. However, the hope of salvaging even a tentative finding from all this effort is strong and justifies risks when methodological scruples would permit no conclusions at all.

TABLE 1

Summary of Findings from Archival Time Series Analyses of the Effect of Psychotherapy on Medical Utilization

Study:	Measure of Medical Utilization (corrected to annual rate)	Psychotherapy Group						Control Group						Diff. in % change, + favors control group
		N	Time: Relative or Absolute	Pre and Post	Pre Average	Post Average	% Change	N	Time: Relative or Absolute	Pre and Post	Pre Average	Post Average	% Change	
Duehrssen & Jorswiek (1965)	Days hospitalized	125	Relative	5 years pre 5 years post	5.4	1.0	-81.5%	100	Absolute	5 years pre 5 years post	5.0	4.6	-8.0%	-73.5%
Follette & Cummings (1966, 1967, 1968)	Medical visits	152	Relative	1 year pre 5 years post	13.5	10.6	-21.5%	152	Absolute	1 year pre 5 years post	11.0	12.3	+11.8%	-33.2%
Fink, et al. (1969)	Medical visits	112	Relative	1 year pre 2 years post	10.53	9.52	-10.0%	319	Absolute	1 year pre 2 years post	8.45	8.46	+0.0%	-10.0%
Kennicott (undated report)	Medical costs	150	Relative	6 mo. pre 6 mo. post	$1118.64	$499.44	-55.4%	150	Absolute	6 mo. pre 6 mo. post	$435.00	$441.48	+1.5%	-56.9%
Goldberg, et al. (1970)	Medical visits	256	Relative	1 year pre 1 year post	4.9	3.4	-30.6%	- - -	- - -	- - -	NONE	- - -	- - -	-30.6%
Uris (1974)	Medical visits	45	Absolute	1 yr. pre('69) 1 yr. post('71) (1970 excluded)	4.2	3.7	-11.9%	90	Absolute	1 yr. pre('69) 1 yr. post('71) ('70 excluded)	4.1	3.2	-22.0%	+10.1%
Kogan, et al. (1975)	Medical visits	148	Relative	5 years pre 2 years post	8.5	7.1	-16.5%	148	Absolute	5 years pre 2 years post	4.3	4.1	- 4.7%	-11.8%
Jameson, et al. (1976)	Medical costs	120	Relative	2 years pre 2 years post	$244.80	$110.64	-54.8%		Absolute	2 years pre 2 years post	$616.20	$237.84	-61.4%	+6.6%
McHugh, et al. (1977)	Medical visits	120	Relative	1 year pre 1 year post	6.7	11.6	+73.1%	- - -	- - -	- - -	NONE	- - -	- - -	+73.1%
Goldensohn & Fink (1978)	Medical visits	169	Relative	1 year pre 1 year post	3.8	3.4	-10.5%	141	Absolute	1 year pre 1 year post	4.6	4.8	+4.3%	-14.8%
Graves and Hastrup (1978)	Medical visits	21	Relative	1 year pre 1 year post	5.8	3.7	-36.2%	42	Absolute	1 year pre 1 year post	3.5	4.1	-17.1%	-19.1%
Kessler (1978)	Medical visits	1,155	Relative	2 years pre 2 years post	6.3	5.8	- 7.9%	- - -	- - -	- - -	NONE	- - -	- - -	- 7.9%
Olbrisch (1978)	Medical contacts (visits) all types incl. dental, university health ctr.	55	Absolute	3 mo. pre 1 yr. post	21.6*	6.0*	-72.0%	55	Absolute	3 mo. pre 1 yr. post	22.8*	6.4*	-72.0%	0%
Patterson & Bise (1978)	Medical visits	1,000**	Relative	6 mo. pre 6 mo. post	7.6	6.2	-18.4%	3,000**	Absolute	6 mo. pre 6 mo. post	3.6	3.1	-13.9%	- 4.5%
Rosen and Wiens (1979)	Outpatient Medical visits	308	Relative	1 year pre 1 year post	5.0	2.9	-42.0%	160	Absolute	1 year pre 1 year post	2.9	2.7	-6.9%	-35.1%

In most studies inadequacies in design probably favor the psychotherapy group over the control group. Perhaps the only exception is is the McHugh study with its apparent long-term, upward trends in utilization. Recognizing then, that the figures are probably biased in favor of psychotherapy, the average benefit of therapy is about a 13% decrease in medical utilization. The upward trend among the Mexican-Americans studied by McHugh may represent increased attention to health as well as the expectable and even hoped for rise in utilization when new services are provided to a previously underserved population. If the McHugh study, which was based on new services in a previously underserved area, is eliminated, then the average benefit calculated from the remaining differences in the last column becomes a 19% decrease in medical utilization as a result of psychotherapy.

Because of the problems in design of most of these studies, the hypothesis is quite plausible that they reflect no beneficial effect of psychotherapy on medical utilization. It seems highly unlikely that the true benefits exceed the 19% estimated decrease in medical utilization obtained by eliminating the McHugh study from Table I. The conclusion can be drawn with confidence that psychotherapy reduces medical utilization by between 0% to 19%. More careful research is needed to narrow this band of uncertainty.

Controlled, Experimental Studies of the Effects of Psychotherapy on Medical Utilization

Controlled experiments entail the assignment of patients to two or more different conditions (e.g., psychotherapy vs. a wait-list control) and the subsequent measurement of outcomes from the different conditions. Sufficient controlled, clinical experimental studies suitable for meta-analysis (Glass, 1977) on the effects of psychotherapy on medical utilization were found in three areas: alcoholism, asthma, and recovery from medical crisis (surgery and heart attack). The details of quantitative reviews of these experiments are presented elsewhere (Mumford, Schlesinger and Glass, 1978). In brief, psychotherapy (primarily behavioral therapies and hypnotherapy) shows impressively large effects on ameliorating the effects of asthma. The effects are even substantial on the reduction of utilization of direct medical services; only 23% of the therapy subjects used as many medical services as half the control subjects.

Averaging results across studies of psychological treatment of alcoholism yields success rates of 51% and 33% for psychotherapy and control conditions, respectively. To put these findings into cost-offset terms, we could conclude that on the average 20 hours of psychotherapy produces 18 "successes" (sobriety 6 months after therapy) out of every 100 persons treated. The relapse rates suggest that if the benefits of the therapy are to be sustained, it must be readministered at periodic intervals. Also, the correlation across the 15 studies

between the number of hours of therapy and the differential "success" rate was positive and reasonably large: +.49.

Review of Controlled Experimental Studies on the Effects of Psychologically Informed Intervention on Patients in Medical Crisis

We have been able to locate 23 experimental studies that test the effect of providing emotional support and/or understanding as an adjunct to medically required care for patients undergoing surgery and recovering from heart attack. The course of recovery was compared with that of a control group of patients not provided the special attention. The circumstances and findings of each study and the problems in analyzing them as a group have been summarized elsewhere (Schlesinger, Mumford and Glass, 1979). In order to compare and pool results from different studies, an "effect size" was computed. The effect size is a standardized measure of average difference between the treatment and control group on an outcome variable.

The effect sizes for all 117 outcome indicators in the 23 studies average +.43 implying that the intervention groups do better than the control groups by nearly one-half standard deviation. These findings are consistent across studies; fewer than 18% of the 117 outcome comparisons were negative.

Among the 117 outcome measures 66 are highly relevant to the physical recovery process ("anesthesia time," "units of blood," "degree of hypothermia," and "days in hospital") while 51 have more to do with patient comfort ("self-report of sadness"). When effect sizes are calculated separately for these two types of outcome, the comparison slightly favors larger effects for the more medically relevant indices, at +.45 versus +.40.

A subset of the outcome indicators is particularly important for its cost offset implications. Ten studies reported the amount of time spent in the hospital by the treatment and the control groups.

The average difference in days hospitalized for these ten studies weighted equally or weighted according to the number of patients studied is slightly more than two days in favor of the intervention group. Is this difference statistically reliable? The estimate is based on data from approximately 2,000 intervention and control patients across the ten studies. Seven of the ten studies gave information on the standard deviation of duration of hospitalization. The average standard deviation is about 4.75 days and $t = 8.53$, significant at any reasonable level. If we analyze the findings using the study as the unit of analysis, a significant t of at least 3.07 results.

These effects occur even though the interventions are mostly modest and not tailored to the needs of the individual patient, i.e., all patients in the experimental groups received the intervention under study. Two studies that attempted to match the intervention to the patient show that when the coping style of patient is compatible with the type of support provided, the intervention appeared to be more effective (DeLong, 1971; Kennedy, 1966).

SUMMARY

A review of the problems in determining whether a cost offset can be expected from introducing a mental health component in primary care shows that the problems are conceptual and methodological as well as practical and statistical. The problems are difficult to solve but not insurmountable.

Most of the archival studies of the effects of psychotherapy on medical utilization are flawed by problems of experimental design. A critical, quantitative review of 15 such studies that takes account of these flaws indicates a likely reduction of between 0 and 19% in medical utilization and costs. Further work is needed to narrow the band of uncertainty.

A critical, quantitative review of 15 controlled, experimental studies assessing the effects of various kinds of psychotherapy on alcoholism and 13 such studies on asthma show positive effects on outcome indicators with clear implications for a significant and sizeable cost offset. A similar review of studies of the effects of "psychologically informed" intervention on patients recovering from heart attack or surgery shows a clear cost-offset resulting from a more than two-day shorter hospital stay for the intervention group.

Quite aside from the intrinsic value of offering specific care for patient's emotional problems and humane and considerate care for their medical and surgical problems, the evidence is that providing psychotherapy and psychologically informed care can be cost effective and that a cost offset may result from the inclusion of a mental health component in primary care systems.

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PLENARY PRESENTATION -- APRIL 3, 1979

MENTAL HEALTH AS AN INTEGRANT OF PRIMARY CARE

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Epidemiological investigations have demonstrated the high prevalence of psychiatric morbidity presented at the level of primary health care. Further investigation shows that many of these conditions are closely associated with physical ill-health and/or social pathology. The implications of these findings for practice and research at the health/mental health interface are discussed.

(The full text of Dr. Shepherd's paper appears in Section VII.)

Mental Health Services in General Health Care: Summary of the Invitational Conference on the Provision of Mental Health Services in Primary Care Settings, April 2, 3
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SECTION V

AN INTEGRATED SUMMARY OF INVITATIONAL WORKSHOP DISCUSSIONS

Each conferee and observer participated in one of three workshop sessions on the second day of the conference. The discussions, conducted simultaneously and ranging across the entire subject matter of the conference, are summarized here under five major topics.

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PROVIDER ROLES AND FUNCTIONS

A discussion of appropriate functions and roles for primary care and mental health care providers in general health settings brought out two points of view. One, more implied than stated, foresaw a very limited role for psychiatry in primary care settings, and that primary care practitioners could, with, training in the requisite diagnostic and case management skills, largely absorb the functions of the mental health specialist. The second point of view was that mental health care in the primary care context would revise and perhaps increase the role for psychiatrists. Increasing the diagnostic skills of primary care physicians was expected to increase the cases of mental disorders recognized, making it likely that more cases would be referred to the mental health specialty sector.

In the second view, psychiatrists would be needed: (1) to assist primary care providers in acquiring and maintaining skills necessary for diagnosis of mental disorders and management of emotional complaints; (2) to collaborate with primary care practitioners both (a) to facilitate their coping with the anxieties and frustrations of caring for patients with psychiatric disorders, (b) to provide direct service to patients; and (3) to serve as referral resources. Close collaboration between psychiatrists and primary care physicians was seen as a promising opportunity for ensuring appropriateness of patient care and minimizing disruption of the continuity of care, which is a hazard in the process of referral.

There was consensus among the participants that a widely recognized and acceptable concept for the division of labor in mental health treatment does not exist. The range in complexity and severity of problems for which patients seek care precludes facile distinctions of the roles and functions of providers. A useful framework for defining roles and functions of providers should be developed in future research. There are recurrent difficulties in delineating the kinds, complexity, and severity of the problems that should be in the purview of various primary care providers, as well as the complexity and severity of the problems that are likely to require secondary or tertiary specialized care by mental health professionals. Difficulties with these distinctions seem to occur more frequently in the ambulatory primary care setting, where the relationship between mental health specialists and primary care practitioners is less clearly defined, than in the hospital, where the roles and functions of "liaison psychiatry" and general health care seem fairly well circumscribed.

In a discussion of how best to determine the appropriate match of patients to providers for optimal care of mental health problems, it was agreed that not all persons with emotional disturbances would be treated appropriately by psychiatrists, and that the goal for the primary care practitioner should not simply be to sort out the emotionally disturbed and refer them to specialty practice. It was suggested that such activities as counseling with parents on child development, psychological preparation for surgery, or counseling the post-myocardial infarct patient by primary care practitioners, are to be expected in the course of general health care. However, criteria have not been established to determine which non-psychotic but identifiably mentally disordered persons could be served optimally by primary care providers.

In the matter of defining the general skills required of providers of mental health care in non-specialty settings, it was emphasized that mental health care begins with diagnosis. The gamut of mental disorders in patients who present to general health care providers makes it essential that the primary physician have a system with fairly broad applicability to make appropriate diagnoses. Especially in ambulatory settings, primary care providers should be able to discern both the patient's underlying disorder and the more immediate reasons for seeking care.

Several participants noted that -- with some exceptions -- complex cases and chronic mental illness requiring long-term care are best treated by mental health specialists. Thus, primary providers should be skilled at referring their patients, when diagnosis so indicates, to mental health specialists or to other social support systems. The general health care providers can then focus on counseling, which serves the functions of interim, crisis-type support and preventive mental health care.

Although the need for primary care providers to give attention to patients' mental health needs was mentioned repeatedly, a cautionary question was raised: Is there a risk, in trying to make primary care providers more sensitive and better therapists in the psychiatric sense, of weakening their skills and abilities to manage the medical problems with appropriate attention? A balance is required between the medical and mental health skills of providers of general health care.

Although there was agreement on some of the general skills necessary for providing mental health care in general health care settings, the "turf" issues remained controversial. A number of participants cited role differentiation as the principal policy issue to be faced, and the discussions of an appropriate "division of labor" focused on the discrete functions of three types of providers: (1) primary care physicians, (2) psychiatrists, and (3) non-physician mental health professionals.

Primary Care Physicians

Whether or not it is theoretically optimal, a large part of mental health care is and will continue to be provided by physicians who are not mental health specialists, it was conceded. In rural areas, where approximately one-quarter of the U.S. population lives, the general practitioner often is the sole provider of health care in any form, including mental health care. Emphasis on the pragmatic issues of how to help those who are providing care to deliver better care was seen preferable to continued debate about who is best qualified to provide mental health care. It was proposed that the basic mental health skills required by most general health care providers are relatively simple: warm, humane interests in the patient and the patient's problems, and a willingness to use psychotherapeutic and crisis intervention as well as pharmacological intervention to help people through acute crises. Beyond these basic skills, the general health care practitioner needs to obtain knowledge from social and behavioral sciences. This knowledge can promote a more humanistic approach to patients, increase skills in recognition and diagnosis of mental disorders and determining their severity, and encourage use of specialty resources in collaboration and consultation.

Although physicians recognize that much of their practice has a psychological framework, it was suggested that many tend to be dubious about the usefulness of collaborating with mental health specialists. In addition, some primary care physicians fail to collaborate or consult with mental health professionals for much the same reason their patients do not seek care from that specialty sector: they do not know enough about what the mental health specialist does.

There was consensus that collaboration in some form must be established. One promising approach to productive interaction between health and mental health practitioners is the interdisciplinary team, in ambulatory medical settings such as those found in some primary care and psychiatric training programs. These programs have shown psychiatry and primary care are not incompatible because of differing approaches to the multiplicity of patient problems. It was also pointed out that the whole primary care team, especially in the absence of other contacts, may become essential parts of the coping mechanisms of patients.

Psychiatrists

An increasing involvement of the general health care sector in providing mental health care has raised a need to redefine some aspects of psychiatry's role. Conferees noted that some health policy-makers had presumed that increasing the numbers and quality

of training of primary care physicians would result in their caring for a greater proportion of the population with mental disorders and a concomitant reduction in the need for mental health specialists. But it was agreed that experience to date does not support the presumption.

Private practice and hospital-based liaison psychiatrists are expected to continue to provide specialty care for severe psychopathology, and to fulfill the traditional function of handling mental health referrals from the general health care sector. There is, however, a growing need for psychiatrists as consultants in ambulatory health care settings. Consultation or liaison psychiatry, in addition to promoting the improved management of a broad range of mental disorders can be a valuable means of continuing education for both general health care physicians and psychiatrists.

The role of psychiatrists as educators in residency training programs may represent the current most effective linkage between psychiatry and the general health care sector, given the still relatively limited opportunities for direct collaboration in the actual delivery of care in established settings. Important contributions of psychiatry to the training and practice of primary care practitioners include teaching diagnostic, therapeutic, and preventive skills, along with guidelines for appropriate referral for specialty care, and explaining the new emphasis on the biopsychosocial or holistic approach to patient care.

The practice of psychiatry in the primary health care setting was seen as an opportunity to revise and broaden the perspective of the psychiatrist on formats for therapeutic intervention. In contrast to specialty mental health services, in which patients are ordinarily seen for prolonged episodes over a relatively brief span of time (such as two or three visits a week over an eighteen-month period), primary health care providers generally follow patients in brief episodes of care over long periods of time (such as two or three visits a year over the course of several years). A successful outcome of specialty mental health service typically has been based on the expectation that the patient will not return after the completion of psychotherapeutic intervention. The definition of successful outcome in primary care is quite the opposite: the primary health care provider assumes that patients will continue to return for health care as needed.

It was suggested that psychiatrists in primary health care settings might employ a "string of beads" approach, in which the patient would work on a theme in a succession of crisis episodes for which he or she would return to the same therapists to pick up the treatment. The treatment course in this approach is not terminated but is considered to have dormant phases. This course could be a workable alternative

for patients who previously deemed psychotherapeutic intervention unacceptable because of the prolonged and costly involvement. Most psychiatrists, however, have not been trained in this kind of task-centered modality, and psychiatric training programs would have to be modified for it to become a part of the psychiatrist's therapeutic resources. This kind of approach may not be feasible for some patients, such as the chronically mentally ill who may need consistent and continuous care.

Non-physician Providers of Mental Health Care

Variability in the type and severity of mental disorders presented by patients seeking help in the primary health care sector has implications for employment of a variety of non-physician providers of mental health care, such as social workers, nurse-practitioners, psychologists, and physician assistants. Conferees noted that for the less differentiated states of mental morbidity, which may often require extensive time and attention, non-physicians in fact may be the most appropriate providers. A number of participants pointed out that non-physician mental health professionals are particularly skilled at assessing and managing psychosocial problems. Examples were cited of several British primary health care settings where the use of medical social workers has achieved some positive results in the economy and efficiency of care for psychosocial problems. It was suggested that perhaps the most important role of these social workers was a coordinative one between the health, mental health, and social service sectors.

The participation of non-physician mental health specialists in general health care settings, both as primary care providers and as consultants, can encourage preventive health programs and patient involvement. The non-physicians also can be effective educators of medical residents.

The economic benefits of employing non-physician mental health personnel also were discussed. There was agreement on the potential advantages of this mode of care, but several participants expressed concern that the quality of care could be compromised to save money. The observation also was made that the training in some of these fields may not necessarily provide adequate skills for many psychologists and social workers, to step into a primary care setting and be helpful.

EDUCATION AND TRAINING

The discussion of education and training focused principally on the needs of non-psychiatrist providers of mental health care in general health settings. The development of adequate programs, workshop participants agreed, probably will require fundamental

shifts in the traditional attitudes and orientation of medical educators. At present, there is great variation in the mental health knowledge, skills, and attitudes of practicing primary care professionals and wide diversity in the mental health training available in medical schools and residency training programs.

The implications for the training of psychiatrists of the growing emphasis on integrated health and mental health care also were discussed. Departments of psychiatry are beginning to consider alternative roles for psychiatrists in relation to the general health care sector, and training programs are likely to place increased emphasis on skills in indirect care and consultation in many kinds of practice settings.

The inadequacy of current programs in medical education and training at a number of levels was discussed. It was suggested that premedical undergraduate education generally pays insufficient attention to the behavioral and social aspects of human biology, and that selection of medical school applicants tends to downplay or disregard "whatever it is that would indicate that they would like to take care of people's needs beyond a purely physical ailment level." There was general agreement that medical school curricula tend to neglect the behavioral sciences. Perhaps the strongest criticism of the current system, however, concerned the limited opportunities for appropriate practical experience in integrated health/mental health care facilities during residency training. Opportunities for health care personnel to get continuing education also were observed to be limited.

Suggested ways to improve medical education and training programs primarily were: (1) revising the content of the standard medical school curriculum, in terms of both orientation and instruction in specific skills; (2) offering more appropriate clinical training experiences to prepare medical students and residents for the practice of integrated health/mental health care; (3) providing appropriate and effective role models throughout the educational and training process; and (4) upgrading continuing education for practicing physicians. Funding and other factors in making such changes also were discussed.

(1) Content Education and training of general health care practitioners should include knowledge from many disciplines that are not necessarily considered "medical," including psychiatry. Fields such as anthropology, economics, and particularly the behavioral sciences and sociology, should contribute to both premedical and medical school curricula; greater emphasis on behavioral medicine should be reflected in the National Board Examinations. A developmental life cycle approach to studying health in relation to mental health was endorsed by several participants. There was general agreement that awareness of patients' social contexts is an important component of integrated health care.

Although promoting a less "biotechnical" orientation and approach among health care providers is essential, the teaching of behavioral medicine also must include instruction in the specific mental health skills that enable physicians to deal effectively with the behavioral aspects of their patients' problems. Three related types of skills were emphasized: detection of mental health problems; accurate assessment and diagnosis of those problems; and appropriate management of them, which requires both an understanding of psychotherapeutic techniques--counseling and medication--and when to make appropriate referrals.

(2) Clinical training Effective application of the skills mentioned above requires practical experience. Several participants observed that, even when students are motivated to become providers of integrated health and mental health care, most training programs do not furnish adequate clinical preparation for the practice of mental health care in general health care settings. For most medical students who do not choose to specialize in psychiatry, practical experience in applying mental health skills under supervision is limited to the psychiatric rotation as a small and discrete part of their medical education, rather than as an ongoing process.

There was general agreement that, to promote effective integration of mental health and general health care, residency training of all potential primary care providers -- including those specializing in psychiatry — should be available and encouraged in integrated care settings, such as neighborhood health centers, continuing clinics, and other primary care settings that include mental health services. Residents should be integrated into primary care teams with psychiatric social workers, nurse practitioners, staff physicians, and the like to encourage sharing of skills and responsibilities. Traditional hospital-based residencies tend to train physicians to interact episodically with their patients, providing limited opportunities to establish the longer-term relationships in which health and mental health care most successfully are combined. Linking such academic centers with various community care systems was suggested as an effective way to provide training in integrated care.

Appropriate practical training will become increasingly necessary, several participants commented, as more physicians are required to fulfill "payback" obligations in underserved areas in return for financial support of medical education. Health care in such areas characteristically lacks the backup support resources associated with better served communities.

(3) Continuing education Concern was expressed that some primary care physicians tend to ignore or minimize the mental health needs of their patients. Another view was that primary care physicians recognize that there are psychosocial components of patient care, but also are

aware of the inadequacy of their training in mental health skills. There was general agreement that improved programs in continuing education are needed. Most participants felt that collaboration among specialist and non-specialist providers of mental health care is the most effective forum for continuing education.

Programs in collaborative post-graduate training for providers who practice in more traditional, non-integrated settings also were described. One model that has been fairly successful on a regional basis involved psychiatrists working with pediatricians in regular collaborative arrangements. "Balint" groups also were mentioned; in these, the consulting psychiatrist does not see patients but helps primary care providers as a group to explore their own sensitivities and feelings related to patient care.

(4) Role models The point was made that there are not enough role models for practitioners of the type of integrated care discussed at the conference. Even with models, learning in this area is difficult because the concepts are complex and exhausting psychological effort is involved in applying them. The prevailing disease-oriented medical models discourage attempts to integrate health and mental health care.

It was suggested that role models must be sufficiently numerous to form a "critical mass" of professionals who believe in and can practice integrated care in order to demonstrate commitment to health/mental health linkages at all levels of care. Participants also emphasized the importance of engaging medical faculty with additional background in psychiatric skills, and psychiatrists and other mental health professionals who have experience working with nonpsychiatric physicians, in the training of primary care residents in mental health skills.

Policies for Education and Training

Although training health professionals to provide integrated care apparently is a major objective of both educators and federal policymakers, current strategies to improve education and training often are not realistic, a number of conferees indicated. State and federal funding policies for medical education and training were particularly questioned.

An increasing proportion of federal funds for psychiatric training is being moved from the psychiatric specialties to primary care programs. Although the purpose of this shift is to improve mental health training in more general programs, the quality of such training was questioned, both in terms of the qualifications of the trainers (low levels of funding necessitate hiring faculty at junior levels) and in terms of available training settings. One educator observed that ambulatory care training for psychiatrists and primary care

providers, in which experience with collaboration in patient care or appropriate referral would be meaningful, is not now funded to any real extent. Training in general medicine is hospital-based and has relatively little emphasis on ambulatory care. Similarly, liaison psychiatry in academic medical centers and general hospitals is largely focused on care of hospitalized patients. There also was concern that the policy emphasis on mental health as part of primary care will downgrade psychiatric programs and discourage the practice of specialty mental health care. Such a trend, it was noted, ultimately would erode the quality of overall integrated care.

The issue of state and federal requirements for payback service by new physicians whose medical education was paid for by the government also was discussed. Several participants expressed concern about inappropriate placements of both general care providers and mental health specialists, and urged that a variety of eligible service settings be considered by policymakers.

REIMBURSEMENT

Workshop participants registered a strong consensus that current patterns of financing do not support an optimal, integrated health/mental health care system in this country. Insurance benefits for treatment of mental disorders are sharply limited, compared with reimbursement offered for the care of other kinds of illnesses. Often there is no provision for out-patient treatment, either by general health care providers or by mental health specialists. Furthermore, the partial reimbursement benefits for mental health care provided by various public and private health insurance programs are so inconsistent as to be viewed as deterrents to the coordination of primary care and mental health care.

The variety of sources of reimbursement for mental health care was discussed: (1) some federal Title XIX and Title XX Social Security Act monies, although limited primarily to direct services provided in federally-funded care settings; (2) Medicare and Medicaid, which again are limited; (3) prepaid health plans, such as offered by health maintenance organizations; and (4) private third-party insurance coverage, which varies in scope among different plans. Obtaining adequate reimbursement for one patient, particularly in comprehensive programs that include mental health care, can entail a complex administrative process of getting funds from several sources. A more uniform national health insurance mechanism of reimbursement, as a prospective plan for the United States and as currently practiced in Great Britain and Canada, was considered a possible solution to problems of funding coordinated health/mental health services.

Conferees highlighted several situations which further complicate reimbursement: (1) a lack of uniform criteria for standard types of care, providers, and provider settings; (2) reimbursement for

mental health care typically is restricted to specialty care and direct services; (3) counseling, especially when provided as preventive care in general health care settings, usually is not reimbursable; (4) indirect services, such as the consultation and coordinating activities that are crucial for providing integrated health/mental health care, almost always are excluded from reimbursement coverage as well. Limited sources of reimbursement also appear to discourage the development and support of ambulatory care, preventive care, outreach, case management, health education, and certain social support services.

It was emphasized that lack of reimbursement deters the involvement both of psychiatrists and primary care practitioners in efforts to integrate health and mental health care. Although there increasingly is coverage for specialty care of mental health disorders by psychiatrists in private practice or specialty inpatient settings, there are minimal financial incentives for spending time in important consulting and ambulatory liaison psychiatry. Also, there is a general lack of reimbursement for mental health care provided by nonpsychiatrists in general health settings. Determining appropriate rates of compensation for such care further complicates the issue: simply equalizing the hourly rates for mental health care by primary care physicians and psychiatrists still will entail a loss for the "ordinary general practitioner who needs to generate more income per hour . . . because of very greatly increased overhead." Care by nonphysician mental health professionals is even less likely to qualify for reimbursement, except in certain prepaid medical plans.

Several participants expressed concern about the effects of current patterns of reimbursement on the quality of mental health care, particularly in the general health care sector. Incentives to diagnose in terms of what is reimbursable, it was felt, has led to widespread masking of mental health problems in this country. Because psychiatric illness typically remains a "non-reimbursable disease" the use of reimbursable labels for mental health problems and treatments is thought to be common.

There is increasing awareness of the value of humanistic approaches to general medical care, but inadequate reimbursement continues to discourage many primary care physicians from investing the time required to care for their patients' emotional and mental health needs. In practical terms, often "it is the time clock that runs the system," one participant said.

The tendency to under-diagnose and under-treat mental health problems, particularly under the financial disincentives of some health maintenance organizations and other prepaid plans, was recognized as having implications for the quality of care.

Reimbursement presupposes quantification of the care process to some extent. But thus far, the input factors of mental health care are more easily defined, measured, and regulated than are patient outcomes. Some caution was expressed regarding reimbursement for services that have not been proven effective. Most participants also criticized the "body count" and "corporate" mentalities they considered to be associated with current policies of accountability and reimbursement.

Participants discussed a number of alternatives to the current system of reimbursement for mental health care: (1) A proposal that has been considered by DHEW would permit federally-funded reimbursement only for mental health services provided after referral from primary care providers, thus establishing a triage function for the primary care system to control mental health services. In view both of the longstanding tradition of direct consumer access to specialty care and the lack of a uniformly well-developed primary care system in this country, this proposal generally has been considered inappropriate. (2) Further support of prepaid health plans that include in-house mental health care was suggested by several participants, although they recognized the need to examine potential trade-offs between adequate care and incentives for cost-containment in such plans. (3) Several participants saw a possibility for including a broader range of mental health services in hospital-based primary care settings; they urged more systematic exploration of "piggy-backing" the costs of currently nonreimbursable activities, such as consultation and care by nonmedical personnel, on services that are reimbursed. (4) Grants to link primary care settings and federally-funded community mental health centers were mentioned as a means of tapping existing mental health care resources without, as one speaker put it, "worrying so much about the larger issue of third-party payments."

Several participants suggested that studies be planned for future consequences of increased availability of reimbursement for mental health care in the general health care sector. Changes in utilization and probably increases in costs will result from a reduced need for masking of mental health care by primary care providers. Assuming that limited reimbursement represents a current means of rationing scarce mental health resources, one participant suggested that lessened restrictions on reimbursement will require tighter definitions of need for mental health care.

There was general agreement that reimbursement issues should be a policy concern, but it was suggested that revised reimbursement practices alone may not have a major impact on the success of efforts to integrate health and mental health care. For consumers in the United States, quality of care may be the ultimate criterion in utilizing mental health services, as suggested by evidence that enrollees

in prepaid medical plans seek such care in other settings and pay separately for them. Greater commitment to quality of care, rather than reduced concern about reimbursement, among providers may be the force that moves mental health care into general health practices.

SOCIAL SUPPORT SYSTEMS

A number of workshop participants urged more effective use of social support systems in health/mental health care. The linkage of formal health care systems with both formal and informal social support systems was seen as essential for care to be integrated at all levels. Such linkages could aid physicians in providing appropriate health and mental health care to their patients and also would promote use of a broader range of non-medical care resources.

There was general agreement that understanding of patients' social contexts at various levels is an essential component of integrated care. For diagnosis, knowledge both of individual and epidemiological factors is necessary. For therapy, the patient's own closest social supports of family and friends often can work effectively with the care provider while such community resources as social agencies, churches, or schools can be involved to promote continued care. Although social support is clearly an important function of the physician — especially in integrated health and mental health care settings -- it was suggested that the problems of many patients may be managed as effectively or even more effectively by schools, welfare departments, clergymen, and other non-medical service systems. Health care providers should be trained to make referrals to other settings when appropriate, and opportunities for such linkages through referral should be explored more completely.

Community support systems are particularly important when mental health care under medical auspices is impractical or infeasible. This often is the case in inner city areas, and presents a particular problem for persons with chronic mental disorder who are no longer likely to receive institutionalized care. If primary care physicians are not available or accessible, the community and the entire social welfare system could absorb and maintain individuals who need mental health care.

Two models of collaboration between health care providers and social support systems were described by one conferee. In the first, primary care providers work with their patients' immediate social supports; in the instance of a black extended family, to promote compliance with hypertension medication. The second model is a "cultural specialty" program being developed in a cross-cultural care setting in Newark, New Jersey. During the past year, five social scientists have worked in a psychiatric reception center and crisis unit on an extensive assessment of patients' natural community support

systems. The program was designed to examine how those support systems -- extended families, churches, indigenous healers -- function as coping resources for patients within the community.

The point was made that other outside of the traditional health and mental health care systems also provide mental health services. In Virginia during 1977, for example, $3 million was spent under Title XX of the Social Security Act to fund mental health services in welfare departments, as compared with $500,000 in Title XIX funding for mental health services in mental health centers.

The British system, with a single integrated Department of Health and Social Services, was discussed as a model for organizing linkages between the health care and social welfare systems in this country. Although some states have organized human services under single departments, separation of federal support for social service and health have discouraged most attempts to establish comprehensive health/mental health care facilities. Some of the more fortunate and entrepreneurial neighborhood health centers, including several represented at this conference, have been able to provide multiservice, comprehensive care. However, as funding decreases for the indirect patient services that constitute a large part of mental health care, one participant foresaw major difficulties for these centers as well.

There was general agreement that the provision of appropriate mental health care to the entire population in need will require more than formal linkages of health and mental health. It was pointed out that a wide variety of community institutions that are not labeled or identified in our society as health institutions, should be considered in the design of a truly comprehensive health care system. Knowledge relevant to the involvement of social support systems in integrated care programs at all levels is already well-developed in traditionally non-medical disciplines.* Several participants urged systematic and useful application of that knowledge.

RESEARCH

Many participants expressed concern that major policy decisions about health manpower development, organization of the health/mental health system, and methods and extent of financing both for training and service delivery are being made on the basis of inadequate research data. There was agreement that health services research,

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*See President's Commission on Mental Health, Report of the Task Panel on Community Support Systems, Vol. II, pp. 139-235. Washington, D.C.: U.S. Government Printing Office, 1978.

epidemiological studies, and studies combining behavioral and health services research are needed for systematic development of knowledge that can contribute to assuring the quality and comprehensiveness of health care.*

More knowledge also is needed for the development of standardized mental health indices, such as levels of distress and levels of psychosocial dysfunction that could be used: (1) by primary care physicians in diagnosing the gravity of patients' complaints; (2) by health and mental health service planners and policymakers; and (3) to determine the incidence of mental illness. Many participants thought that extending treatment assessment from the specialty mental health sector to primary care practice will require all forms of health services research — clinically-oriented, institutionally-oriented, and systemic studies.

Clinically-oriented studies could be designed to determine how conditions of practice influence effectiveness of both health and mental health services and develop a broad range of outcome criteria including patient satisfaction and the cost of care as well as effectiveness of treatment, specifically: (1) collect more data on mental disorders that primary care providers may identify, misidentify, treat, not treat, or refer; (2) focus on the natural history of mental disorders in general practice populations; (3) examine the treatment methods employed by general health care providers for patients whom they identify as mentally disordered; (4) determine characteristics of providers and patients and the combinations of resources that are employed in various practice settings in which health and mental health care are provided and that affect the processes and outcomes of care.

Institutionally-oriented studies would bear on such issues as determinants of utilization patterns of various providers of mental health services, or the organizational and administrative features of primary care settings in which health and mental health services are delivered. There was debate whether an assumption is warranted that average medical utilization is proper medical utilization, or that a reduction in medical utilization is a measure of effectiveness. Research was urged for human as well as economic factors, such as interprofessional working arrangements, including clinical team organization and functioning, practitioner training, and competency. Some issues of the organization of services could be resolved by comparing a number of setting for their effectiveness. Other questions are how staff time is spent, who is being served, what services are provided, accessibility of those services, client satisfaction and level of functioning before and after services.

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*Note: No attempt has been made to prioritize the areas identified by conference participants as needing futher research.

Systemic studies would concentrate on such issues as the influences of various financing mechanisms on the delivery of services. Of particular importance is examination of the economic incentives and disincentives in primary care settings as they differ among fee-for-service, prepaid health plans, neighborhood health centers, and so forth.

Evaluation research is need on training methods for primary care physicians who require modified forms of mental health specialty skills to provide appropriate mental health care. An example of this kind of study would be one in which "Balint" groups are evaluated as a training modality and as a mechanism for improving provider satisfaction, particularly in settings such as HMOs or clinics, where there is considerable turnover of professional staff.

Epidemiological research was suggested by a number of participants who saw a lack of precision in definition, identification, and classification of mental disorders as a major problem. More accurate data on incidence and prevalence of disorders, identification of risk factors, and the range and natural history of emotional difficulties of patients seen in primary care settings were mentioned as other areas for investigation.

There is a need for better outcome studies to determine criteria for the effectiveness of different kinds of mental health interventions as they vary among kinds of providers and kinds of patients. Development of better ways to measure outcome was seen as a necessary first step. Research on outcome is made difficult by the many definitions of positive outcome. The observation was made that certain types of interventions may have a beneficial effect on the system for instance in efficiency and the cost of the process and not do anything meaningful to the patient.

Quality assurance research was emphasized by many participants. Studies should develop both definitions of quality care and techniques to measure it.

Discussion in this conference did not take into account the role of specialist physicians such as obstetricians/gynecologists, cardiologists, allergists, and gastroenterologists who have been called part of a "hidden system" for delivering general care in the United States. Recent data from two national studies have indicated that "one of every five Americans now receives continuing general medical care from a specialist physician." 1/ It would appear appropriate to investigate (1) to what extent physician specialists are able to identify mental disturbances in their patients; (2) the incidence of specific disorders; (3) the kinds of mental health interventions medical specialists are most inclined to adopt; (4) mental health skills of specialist physicians; and (5) mental health content of medical specialty training programs.

1/ Linda H. Aiken, et al. "The Contribution of Specialists to the Delivery of Primary Care: A New Perspective." New England Journal of Medicine. Vol. 300, No. 24 pp. 1363-1370.

VI

SUMMARIES OF PANEL PRESENTATIONS: FUTURE DIRECTIONS IN COORDINATION OF MENTAL HEALTH SERVICES AND PRIMARY CARE

Julius Richmond, M.D.
Assistant Secretary for Health
Department of Health, Education, and Welfare

Discussions at this conference have both theoretic and practical implications for various aspects of health services delivery beyond mental health and primary care. Patients must be considered in terms of their social contexts, whether or not the problems overtly appear to be mental health concerns, and thus an understanding of emotional development over the life cycle is important for all physicians. Pediatrics provides an excellent example of a field in which biosocial and developmental factors are integrally involved in health.

After years of persistent, largely independent efforts to promote the integration of mental health concepts and programs with general health care and with primary health care in particular, it appears that finally the time is right for broader acceptance of and formal commitment to this concept. The President's Commission on Mental Health focused significant attention on this issue, as has the general trend toward providing comprehensive services in primary health care settings. This trend also represents movement towards the World Health Organization (WHO) goal of primary health care for all by the year 2000.

Clearly, however, the implementation of these policy goals depends on a practical base of scientific knowledge. The growth and diversity of programs committed to coordinating health and mental health services has contributed significantly to the necessary knowledge base. Dr. Richmond believes that sufficient models for achieving the WHO goal already exist, many of them in the developing world. He cited as an example the Cuban health care system which utilizes a primary care system with two levels of organization: in very rural areas, primary care physicians work individually as part of required post-graduate social service; at the "polyclinic" level, primary care teams -- each including a pediatrician, an internist, an obstetrician-gynecologist, and a psychiatrist and a psychologist (who are consultants for community social, as well as health, services) -- administer ambulatory care. Continued expansion of the practical knowledge base, especially through more systematic and sophisticated means of evaluating existing programs, will further promote progress in this area.

Gerald Klerman, M.D.
Administrator
Alcohol, Drug Abuse, and Mental Health Administration, DHEW

The federal commitment to integrating mental health and primary health care has been shaped by recent advances in both epidemiological research and organizational research. The development of epidemiological methods to quantify the extent of mental illness, both in the community and in the primary care system, has enabled researchers to document the high degree of prevalence and the diversity of diagnostic considerations that make this issue particularly important in public policy terms. As federal efforts to implement mental health services in primary care settings have expanded, organizational studies which benefit from the involvement of a range of behavioral and health services sciences have become increasingly important as well.

Linkage grants initiated by the Bureau of Community Health Services and developed on the regional level in cooperation with National Institute of Mental Health in fiscal year 1978, along with current budget requests reflect "momentum" within various federal agencies to increase both the number and plurality of modes for integrating mental health and primary care. At the same time, the need to incorporate program evaluation into these efforts has been stressed. Although an emphasis on evaluation of new programs clearly is warranted, Klerman suggests that more appropriate measures of both outcome and intervention are needed. The outcome measures most often used in U.S. studies have focused on organizational variables -- cost-offset, medical utilization, and referral patterns -- and have generally neglected less quantifiable but significant "human" variables such as relative symptom reduction, improved ability to function, and patient and provider satisfaction. Intervention variables that continue to merit attention relate to: 1) treatment -- controversies concerning the merits of psychotropic drug and/or counseling therapies indicate the ongoing need for controlled clinical research; 2) personnel -- further investigation of appropriate qualifications for providers of mental health care in primary care settings is needed to develop adequate training programs; and 3) organizational arrangements -- various modes of integration in addition to the linkage mechanism currently in vogue should be studied.

Dr. Klerman stated that the next phase of research should attempt to better evaluate what is known about the determinants and dimensions of program outcomes. Such studies will have particular relevance in terms of the current general public policy trend to increase support for the delivery of a full range of specialty services, including mental health care, at the primary health care level.

George Lythcott, M.D.
Administrator
Health Services Administration, DHEW

Successful coordination of mental health services and primary care presupposes closer integration of care and caring in medical prevention, treatment and control, and in medical services, training and research. "Care" reflects technical knowledge and skill; "caring" reflects deep personal involvement and commitment. Although the two concepts clearly should not be mutually exclusive, the current public policy focus on coordinating care and caring indicates growing recognition that medical services often do not meet the real needs of patients. If federal efforts to coordinate these elements in service, training, and research programs are to succeed, collaboration in terms of actual functions and activities must be emphasized.

1) Services for both the elderly and children -- particularly handicapped children -- entail special consideration of care and caring by both mental health and primary health care providers. In each of these services areas, the Bureau of Community Health Services (BCHS) within HSA is working with other federal agencies, including the NIMH, to develop specific programs of collaboration at the levels of policy-making, planning, and service provision.

2) Training programs in several states are directed toward preparing primary care providers to deal sensitively and effectively with mental health concerns, either directly or through linkages. The programs also have involved cooperation of ADAMHA and HSA at the federal level. The recruitment and placement of mental health personnel within the National Health Service Corps of BCHS is also part of the overall training effort. Planning with NIMH is currently underway to expand Corps supportive mental health manpower, specifically to meet the health/mental health needs of patients with chronic mental illness.

3) Research efforts, such as the planned joint evaluation by HSA and NIMH of the 1978 health/mental health linkage grants, should be extended to other areas of common interest to ADAMHA and HSA.

If enacted, the Community Mental Health Systems Act will support the development of state-based systems of care and caring that would involve coordination at the federal level and between federal agencies and the States.

To effectively integrate mental health services into primary health care, new dimensions of care and caring at the primary level also should be considered. Because of the interlocking nature of

of behavior and health, self-care and caring should be included formally as primary health care concerns, especially among underserved populations to whom access to other levels of care is often limited. Mutual health and formal and informal social support systems also should be expanded as part of primary care. Advocacy -- although a special aspect of care at all levels — is particularly important to ensure the quality of primary care health services and should be emphasized as well.

EXECUTIVE SUMMARY:
COORDINATED MENTAL HEALTH CARE IN NEIGHBORHOOD HEALTH CENTERS*

Jonathan F. Borus, M.D., Barbara J. Burns, Ph.D.,
Alan M. Jacobson, M.D., Lee B. Macht, M.D.,
Richard G. Morrill, M.D., and Elaine M. Wilson, B.A.

This report is drawn from the authors' cumulative clinical, administrative, and research experience in both Community Mental Health Centers (CMHCs) and Neighborhood Health Centers (NHCs) over the last decade as well as a review of the relevant literature. From our experience we feel that the neighborhood-based conjoint health-mental health setting of the NHC is an excellent context for the provision of primary mental health services, i.e., problem and diagnostic evaluation, crisis intervention, individual, group and family psychotherapies, aftercare services (including psychoactive medication) for the chronically ill in the community, and prevention/educational outreach programs about mental health and mental illness. We have been impressed by the opportunities that such a setting provides for mental health professionals to collaborate with primary physicians in the latter's roles as case-finders and treaters of patients with defined mental disorder, patients with combined psychiatric and medical problems, and patients reacting to either external or illness-related stresses.

The report's first section traces the history of public mental health and health services in the U.S., discusses levels of care, and presents an overview of the current fuctioning of NHC mental health programs. The second section outlines five hypothesized advantages of providing primary mental health services as part of primary health care in the NHC's organized neighborhood setting and the third section reviews theoretical, clinical, and research data relevant to these hypotheses. A summary of these latter two sections, in which the hypothesized advantages and related findings are reviewed, follows.

1. Advantage: The provision of mental health services within a neighborhood-based, primary health setting can improve their accessibility and acceptability to and utilization by neighborhood citizens.

*An earlier version of this paper was developed at the invitation of the Institute of Medicine and was submitted to the President's Commission on Mental Health, 1977. It was used as a background paper for this conference. The full text comprises Volume II of the conference proceedings.

This hypothesis is corroborated by quantitative data from a six month study at Boston's Bunker Hill Health Center in which mental health utilization rates were five times higher than NIMH data on average national utilization. This higher utilization occurred across sexes, and for all age groups and marital statuses. The services disproportionately reached usually underserved populations including patients from the lower socio-economic classes, children and married adults. It is felt that this increased utilization reflects the easy access to these centers, whose neighborhood locataion decreases geographic and travel barriers to care, as well as an increased acceptability of the NHC as a mental health service setting to citizens. Acceptability is encouraged by the frequent use of indigenous care-givers who understand local culture and values and the fact that the mental health services are provided within a trusted health institution with which many people are familiar and comfortable from prior use of its health, dental or health-related social services. Mental health services offered in a multi-service setting are also less stigmatized as the patient does not have to automatically label himself as mentally disordered simply by walking through the door. As below, patients frequently present with somatic complaints to the primary physician and then "slide over" into specialist mental health care.

2. Advantage: The conjoint health-mental health delivery system can improve case-finding, successful referral, coordination of care, long-term follow-up, and preventive/educational efforts to meet general and specific population needs.

Primary physicians are major case-finders and treaters of patients with mental disorder. It is estimated that 60% of all patients with mental disorders seen in primary care is not referred to mental health specialists. Working side by side in the NHC, the primary physician can form a collaborative relationship with the psychiatrist and build up the necessary trust to seek consultation about patients with mental disorder whom the primary physician decides to treat alone. In the conjoint setting, the primary physician can also easily refer patients for mental health specialist care whom he cannot best handle. The latter is supported by a study of 19 Boston NHCs in which almost half of all referrals for mental health care came from the medical staff of the health center.

The physical proximity and the ability to form professional relationships between primary physician and mental health specialist also facilitates collaboration, mutual training, and communication about treatment planning to foster coordinated rather than fragmented care for patients with combined or multiple health and mental health problems. The setting is also an excellent one for long-term follow-up care. Patients with chronic or episodic mental disorders often resist continuing in mental health care during a period of remission of symptoms but will continue their contacts with the NHC for their

costs, including the total costs for the multiple outpatient mental health services needed by chronically ill patients living in the community.

4. Advantage: The provision of mental health services within the NHC can increase the priority of and concern for mental health problems among community citizens.

Health has a much higher priority and is a less stigmatized issue for citizens groups to come together around than mental health. The 10,000-50,000 person NHC service area is smaller than the CMHC's 75,000-200,000 catchment and the smaller area's citizens are more likely to have some sense of cohesion and shared destiny which allows them to relate to the NHC as "theirs." It has been our experience that mental health professionals can work closely with citizens groups in NHCs to plan and promote mental health programs, including aftercare programs for the chronically ill, which fit well and are accepted by the neighborhood.

5. Advantage: The conjoint health-mental health setting of the NHC can offer unique opportunities for necessary training in primary health and mental health care.

The NHC offers primary practice and mental health trainees opportunities for both front-line, acute ambulatory care and long-term care of chronic illness in the community. Training in their patients' neighborhood can help both sets of providers consider the impact on clinical care of socio-environmental, ethnic and cultural, and public health aspects of care often ignored in institution-bound training. Importantly, the proximity to other trainees and availability of collaborating role models can help both primary practice and mental health professional trainees overcome prior negative inter-professional stereotypes to learn to use each other's expertise to their patients' benefit.

The fourth section of the report develops ten issues relevant to the NHC delivery system and suggests alternatives to current national mental health policy concerning these issues, as briefly outlined below.

1. NHCs are proposed as a preferred setting for the delivery of primary mental health care in the public sphere. The conjoint health-mental health setting and location in the community allow it to address itself to the medical, psychological, socio-environmental, and public health aspects of patient care.

2. Closer linkages are proposed between NHCs and CMHCs. Although the NHC setting is excellent for providing primary mental health services, CMHCs are vital sources of secondary and tertiary level care for many intensive and expensive services such as inpatient care, rehabilitation, etc. Both CMHC and Bureau of Community Health Services legislation could provide incentives and requirements for closer linkages between NHCs and CMHCs.

3. New sources of support are proposed to meet critical needs for consultation, collaboration, inservice training, and other indirect services which foster coordinated rather than fragmented care. Other indirect services, such as education, prevention, and screening outreach programs to increase access to care, training of health and mental health professionals, and evaluation research efforts to understand these delivery systems also need to be supported. Although essential to a coordinated care system, few of these critical indirect services are paid for by current reimbursement schemes.

4. Methods are proposed to interlink NHC and CMHC citizen groups and to provide citizen and professional input into Health Services Agencies concerning mental health needs and issues.

5. Additional resources are proposed to stimulate the development of facilities in NHCs to provide long-term aftercare and day treatment for the chronically ill in the community.

6. Linkages are proposed between NHCs and Health Maintenance Organizations, multi-specialty private group practices, and solo private physicians to collaborate in providing coordinated care.

7. Support is proposed for greater in-service and professional training of both primary physicians and mental health professionals in NHCs and other coordinated primary health and mental health care settings. Part of residency training for both primary physicians and psychiatrists could occur in the NHC setting as well as subspecialty training for selected professionals who wish to develop the clinician-executive skills necessary to effectively lead such conjoint health delivery systems.

8. Evaluation research outcome studies are proposed of the NHC system of care to complement existent preliminary studies of service provision and utilization.

9.-10. Alternative funding mechanisms to pay for the direct and indirect services provided in NHCs prior to (9) and as part of (10) National Health Insurance plans are proposed.

The report concludes with <u>three recommendations</u>. These are that national policy, as embodied in federal health services program legislation, government and private health financing programs, and National Health Insurance plans, should encourage and fiscally support:

1. further development of Neighborhood Health Centers and other relevant population-based settings which provide mental health services as a coordinated part of primary health care.
2. those indirect services which facilitate coordination rather than fragmentation of primary health and mental health care and outreach into the community to increase citizen accessibility to and acceptance of necessary mental health services.
3. needed professional training in and critical evaluation research about Neighborhood Health Centers and other conjoint health-mental health primary care settings.

TRAINING FAMILY PHYSICIANS IN MENTAL HEALTH SKILLS
IMPLICATIONS OF RECENT RESEARCH FINDINGS

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England

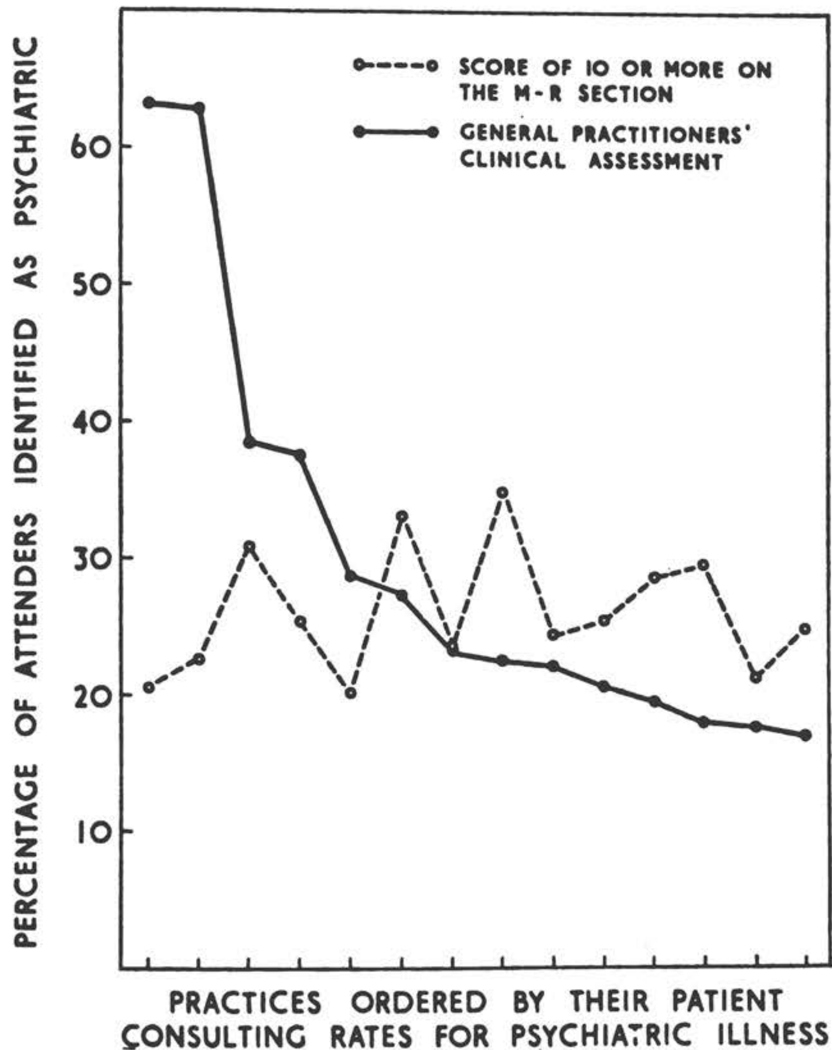
Many of the well-known surveys of mental disorders among patients attending primary care physicians have shown very wide variations between individual practitioners in their estimates of the frequency of such conditions. Shepherd 1/, for example, showed a nine-fold variation between family physicians in London, and surveys in the United States have shown even wider variations. The results of five recent surveys are summarized in Table 1, which shows the percentage of consecutive attenders thought "psychiatric" by the primary care physician. The mean is the figure which is most usually quoted when reference is made to these surveys, and it is often conveniently forgotten that this mean is arrived at by averaging the pronouncements of very heterogeneous observers.

Table 1. INTER-PRACTICE VARIATION IN THE DETECTION OF PSYCHIATRIC MORBIDITY: THE FIGURES REFER TO PERCENTAGES OF CONSECUTIVE ATTENDERS

	Number of Physicians	Mean	Range
Marks, Goldberg & Hillier 2/ Manchester, U.K.	91	14.2%	15-64%
Locke et al 3/ Prince George's County, Md.	79	9.0%	0-44%
Locke & Gardner 4/ Monroe County, N.Y.	58	16.9%	0-37%
Leopold, Goldberg & Schein 5/ W. Philadelphia, Pa.	32	16.3%	0-92%
Goldberg & Steele 6/ Charleston, S.C.	45	39.0%	0-85%

When psychiatric screening tests are used simultaneously during such surveys, they typically show much less variation between the various practice populations than that suggested by the doctors' own assessments. Figure 1 shows 14 practices in Michael Shepherd's well-known study, arranged in rank order, so that the practice with the highest rate of ascertainment of psychiatric illness is on the extreme left while that with the lowest is on the extreme right.

Figure 1



The continuous line shows these assessments -- varying from 63% on the left to 18% on the right. The dotted line shows the probable cases predicted by the Cornell Medical Inventory. It can be seen that so far from there being any association between the two variables the best regression line between the points on the dotted line has a positive slope. Nor can it be concluded that the doctor where the two lines cross is a very clever fellow, and that his colleagues perched at either end of the line are various degrees of fool. The doctor where the lines cross could be identifying completely different individuals from those picked out by the questionnaires: it may just happen that they pick out the same proportion of the population. What we can say is that the doctor on the extreme left has some sort of bias towards perceiving patients as psychologically sick, and that the reverse may be true of the doctor on the right.

Figure 2 has a familiar look about it. But we are now using the General Health Questionnaire instead of the Cornell Medical Inventory; we are studying 29 second and third year family practice residents rather than established physicians; the time is 1979, and the place is Charleston, South Carolina. But nothing else has changed.

Figure 2

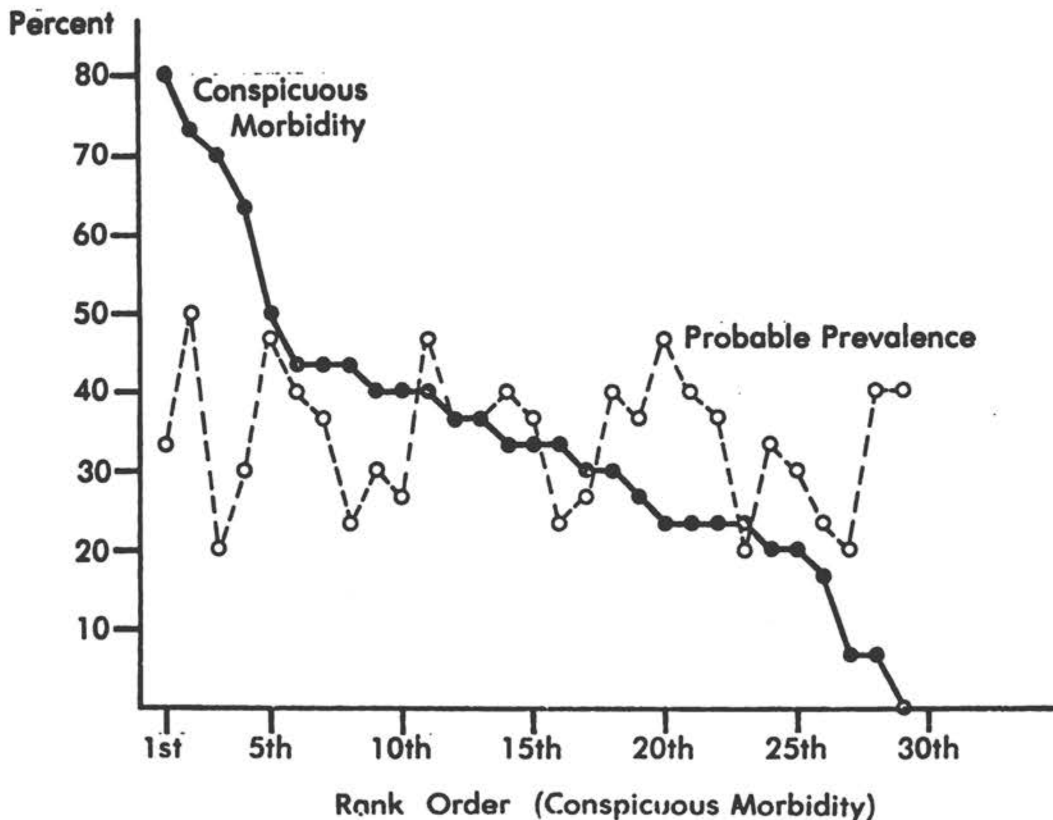


Table 2 shows that there is in fact no correlation between the level of disorder reported by the doctors and the level of disorder in their population predicted by a screening questionnaire. The results now include a large survey that we carried out in Manchester with similar results.

Table 2. RELATIONSHIP BETWEEN THE LEVEL OF THE DISORDER REPORTED BY THE DOCTOR AND THE LEVEL ASSESSED BY THE PSYCHIATRIC SCREENING TEST

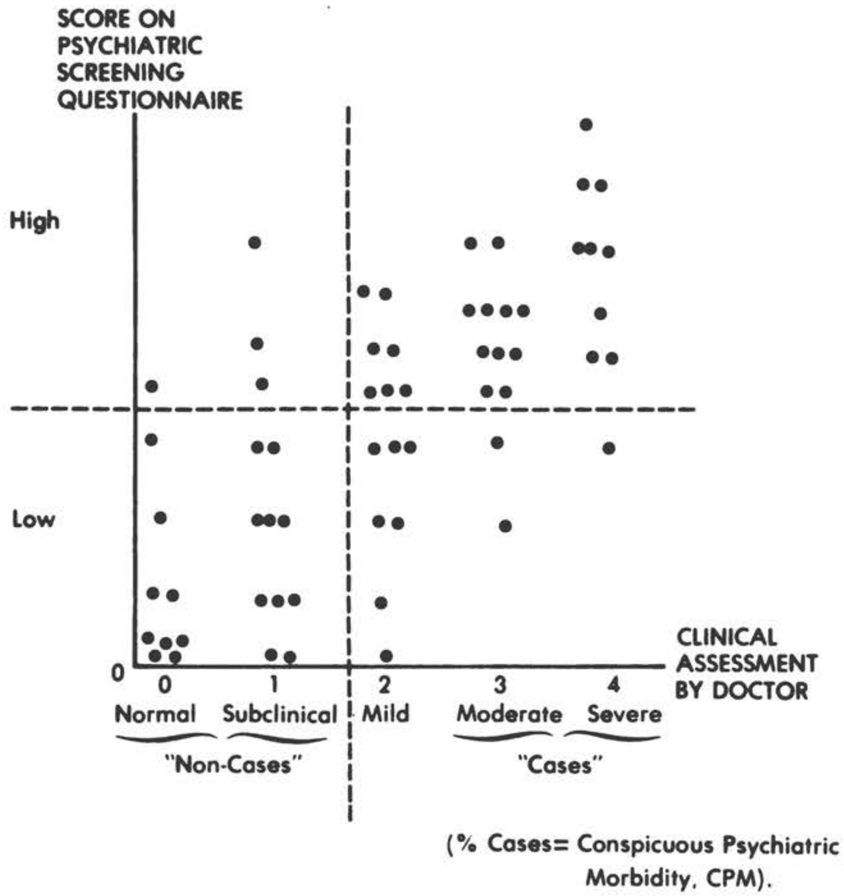
Shepherd et al. 1/	
14 General Practitioners, London, England	-0.31 (NS)
Marks, Goldberg & Hillier 2/	
22 General Practitioners, Manchester, England	-0.17 (NS)
Goldberg & Steele 6/	
29 Family Practice Residents, Charleston, S.C.	+0.08 (NS)

Let me be very clear about the conclusion to be drawn from these data. One cannot conclude that there is no association between an individual physician's assessments and the symptom levels of his patients. The reverse is in fact true, and we shall be returning to that. But it is reasonable to assume that a doctor who tells you that 90% of his patients are mentally sick is no more likely to have a greater number of sick patients attending his office than a doctor who tells you that only 10% are sick. The difference between them resides not in their patients, but in their concepts of psychiatric disorders and the threshold that they adopt for case identification.

Figure 3 shows the ratings made by an imaginary physician "A" for 60 patients, each of whom has completed a screening questionnaire. The scores on the screening questionnaire are shown on the vertical axis, and the doctor's rating of the degree of psychiatric illness is shown on the horizontal axis. It can be seen that the correlation between the two measures is quite good, at +0.6. This doctor identifies 62% of his patients as sick.

His colleague, physician "B", makes exactly the same ratings and so has the same correlation coefficient; but he has a more restrictive view of illness. We can see in figure 4 that his threshold has been moved to the right, so that only 17% are cases. Physician "B" can be said to have a negative bias towards identifying psychiatric illness; he will report a low rate and will tend to fail to identify cases among his patients with high scores (i.e. he will have a low "identification index": see reference 2). He will have the compensatory advantage that he will rarely accuse asymptomatic patients of being psychologically sick (i.e. he will have a high "stability index": reference 6).

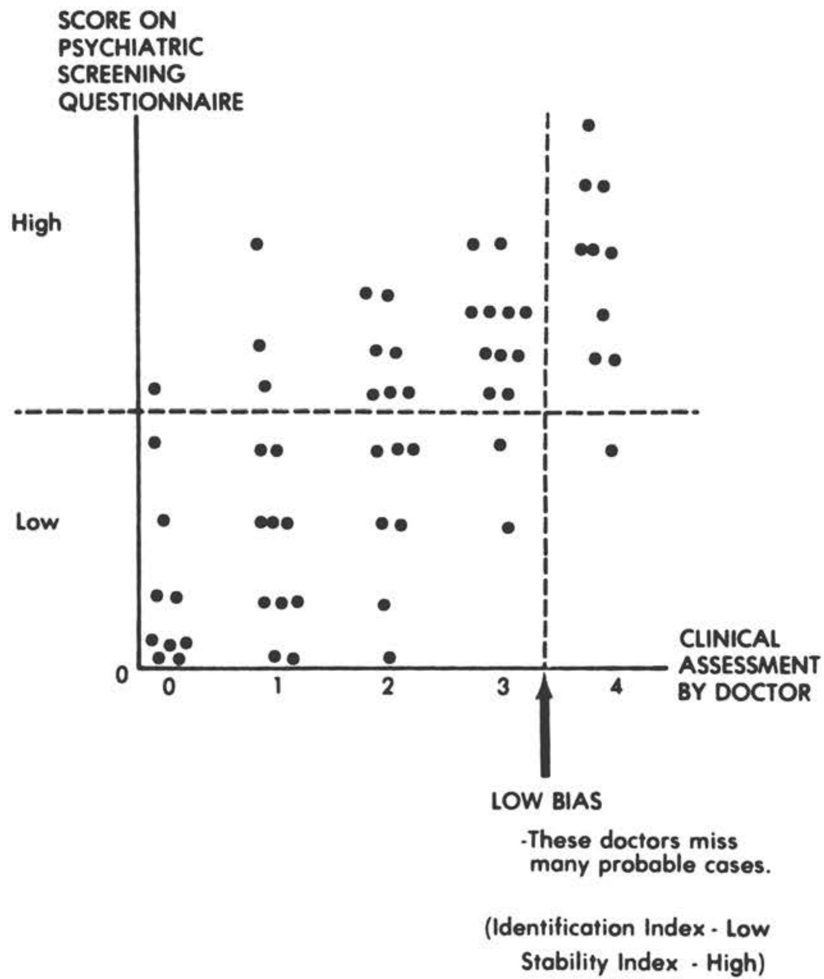
Figure 3



(% Cases= Conspicuous Psychiatric Morbidity, CPM).

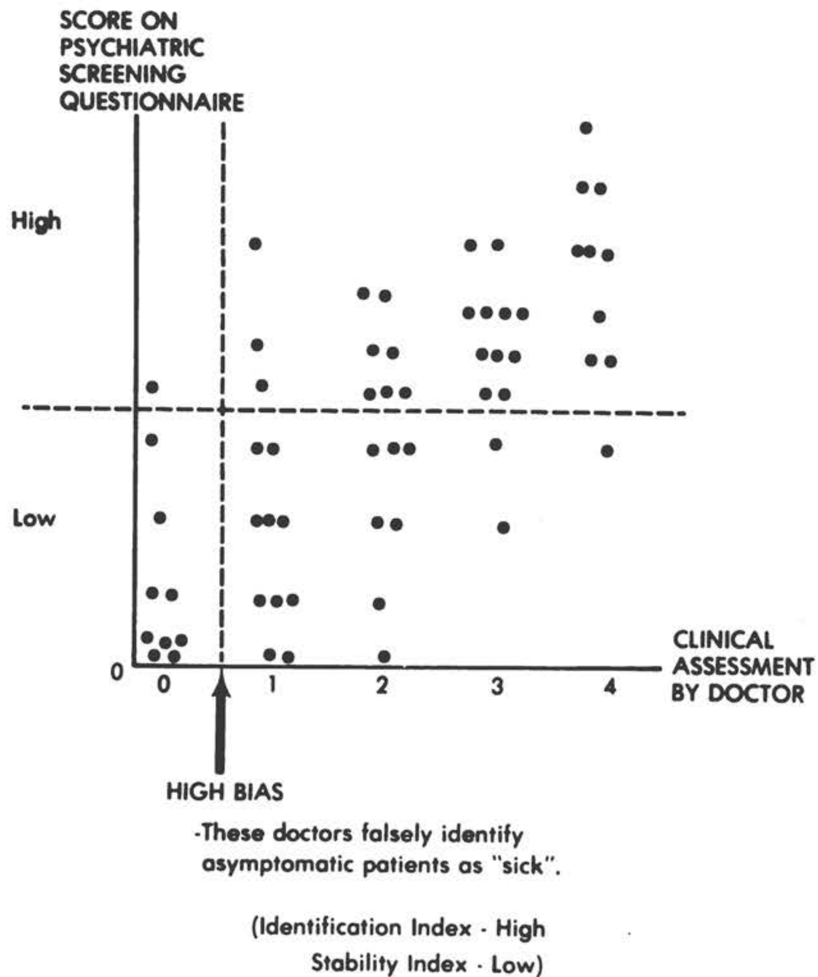
Physician "A"
Correlation Between Doctor and Screening Test + .60

Figure 4



Inevitably, physician "C" has a high bias towards diagnosing illness, with a conspicuous morbidity of 83%. Such doctors rarely fail to identify symptomatic patients as "sick"; yet this advantage will be purchased at the price of frequently identifying asymptomatic patients as "sick" probably because as raters, they tend to guess "sick" when in doubt.

Figure 5



These mythical physicians have been shown to emphasize the point that a doctor's assessments of the level of mental illness tells us more about him than about his patients: what it tells us about him has been studied by Michael Shepherd and ourselves.

Shepherd and his group 1/ were able to account for 51% of the non-random variance of the doctor's assessments in terms of two variables: the "mobility index" was an ecological variable related to the turnover of patients in each practice, and the "psychosomatic score" was an attitude scale which measures the extent to which the doctor thinks psychogenic factors are important in the etiology of various illnesses. The more important he thinks they are, the higher will be his estimate of psychiatric morbidity.

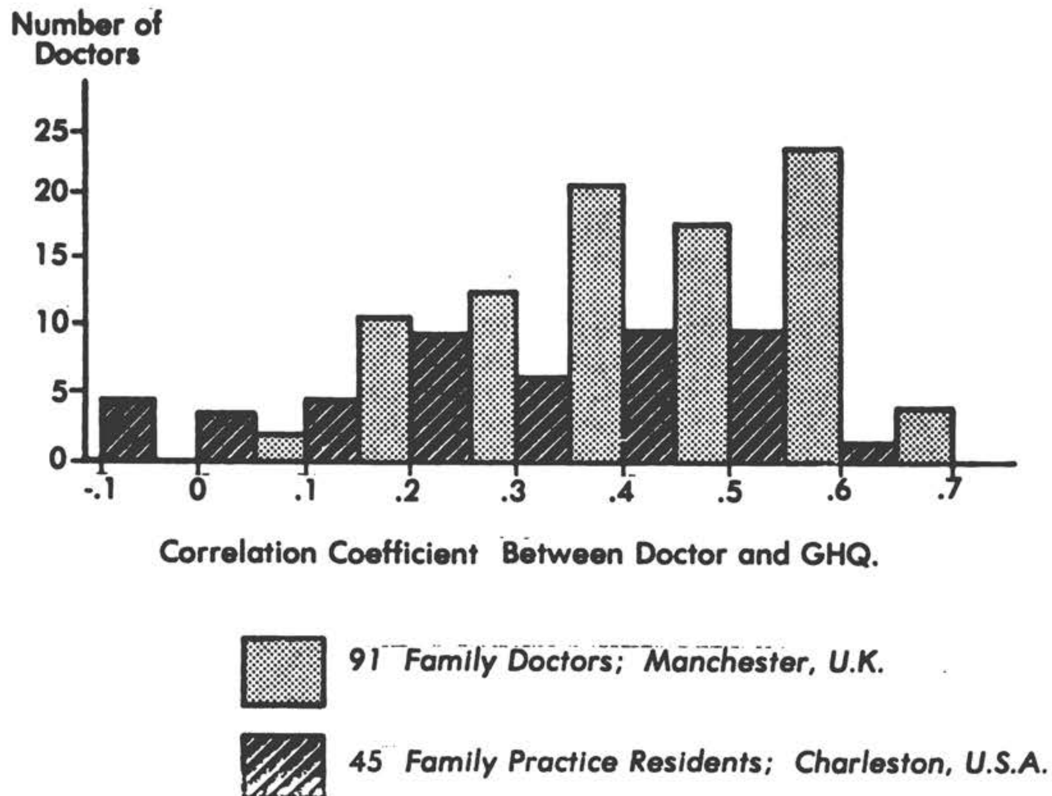
Our recent study in Manchester 2/ was able to include rich observational data made by a psychiatrist observing over two thousand interviews by 56 family doctors, and succeeded in accounting for 53% of the variance of the doctors' assessments. A dimension we have called "interest and concern" accounts for a quarter of the variance, and is characterized by the doctor being rated as an empathic interviewer by the observing psychiatrist; having a tendency to ask patients about their home and their family; and being interested in psychiatry. The next dimension, "psychiatric focus," replicates Shepherd's earlier finding. These doctors score highly on Shepherd's scale concerned with psychogenic factors in illnesses, are once more rated as "interested in psychiatry," and have a tendency to ask questions of a psychiatric nature during their diagnostic interviews. Finally, older doctors who have spent longer times in the practice being observed are likely to have rather higher rates than younger, newly arrived doctors.

The data presented so far support the view that the level of disorder reported by individual doctors tells us very little about the psychological abnormalities among their patients. This however is not to say that their collective assessments are of no value.

Shepherd showed a correlation of +.19 between CMI score and the doctors rating of "case" versus "non-case." More recent work, using the GHQ as the screen, and allowing the doctors a six point scale of degree of psychological disturbances rather than the two-way classification used by Shepherd, shows figures for Spearman's rank order correlation coefficient of between .3 and .4. 2/,6/ These correlation coefficients measure the degree of association between the patients' symptom levels on the one hand, and the physicians' ratings of the degree of disturbance on the other. They take no account of the threshold that an individual doctor uses for case identification, or indeed of the threshold score used for the screening test. We are measuring the ability of a doctor to make ratings that are congruent with his patients' symptom levels, and the striking thing about such a measure is how variable doctors are among themselves in this important respect.

Figure 6 shows that although the mean coefficient for 91 British GP's was +.36, some have coefficients as high as those obtained by trained psychiatrists using lengthy research interviews despite the hurried nature of their own interviews, while others have coefficients that indicate their total inability to make accurate ratings. It can be seen that the situation in the United States is similar to that in England. What determines whether a doctor will have a high coefficient or a low one?

Figure 6



It proved possible to account for almost two-thirds of the variance of correlation coefficient. 2/ Once more, the dimension "interest and concern" turned out to be important, since it accounted for 40% of the variance. This time, however, the dimension of "conservatism" was accounting for a further 19% of the variance. Conservatism is conceived as a broad personality dimension reflecting inflexibility, resistance to change, and authoritarianism rather than a political dimension. It tells you very little, for example, about voting habits. Less conservative doctors are not only better able to rate their patients' disorders accurately, but are also more likely to ask "probe" questions with a psychiatric content.

It seems likely, therefore, that ability to make accurate psychological assessments is partly related to attitudinal and personality factors, and partly related to the possession of certain skills as an interviewer. It is the latter that offer more promise to the planner of training programs for family practice residents.

The random rating behaviors of certain family doctors on each side of the Atlantic necessarily indicates that much psychiatric morbidity is missed. The amount that is missed of course depends upon the doctor; an average Manchester GP detects rather more than half of the cases predicted by the screening questionnaire. 2/,8/ Once more, the range is very wide. Some detect all of them; others almost none. Does this matter?

Preliminary evidence suggests that it does. In one practice in Yorkshire 9/, we randomly assigned patients with high scores on the screening questionnaire who had been rated by the doctor as psychologically normal to an index condition in which the doctor was invited to discuss the responses on the GHQ with the patient, and a control condition in which the information was withheld from him. Three months later, 90% of the index group were well, but only 40% of the control group. Patients in the control group gradually improved with time, but had to endure an average of 5.3 illness-months following initial consultation, in contrast to the 2.8 illness-months for the patients whose disorder had been discussed with their doctor.

Before we consider the implications that such findings have for the future training of family physicians, let us turn briefly to consider the treatment that emotionally disturbed patients actually receive from family physicians. In their research among depressed women found during a community survey in the London borough of Camberwell, Brown and Ginsberg report that the majority of such patients attend their doctors hoping that they will have an opportunity to discuss their problems with him. What they typically get is a short interview and a prescription for a psychotropic drug. In Ginsberg's words:

> "Women go to the doctor with the hope that they might gain help but usually with low expectations that the kind of help they will receive -- that is, a prescription for a psychotropic drug -- will be effective." 10/

The evidence that we have certainly suggests that although lip-service is paid to psychotherapeutic help, pharmacology is what the patients actually get. Shepherd 1/ asked family doctors to respond to a set of clinical vignettes, each of which was followed by a range of possible actions. One of these was always a drug therapy, one was always referral to a specialist service, one was an appropriate form of psychotherapy, and so on. The psychotherapeutic choice was usually the one chosen by his doctors, yet he observed that in practice his survey showed that psychotherapy was not often used. In Shepherd's words:

> "It is evident how much our practitioners relied on drugs even though they were clearly aware of the role of psychological and social factors in the presenting conditions. While a substantial number of patients presented somatic symptoms, for which a somatic form of treatment might have been regarded as understandable, this would not account for more than a small part of the whole picture."

Our survey in Manchester confirmed Shepherd's findings. The research psychiatrist frequently saw family doctors giving psychotherapeutic help in the form of allowing patients to ventilate problems, empathic listening and giving them reassurance during the course of their clinical interviews. Yet of the 2,092 interviews observed, not a single one was an interview in which the patient had expressly come for psychotherapeutic help and the session was formally devoted to that kind of help. In fairness, I should perhaps say that in the Family Practice Residency Training Program at Charleston, I have quite often seen such sessions, and that I freely acknowledge that there are many General Practitioners in England who do give such help. All that I am saying is that such help is relatively infrequent in the actual working conditions observed by us in a large sample of general practices in the north of England. Since the topic of this paper is training, it is also worth recalling that the older generation of the family doctors studied will have had an undergraduate training in psychiatry which was wholly inadequate by present day standards, and that very few of them will have had any training at all aimed at helping them to acquire psychotherapeutic skills.

Hawton and Blackstock 11/ have recently interviewed family doctors who had been looking after 122 patients who had deliberately poisoned themselves with psychotropic drugs. 63% had seen their doctors in the month before the attempt, and indeed 45% had seen him six or more times in the previous year. The family doctors

had identified many interpersonal and social problems among these patients, but had responded to them with drugs rather than with counseling. At least 80% of the patients used drugs of the class prescribed for their overdose.

The authors are not opposed to the use of psychotropic drugs by family physicians, but they observe that they should be prescribed only for clear indications:

> "Antidepressants in therapeutic doses where there is clear evidence of underlying depressive illness; tranquillizers for short periods to help patients through crises when levels of anxiety are such that their coping ability is grossly impaired; and non-barbiturate hypnotics for short periods where insomnia, secondary to stress, is undermining an individual's resources, such as during a severe grief reaction... Automatic represcribing, found to be so common for psychotropic drugs by Freed, should be avoided if at all possible." 11/

To what extent do primary care physicians prescribe psychotropic drugs which are appropriate to the symptoms experienced by their patients? Hard facts are thin on the ground. One problem is that the patients cannot be neatly divided into those with anxiety states and those with depression: the majority of patients seen in primary care settings have combinations of depression and anxiety, with or without somatic symptoms. Downing and Rickels 12/ succeeded in showing that those prescribed anxiolytics were somewhat more anxious than those who were depressed, and that the reverse was true for those prescribed antidepressants. However, all the physicians included in their study were members of a Psychopharmacology Research Group, and indeed many were psychiatrists. It is not clear whether physicians without a special interest in the action of psychotropics would be so discriminating; available evidence is not encouraging. In his extensive study of the prescribing of psychotropic drugs in general practice, Parish 13/ showed that many of the physicians studied used psychotropics in an idiosyncratic and undiscriminating way. Thus one relied almost solely on phenobarbitone, another on butobarbitone, and a third prescribed either "Librium" or "Mandrax." Furthermore, it seemed likely that use of a favorite drug was linked with attachment of a favorite diagnostic label.

> "One practitioner's frequent diagnosis was 'nervousness' or 'debility' for which he constantly prescribed Beplete... in another instance 'nervous dyspepsia' was frequently diagnosed and treated with Melleril, and in a third practice tension headache was the most commonly diagnosed disorder and (was usually treated with) Librium and Valium."

Should it be thought that British physicians are particularly remiss in their prescribing of psychotropics, Hyams, et al 14/ studied 227 primary care physicians in Oregon and New York: although drugs and physical examinations were preferred to insight-oriented psychotherapy as treatment methods, 32% of the physicians failed to name even one correct drug for the management of anxiety or depression.

I wish to draw four harsh conclusions from this body of research before surprising you all and ending my remarks in a constructive and optimistic fashion.

1. Estimates of the level of psychiatric disorder in consulting populations made by primary care physicians are almost completely valueless if one's aim is to arrive at valid estimates of prevalence.

2. Although many primary care physicians make accurate assessments about emotional disorder, many others are very poor at making such assessments. Thus in some practices emotional disorder commonly goes undetected, while in others asymptomatic patients are commonly labelled as sick. The ability to make accurate assessments is related to personality variables and interview style.

3. Failure to detect emotional disorder can have undesirable consequences for the patients. Although minor disorders will tend to remit spontaneously with time, more severe disorders are favorably affected if the doctor detects them.

4. Treatment of detected disorders is often haphazard at present. Inappropriate prescription of psychotropics appears to be widespread and inadequate training in counselling skills is the rule rather than the exception.

Implications for Training

Family practice residents need to acquire skills in three related areas, all of them concerned with the way in which they are taught to interview their patients. 15/

The first group of skills is concerned with the detection of psychiatric disorder. The way the interviewer starts is often of crucial importance: things often go wrong from the beginning. It is essential for the doctor to ask open questions at the outset, and to spend some time clarifying the patient's complaint. The doctor needs to be sensitive to verbal and non-verbal cues relating to psychological distress, and to possess skills to help shy patients to talk and to direct and focus communications from over-talkative, circumstantial patients. The most effective methods for helping trainees to acquire these skills are probably programmed learning

videotapes followed by feedback from behavioral science teachers of their own interviews with patients during the first year of training.

The second group of skills is related to assessment and diagnosis. Trainees need not only skills, but knowledge of the more important syndromes seen in a primary care setting, in order to be effective in "making their diagnoses simultaneously on physical, psychological and social levels." 16/ Teaching in this area should be combination of seminars and lectures for the required factual knowledge, and feedback from teachers of actual recorded interviews as in the first area.

The last area concerns management skills. Doctors who are not confident of their ability to manage psychological disorders will not wish, or dare, to become proficient at eliciting such disorders. The teaching required here is important but time consuming for the teachers: supervision by experienced teachers of the trainees' treatment of individual patients throughout the training years.

Now who is to carry out such teaching? Dr. Hiram Curry, Chairman of the Department of Family Practice at Charleston, writes:

> "We can anticipate...that psychiatrists will criticize as behavioral science becomes a more important part of the curriculum at the expense of traditional psychiatric training. Psychologists will vie for a larger piece of the action, and in my judgment they should get it. There has been heavy emphasis in the past on understanding marked abnormal behavior...(but) we now realize that we should make a heavy investment in understanding normal as well as unusual behavior, both in our patients and in ourselves." 17/

There is much to be said for this point of view; but there have been undesirable consequences. The behavioral and social scientists imported to replace psychiatrists as teachers about psychological disorders often attack their own caricature of the "medical model" with relish, but may neglect to ensure that the trainee becomes proficient in the assessment of the more important syndromes of psychological disorders. The baby is thus thrown out with the psychiatric bathwater. Dr. Curry continues:

> "Some traditionalists imply, by their actions, that only doctors have information which is truly valuable to aspiring physicians. This is far from true. In the future, psychologists, social workers, epidemiologists, nutritionists and others will have more important roles as teachers."

Dr. Curry reaches this conclusion -- with which I largely agree -- with the following argument:

> "It is not a safe assumption that the study of psychology in college permits us (as doctors) to understand the average person who is not well...17/

But this knife cuts both ways. How will this motley army of social scientists learn to "understand the average person who is not well" themselves? Certainly not by studying psychology at college. All too often, it seems to me, psychiatrists and social scientists alike assume that what the family physicians need are the skills they themselves possess -- perhaps suitably scaled down.

But both psychiatrists and social scientists are often unfamiliar with the typical patient seen in a primary care setting. Where the social scientist is concerned, a college sophomore with anxiety about public speaking, or an articulate middle class client with a minor sexual problem, are both rather poor role models for the kinds of problem with which his trainee will daily have to deal. In contrast to the psychiatrist, the primary care physician is likely to see transient affective disorders rather than long-standing personality disorders, and to have patients who present with a baffling melange of somatic and affective symptoms.

By virtue of his medical qualifications, the psychiatrist has a unique contribution to make to the training of the family physician. He will, of course, assist other social scientists in helping the trainee to acquire appropriate counseling skills; but he has four special contributions to make.

First, his knowledge of physical diagnosis will assist him in helping trainees to appreciate the interactions between psychological and physical factors in the causation of pains and other somatic symptoms. It is not easy for a social scientist without medical qualifications to know how reasonable a trainee is being when he persists with closed questions concerned with physical disease to the relative neglect of psychological functions.

Second, his knowledge of the syndromes of psychological disorder should help his trainees acquire the probe questions which are necessary for accurate assessment of the patient's current psychological status. The syndromes which the trainee should be able to assess are those in which diagnosis implies special management procedures: for example, those depressive states which are especially responsive to drug therapy; the presentations of substance abuse in a primary care setting; and the assessment of confusional states in the elderly.

Third, he should be largely responsible for teaching the proper use of psychotropic drugs, and helping his trainee to understand how

any drug therapy is to be incorporated into a general plan of psychological and social help tailored to the needs of the individual patient.

Finally, he should be responsible for helping trainees to grasp the indications for referral to a psychiatrist. All too often, the new omnipotent brand-image of the Family Physician makes the trainee feel that he has failed if he asks for specialist help. Nor is it the case that all major syndromes should be referred, and that all minor syndromes should be treated by the family physician. On the one hand, the family physician will often have a role to play in the management of long-term major disorders, and will therefore need the skills to make appropriate clinical assessments, when the occasion demands, of patients who are receiving depot injections of phenothiazines or who are on long-term lithium therapy. And on the other hand, neurotic and characterological problems often require specialized psychotherapeutic skills for their management which it would be unreasonable to expect every family physician to possess.

I will finish on an hortatory note. Our first task is not to train today's family physician; nor is it to train the physicians of tomorrow. Our first task is to train the teachers. Psychiatrist and social scientist will both be required on the faculty, for each has expertise that the other all too often lacks. But there must be an agreement about the aims of the teaching programs; and, above all, the teaching must be adapted to the particular needs of the family physician.

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THE PRIMARY CARE PHYSICIAN: MENTAL HEALTH ISSUES

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Kafka wrote in A Country Doctor that "to write prescriptions is easy, but to come to an understanding with people is hard." 1/ That truth undoubtedly explains in large part the prominence enjoyed by psychotropic drugs among the 1.4 billion prescriptions written last year for the seventy million Americans who regularly take drugs ordered by physicians. How did this gap emerge between the technical skills and knowledge exemplified by the use (and abuse) of modern pharmaceuticals and the all-too-often deficient mental health skills of the prescribing physician? Rasmussen traces the separation of medicine and psychiatry back four centuries to the decision by the Church to permit the study of the human body by dissection. In exchange for this permission, the medical community accepted a tacit prohibition against corresponding scientific investigation of man's mind and behavior--attributes which were firmly identified with the soul. 2/

Engel observes that with "mind-body dualism firmly established under the imprimatur of the Church, classical (medical) science readily fostered the notion of the body as machine, of disease as the consequence of the breakdown of the machine, and of the doctor's task as repair of the machine." 3/ Into this gap between mind and body steps — or is pushed — the primary care physician who is often expected by his patients to be part mechanic and part priest. Functioning as he does in what Friedson terms a client-dependent form of practice, 4/ the primary care physician should, and usually does, feel an obligation to fulfill or at least acknowledge the patient's expectations. Furthermore, one of the distinct attributes of primary care is an understanding of the doctor-patient relationship and how this relationship can be used to ameliorate physical illness and mental health problems.

Carmichael has argued that family medicine as one form of primary care is more identified with psychiatry as a "behavioral discipline" in contrast to the traditional surgical and medical disciplines. 5/ The functions of the "behavioral disciplines" are mainly helping

and caring rather than healing or curing, and the relationships are characterized by mutual participation and not activity-passivity or even guidance-cooperation.

The primary care physician trying to pull medicine and psychiatry together soon learns that each discipline brings with it very different personal rewards. Physicians and medical students value making a diagnosis, providing successful treatment or controlling the patient -- actions which provide prompt or immediate gratification for the doctor. Less valued are giving help and care and making personal affiliations -- actions which are slower and for which gratification is usually delayed. 6/ The pace of these latter services and rewards is matched by the process of slow assimilation of material needed to learn the psychiatric contributions to medicine -- learning which has difficulties involving "not only intellectual understanding but also emotional processes, mobilization of anxiety, empathy with patients, and the growth and maturity of the student," resident or physician. 7/ Put another way, the primary care physician extends his knowledge of medicine by including new ideas and discoveries -- by reading journal articles or attending conferences. In psychiatry, on the other hand, "knowledge generally increases not through new information but through deeper understanding of the known." 8/

Abundant opportunities exist for the primary care physician to acquire this deeper understanding. Lipowski estimated that 50-80% of medical outpatients have psychiatric illness serious enough to warrant special attention. 9/ Goldberg diagnosed a psychiatric illness in 34% of patients with small bowel disease attending a follow-up clinic at St. Thomas' Hospital. 10/ This rate is close to that in patients seeing a general practitioner and higher than rates in the community. 11/ After the Mid-town Manhattan study revealed that 81.5% of the population had emotional symptoms it became clear that we needed to distinguish between mental disorders and the emotional problems of living. Using the nosology of mental disorder in Section V of the I.C.D.A. to classify psychiatric visits, the National Ambulatory Care Survey of 1973-74 provided the following data for 645 million physician visits (about 70% of total ambulatory visits in the United States):

> "Mental disorder was diagnosed in 78% of visits to psychiatrists, 4% of visits to general practitioners, and 9% of visits to internists. Because of the larger number of visits to non-psychiatrists, 59% of all visits by patients with mental disorders were to these physicians." 12/

How did the physicians respond to these patients? Overall, 4% of visits included psychotherapeutic/therapeutic listening therapy. Psychiatrists provided this therapy in 73% of visits with a mean

duration of 45 minutes while non-psychiatrists used psychotherapeutic listening in 2% of visits with a mean duration of 19 minutes. Again because of greater numbers the non-psychiatrists accounted for 46% of all visits which provided psychotherapeutic/therapeutic listening. In patients with a principal diagnosis of mental disorder the non-psychiatrists all used other treatments, such as drug therapy, medical counselling/advice or general history and physical exam, more than psychotherapeutic/therapeutic listening.

Inadequate or inappropriate response to patients with mental disorders is by no means limited to the ambulatory setting. Moffic and Paykel detected 43 depressed patients among 150 medical in-patients; but only six had any mention of depression in the chart, four were receiving anti-depressants and two had been referred to psychiatry. 13/ The behavior of non-psychiatrists in both settings may reflect the fact that psychiatry as a body of knowledge is intrinsically anxiety-provoking. 14/ Lazarson notes that "even more anxiety-provoking than the theoretical body of knowledge is work with the clinical source of all theory -- the patient." 15/ The affect of patients with mental disorders re-evokes in the physician those "problems and conflicts whose existence and solution took place exclusively in his unconscious, and towards whose revival there are the strongest resistances." 16/ The consequences of this behavior for primary care physicians already burdened with anxiety about their patients' medical needs are that emotional problems often present as an enigma. Some physicians completely fail to recognize mental disorders or are uncomfortable with patients whom they label malingerers, hypochondriacs, crocks or "problem patients." Management of these patients often includes extensive diagnostic or treatment plans with the minority of patients receiving time for ventilation and therapeutic listening through repeated visits.

In their study of 88 general practitioners Peterson et al found that most physicians recognized the emotional situation of some patients, some physicians attempted to treat emotional problems without any real basis of knowledge, and only a few physicians were prepared to do something about the problems. 17/ Paradoxically, the characteristics of the therapeutic relationship in primary care practice, with more spontaneous intimacy and greater continuity, should enable the physician to treat mental illness more effectively than specialists. 18/ Many primary care physicians do possess good interviewing skills, develop therapeutic relationships with their patients, are empathic, and support patients through normal life crises. But these skills and attitudes which suffice for the emotional problems of living are inadequate to deal with mental disorders such as: (in order of frequency in primary care practice) neurotic disorders, psychophysiologic disorders, behavioral disturbances of childhood, character disorders, and more severe depressive and schizophrenic psychotic disorders. 19/

No one is more aware of these deficiencies in mental health skills than the primary care physicians themselves. Forty-six percent of family physicians surveyed by Fisher, et al. were dissatisfied with their own competence to treat mental illness, and only 10% thought their psychiatric training very good in relation to their present practice. 20/ Similar results have been reported for internists. 21/, 22/ When one compares the mental health skills primary care physicians think important with the opinion of psychiatrists and psychologists, a high level of agreement exists. A survey of psychiatrists, psychologists and non-psychiatric physicians produced the following list of the ten most important topics in psychiatry which the physician should know:

Interviewing
Suicide evaluation
Psychopharmacology
Chronically-ill or dying patients
Psychophysiologic disorders
Psychiatric referral
Doctor-Patient relationship
Drug and alcohol abuse
Differential diagnosis of mental illness
Sexual problems. 23/

Rural general practitioners ranked all but drug and alcohol abuse and sexual problems in their list of most important topics in psychiatry. 24/ In another study of family practice Werkman, et al. found alcohol abuse and marital problems in the most common psychiatric disorders. 25/ The fact that they are often the most difficult disorders to treat may account for the rural practitioner's failure to include them among the most important topics -- an example of inner resistance against threatening material in the body of psychiatric knowledge. 26/

In the face of these difficulties what accounts for the current emphasis on teaching psychiatry and behavioral science to primary care residents? Certainly it would be easier to support the resident's enthusiastic and skillful pursuit of organic disease while making other arrangements for dealing with those mental disorders which are less well-defined and frequently viewed as less legitimate aspects of patient care. 27/ But in moving beyond the biomedical model we acknowledge that the primary care physician is ideally placed for the prevention, diagnosis and treatment of mental disorders for the following reasons: "many mentally disturbed patients present with physical complaints; physical and mental illness frequently coexist; some stigma is still attached to seeing a mental health specialist; the important social and family context of the patient are already known; and the potential for long-term follow-up is present." 28/ To take advantage of these opportunities the primary care physician needs to acquire specific mental health skills.

Several authors have described curricular objectives for teaching these skills, 29/, 30/ and a detailed list of educational goals was submitted to the Bureau of Health Manpower by the American Psychiatric Association in 1977. As part of a curriculum project for the Harvard Care Program, Lipsitt, et. al. described the mental health skills which when mastered by the primary care physician would permit him to function effectively in treating the "whole" patient as well as deal with problems commonly seen in general practice. 31/ These skills are broadly defined in three categories: sensitivity skills, therapeutic skills, and referral skills.

First, the sensitivity skills; the overall objective in this category is to educate primary care physicians to be more sensitive to patients and their needs for treatment and understanding. Implicit to the achievement of this objective is the physician's awareness of his own reactions and the effect on him and on the patient of the treatment process or the building of a therapeutic alliance. To have this awareness the physician must be capable of sufficient introspection to assess his own attitudes and values. One measure of this sensitivity to patients is the degree to which the physician shares Carmichael's conviction that it is his responsibilty to "establish a setting in which the patient can state his thoughts and feelings with complete freedom." 32/

Sensitivity to patients also requires an understanding of the process of normal growth and development through the life cycle, and of the problems of adaptation and solutions at each stage of the cycle. Understanding of economic, class and environmental influence on illness is also necessary for physician awareness of treatment needs in the context of the patient's own frame of reference. 33/ Knowledge of the influence of these psychosocial factors must then be combined with knowledge of community resources for planning the most appropriate treatment. Only when these skills of sensitivity are developed can the primary care physician make intelligent judgments about the proper mix of therapeutic listening, crisis intervention, or empathic support for a patient with a problem of living.

The therapeutic skills are built on the foundation of sensitivity skills. Here the primary care physician learns how to counsel various kinds of patients with problems complicating, causing, or resulting from their medical and/or psychosocial conditions. To provide this counselling the physician needs:

- to understand the "psychosomatic approach" in its broadest sense;

- to be experienced in the rudiments of history taking, interviewing skills and minor psycho-therapeutic techniques; and

- to recognize and deal with the acute (though often low level) anxiety and depression frequently related to illness.

The importance of the history-taking and interviewing skills cannot be stated too strongly. Engel states that "the most essential skills of the physician involve the ability to elicit accurately and then analyze correctly the patient's verbal account of this illness experience. The biomedical model ignores both the rigor required to achieve reliability in the interview process and the necessity to analyze the meaning of the patient's report in psychological, social and cultural, as well as in anatomical, physiological, or biochemical terms." 34/ By application of these principles the primary care physician can recognize and deal with emotional and mental problems in patients presenting with essentially non-psychiatric conditions, understand the issues which impact on patient compliance, and support the patient in following the medically indicated regimen.

In addition to managing common anxiety and depression these skills enable the primary care physician to deal with problems of living; couples' counselling; and marital, sexual, adolescent and family problems. Therapeutic skills enable the physician to manage problems of grief, terminal illness and adjustment to disability; and provide the base for acquiring knowledge and experience in the disorders of craving (obesity, alcoholism, and drug abuse) and awareness of personality patterns that place the patient at risk of developing habituation to medications prescribed by the physician.

The category of referral skills includes learning to recognize serious psychiatric disorders and developing skills of the referral process, utilizing appropriate resources. To make appropriate referrals for specialized mental health services the primary care physician must:

- develop diagnostic skill for the major psychiatric disorders;

- be able to elicit data relevant to suicidal or homicidal potential;

- know how to arrange for psychiatric hospitalization when needed;

- be able to provide initial management of psychiatric emergencies until the services of a psychiatrist can be arranged if necessary;

- know how to work with psychiatrists in providing proper treatment; and

referrals are facilitated, and the primary care physician can gradually increase the level of responsibility he assumes for managing more seriously ill psychiatric patients or medical patients with significant mental disorders. The disadvantages center around the disruptive influence of severely-disturbed patients on the practice itself and the occasional patient whose mental disorder or the intensity of the transference-counter-transference distracts the primary care physician from appropriate management of medical problems in that patient. At the moment this seems to be a small price to pay for the opportunity to break down distinctions between psychological and physiological events. As Dr. Regier and his colleagues noted, much of the ability of primary care physicians "to deal with more explicitly defined organic illness may well depend on the ease and competence with which they respond to the presentation of mental disorder and broader emotional concerns." 40/

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REIMBURSEMENT BY MEDICARE FOR MENTAL HEALTH SERVICES BY GENERAL PRACTITIONERS - CLINICAL, EPIDEMIOLOGIC AND COST CONTAINMENT IMPLICATIONS OF THE CANADIAN EXPERIENCE

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This paper describes some Canadian experiences in paying for psychiatric services by general practitioners under a national health insurance program. The first part of the paper outlines the national health insurance program; the second part gives national and regional data on utilization; the third part describes some cautions and concerns these data raise for future programs, and the paper concludes with an agenda for future research.

CANADIAN NATIONAL HEALTH INSURANCE FOR PSYCHIATRIC SERVICES

In 1961 the Canadian Government established a Royal Commission on Health Services to review the state of health services and make recommendations for the future. A Royal Commission project on the extent and results of psychiatric services in Canada identified marked limitations in insurance reimbursement for psychiatrist's care. 39/ There was very little opportunity for general practitioners to be reimbursed for counselling and psychotherapy. 45/ The 1964 Report of the Royal Commission on Health Services laid the framework for national health insurance. 8/ Recommendation Number 29 stated that:

> "Henceforth all discrimination and distinction between physical and mental illness in the organization and provision of service, the treatment, and the attitudes on which these discriminations are based, be disallowed for all time as unworthy and unscientific."

The authors acknowledge the unpublished tabulations from Health Information Division, Information Systems Directorate, Policy, Planning and Information Branch, Department of National Health and Welfare, Canada; Program Development Division, Nova Scotia Department of Health; Maritime Medical Care Inc., and Carl d'Arcy, Ph.D., University of Saskatchewan; the help of Mrs. B. Brunelle, and the Audio-Visual Division of Dalhousie Faculty of Medicine.

The Commissioners specified that the medical services benefit should incorporate insured medical services for "the diagnosis and treatment of all physical and psychiatric conditions including mental retardation" (Recommendation 30a).

By 1971 all 10 provinces had introduced comprehensive medicare programs for all age groups. The provincial programs were very similar since, although provision of health care in Canada falls within provincial jurisdiction, the provinces had to meet federal requirements in order to benefit from the federal cost-sharing agreement which began in 1968. These federal requirements included: 7/

(1) comprehensive coverage for all medically required services rendered by a physician or surgeon;

(2) universal availability to all eligible residents on equal terms and conditions, with insurance coverage for at least 95% of the total eligible provincial population;

(3) accessibility uninhibited by excessive user charges;

(4) portability of benefits among Provinces - a resident of one Province would be able to get equivalent benefits if he moved to another Province;

(5) administration on a non-profit basis by a public authority.

The provincial medicare programs did not change the delivery of clinical services, which continued to be provided mainly by private practice physicians working on a fee-for-service basis. 24/ The patient has choice of physician; the physician submits a claim for an individual patient. The method by which the provincial costs are financed varies from Province to Province; in Ontario there is an annual premium, Nova Scotia has a sales tax. Currently physician satisfaction with medicare varies, satisfaction being highest in the Maritime Provinces. 33/

UTILIZATION OF PREPAID PSYCHOTHERAPY

Table 1 shows the use of prepaid psychotherapy and counselling services in 3 Canadian regions over a 6-year period, 1972-1978. (Consultations and hospital visits are excluded). During 1977-78 the population of 22.6 million used 3.8 million services costing $91.2 million. In relation to population there were 170 services per 1,000 population costing $4,043 per 1,000 population. Over two-fifths (42.75%) of these services were provided by general practitioners. Regional utilization ranged from 76 to 194 services per 1,000 (Figure 1). In relation to total expenditures (excluding pathology, radiology and certain specialized services) psychiatric

TABLE 1

Psychotherapy Services: Number of Services and Payments, Rates per 1,000 Insured Persons, Percentage Distribution by Specialty, Nine Provinces, by Region, 1972-73 to 1977-78

Preliminary

		Maritimes	Central	Western	9 Provinces
1972-73					
Number of Services	(No.)	58,522	1,792,443	540,933	2,391,898
Payments	($)	820,595	30,839,389	9,472,382	41,132,366
Services per 1000 Insured Persons	(No.)	38.22	129.32	93.98	113.11
Payments per 1000 Insured Persons	($)	535.99	2,225.06	1,645.65	1,945.07
Percent done by:					
General Practice	(%)	32.77	36.16	33.38	35.45
Psychiatry	(%)	64.99	59.80	63.54	60.77
Other	(%)	2.24	4.04	3.08	3.78
1973-74					
Number of Services	(No.)	72,054	1,991,206	585,151	2,648,411
Payments	($)	1,087,816	34,413,849	10,231,261	45,732,926
Services per 1000 Insured Persons	(No.)	46.55	142.18	99.97	123.72
Payments per 1000 Insured Persons	($)	702.72	2,457.25	1,748.04	2,136.45
Percent done by:					
General Practice	(%)	38.68	35.95	33.02	35.38
Psychiatry	(%)	59.21	60.13	64.12	60.99
Other	(%)	2.11	3.92	2.86	3.64
1974-75					
Number of Services	(No.)	91,587	2,306,866	685,096	3,083,549
Payments	($)	1,702,349	43,732,036	12,376,181	57,810,566
Services per 1000 Insured Persons	(No.)	58.29	162.48	114.64	141.80
Payments per 1000 Insured Persons	($)	1,083.61	3,080.15	2,070.98	2,658.57
Percent done by:					
General Practice	(%)	44.69	38.43	34.54	37.75
Psychiatry	(%)	51.40	57.89	62.98	58.83
Other	(%)	3.91	3.68	2.48	3.42
1975-76					
Number of Services	(No.)	105,113	2,658,953	762,824	3,526,890
Payments	($)	2,153,432	51,890,988	16,702,889	70,747,309
Services per 1000 Insured Persons	(No.)	65.94	185.11	125.05	159.89
Payments per 1000 Insured Persons	($)	1,350.96	3,612.57	2,738.18	3,207.33
Percent done by:					
General Practice	(%)	45.13	39.55	43.76	40.63
Psychiatry	(%)	50.59	56.38	53.35	55.56
Other	(%)	4.28	4.07	2.89	3.82
1976-77					
Number of Services	(No.)	113,914	2,741,233	851,717	3,706,864
Payments	($)	2,525,174	58,493,260	19,693,574	80,712,008
Services per 1000 Insured Persons	(No.)	70.58	188.86	137.02	165.89
Payments per 1000 Insured Persons	($)	1,564.54	4,029.85	3,168.21	3,612.08
Percent done by:					
General Practice	(%)	48.46	39.53	46.90	41.50
Psychiatry	(%)	47.24	58.32	49.83	56.03
Other	(%)	4.31	2.16	3.27	2.48

TABLE 1

CONTINUED

1977-78		Maritimes	Central	Western	9 Provinces
Number of Services	(No.)	123,431	2,839,857	885,175	3,848,463
Payments	($)	3,096,355	66,384,856	21,756,644	91,237,855
Services per 1000 Insured Persons	(No.)	75.77	194.24	140.08	170.53
Payments per 1000 Insured Persons	($)	1,900.77	4,540.68	3,443.05	4,042.80
Percent done by:					
General Practice	(%)	49.90	40.00	50.58	42.75
Psychiatry	(%)	47.07	59.16	46.40	55.84
Other	(%)	3.03	0.85	3.02	1.42

NOTES

1. The figures are based upon fee-for-service payments made by the medical care insurance plans of nine provinces to physicians residing in the province making the payments. Out-of-province payments are excluded. Also excluded are services not covered by provincial plans, e.g. Workers' Compensation, services rendered by physicians paid on a salary, sessional or other non-fee basis.

2. Psychotherapy includes individual, group and family psychotherapy or psychoanalysis, hypnotherapy, and certain "counselling" services.

3. Figures are adjusted to make them as comparable as possible. For example, in provinces where psychotherapy services are paid in terms of 15 or 30 minute units, it is assumed that the average psychotherapy service takes 45 minutes.

4. Data for the two central provinces and for Manitoba are on a date-of-service basis. Those for the other provinces are on a date-of-payment basis.

5. The "Maritimes" consist of Prince Edward Island, Nova Scotia and New Brunswick. Newfoundland is excluded because comparable data for earlier years were not available. "Central" comprises Quebec and Ontario. The three prairie provinces and British Columbia make up the "Western" provinces.

6. Grouping and adjustment procedures were revised recently. Checking of the results is still under way, and consequently the figures are treated as "preliminary" until further notice.

Health Information Division,
Information Systems Directorate,
Policy, Planning and Information Branch,
Department of National Health & Welfare,
March 1979.

FIGURE I

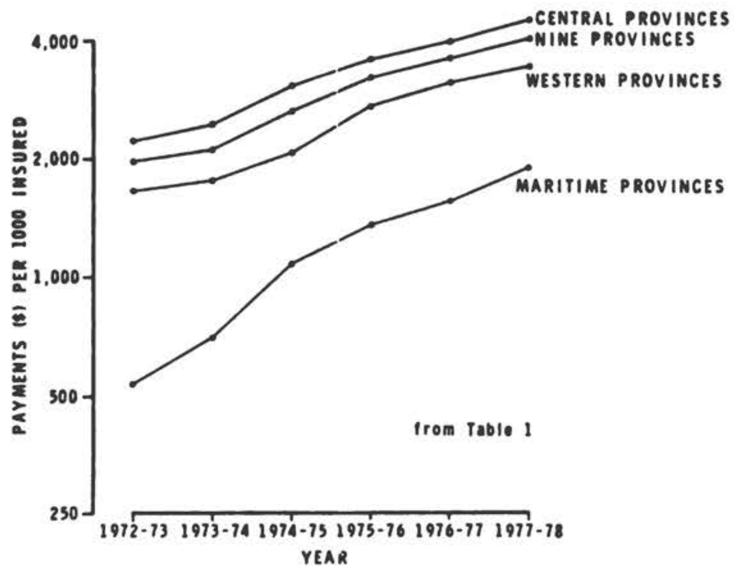
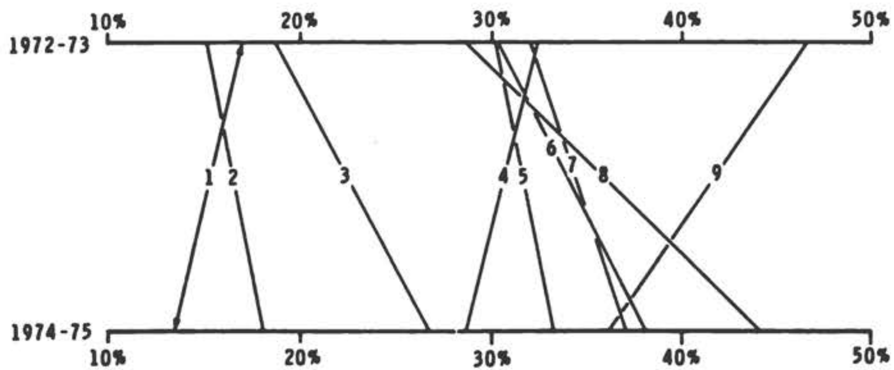


FIGURE II



services amounted to 5.2% of the total costs of insured physician services, with an inter-regional range of 3.0% to 5.8%.

In comparison to six years earlier (1972-1973) the absolute number of services in 1977-78 had increased by 61%, the cost by 122%, the services per 1,000 population by 51%. The proportion of medical payments for psychotherapy services had increased from 3.95% in 1972-73 to 5.2% in 1977-78, an increase of 32%. The proportion of psychotherapy services from general practitioners increased from 35.45% to 42.75%.

Provincial trends in the proportion of psychotherapy services from general practitioners were not uniform. Figure II shows the proportion of psychotherapy services by general practitioners in nine Canadian provinces between 1972-73 and 1974-75. In some provinces the proportion of psychotherapy by general practitioners decreased (Provinces 1, 4 and 9), while some provinces (No. 8) showed striking increases. Later this paper will refer to some of the factors related to increased psychotherapy by general practitioners.

RECORDING OF PSYCHIATRIC MORBIDITY IN CANADIAN INSURANCE PLANS

Other papers in this Conference have shown the wide variations in recording of psychiatric morbidity by general practitioners. There is evidence that the recording of psychiatric morbidity by general practitioners can be enhanced under health insurance. In contrast to the United States, where the majority of private practice office visits for mental disorders are to psychiatrists, 35/ more Canadian patients are given diagnoses of mental disorders by general practitioners than by psychiatrists. Table 2 shows the pre- and post-medicare experience of general practitioners in Quebec. The number of psychiatric visits nearly tripled and variation among physicians in the recording of mental disorder was halved. 31/

The Canadian system meets many of Shepherd's desiderata for a cooperative psychiatric morbidity survey of general practice. 47/

(1) Participation of a large representative group of collaborating doctors.

(2) Use of a uniform diagnostic classification.

(3) Use of clearly defined standardized indices for measuring morbidity in terms of time periods and in relation to population-at-risk.

The Canadian universal prepaid hospital insurance plan does not discriminate against mental disorders. The provincial data bases of individual hospitalizations and medical services enable detailed studies of the use by the general population of specialized psychiatric services, mental health services from private practitioners, general

TABLE 2. PSYCHIATRIC SERVICES BY ACTIVE GENERAL PRACTITIONERS QUEBEC, JANUARY-MARCH, 1971 AND 1975

			1971	1975	Change
All Visits and Consultations					
	Number	Mean	2,003	1,629	-19%
		Coefficient of variation	.61	.50	-18%
	Payments	Mean	9,735	11,579	+19%
		Coefficient of variation	.43	.45	+ 5%
Psychiatric Visits and Consultations					
	Visits as Percentage of All Visits and Consultations	Mean	.93%	3.24%	+248%
		Coefficient of variation	6.86	3.4	-50%
	Payments as Percentage of Payments for All Visits and Consultations	Mean	1.47%	4.27%	+190%
		Coefficient of variation	4.98	2.73	-45%

From Mathematica Policy Research, 1978

hospital care for mental disorders, and in some provinces with pharmacare the use of prescribed psychopharmaceutical agents. 26/ These data, by and large, have not been extensively used for health services research. The next section describes the uses of these data bases for epidemiologic research in Saskatchewan. 10/-15/

CONSPICUOUS PSYCHIATRIC MORBIDITY - SASKATCHEWAN

Saskatchewan led the Canadian provinces in establishing prepaid hospital care in 1947 and prepaid medical care in 1962. Carl d'Arcy of the Psychiatric Research Branch at the University of Saskatchewan recently completed a detailed analysis of conspicuous psychiatric morbidity recorded for Saskatchewan residents over a 2 year period.

He collated the data bases of the specialized psychiatric services, general hospitals and fee-for-service physicians to develop a file of unduplicated persons given a diagnosis of a mental disorder (including ICDA-8 category 793.0) during a two year period in the province of 920,000. In the "pyramid" of Figure III patients are classified in a hierarchical manner -- persons seen in more than one sector during the two year interval are assigned only to the top-most sector and not to lower sectors. The cumulative percentages shown are population-based, not the proportion of patients attending physicians. (Over 20% of residents did not attend a physician during a calendar year.)

a) Specialized psychiatric inpatient services - about 2,400 persons were first admissions — 1/4% of the population.

b) Specialized psychiatric outpatient services - about 6,000 persons were first admissions. Cumulatively 0.91% of the population were first admissions to the specialized psychiatric services during the two year period.

c) Specialized psychiatric services - another 10,000 individuals were readmitted during the two year period. Cumulatively, 2% of Saskatchewan residents were seen in the specialized psychiatric services.

d) General hospital non-psychiatric wards - another 10,000 individuals were hospitalized in non-psychiatric wards. Up to this point 28,000 individuals, 3.1% of the general population, were recorded from the specialized psychiatric services and general hospital in-patient wards.

e) Private practitioners recorded a diagnosis of mental disorder for another 94.6 thousand individuals. Cumulatively, 13.3% (1 in 7.5) of Saskatchewan residents were recorded by medical agencies or physicians as having a mental disorder during the two year period. The age group 20-39 had the highest rate of recorded mental disorder, 25.6% for women and 13.0% for men.

Diagnostic Distribution - One Calendar Year (1972)

Figure IV shows the diagnostic distribution among various treatment sectors during 1972. The height of each bar is proportionate to the number of patients reported in that sector; the width shows the proportion of patients within the specified diagnostic group. Functional psychoses made up 30 percent of the psychiatric inpatient service patients, 9 percent of admissions to the mental health clinic, 7 percent of the mental disorders in general hospital wards, and 4 percent of the mental disorders recorded by physicians in private practice. The picture for psychoneuroses and psychosomatic disorders

FIGURE III

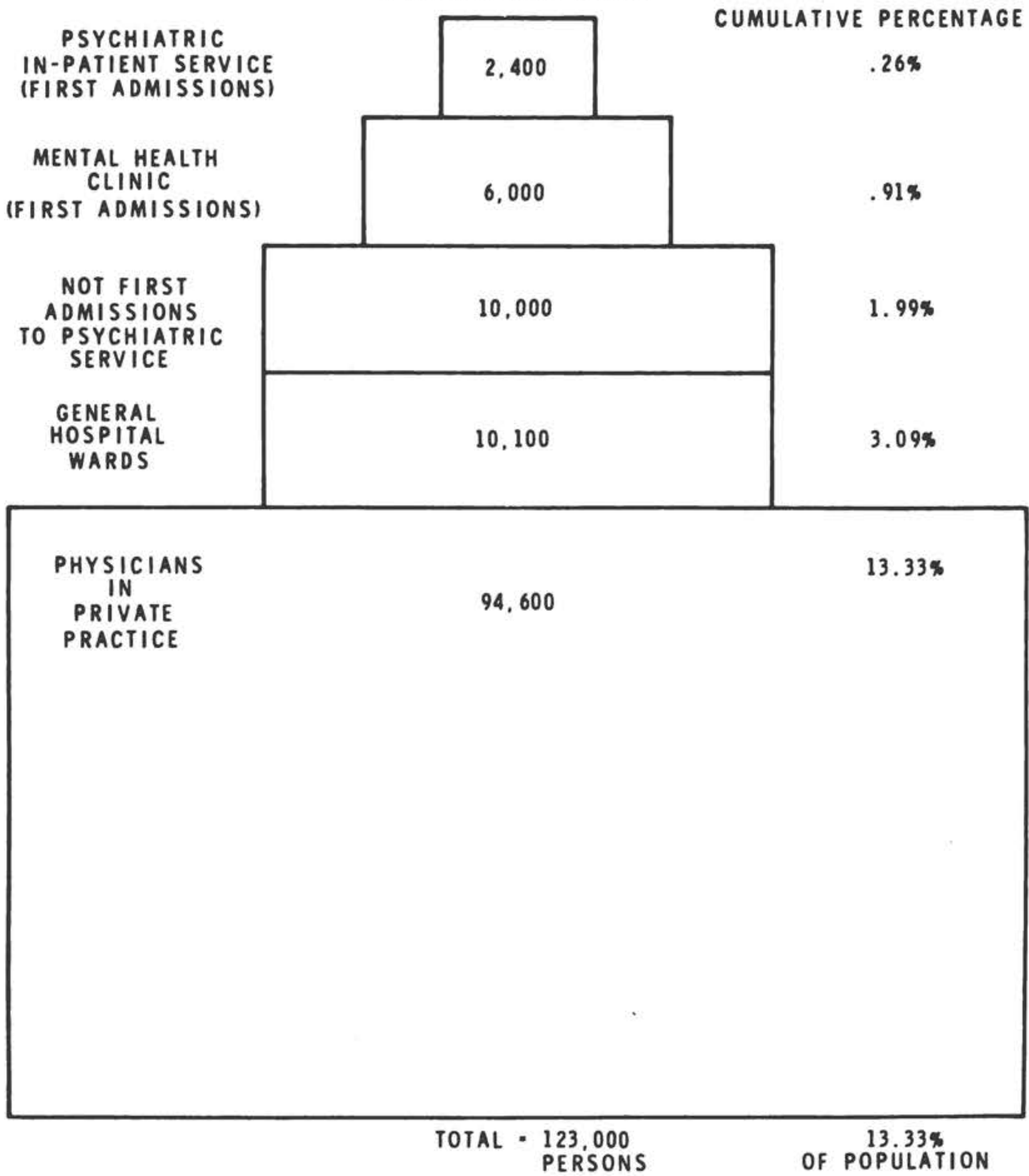
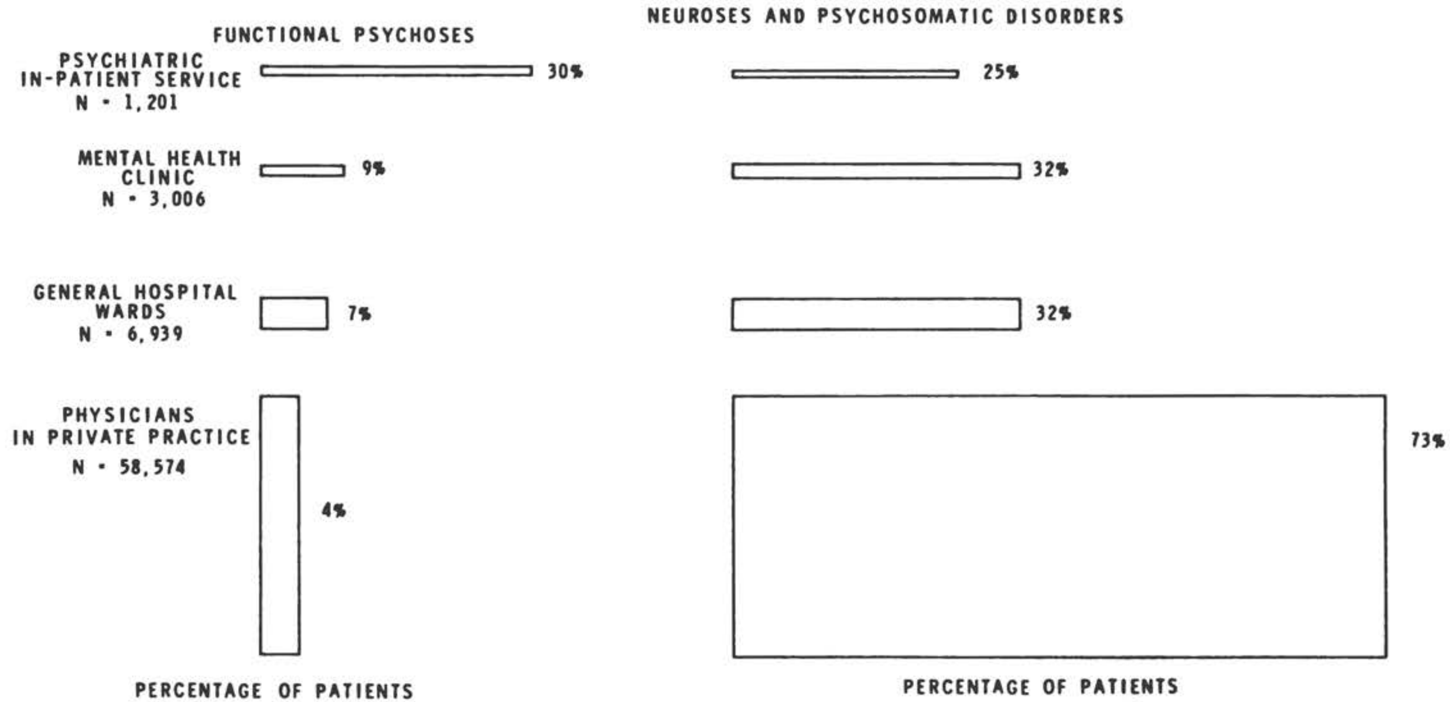


FIGURE IV



is different. Twenty-five percent of psychiatric in-patients had a diagnoses of neurosis or psychosomatic disorder in comparison to 73 percent of the patients seen by physicians in private practice.

Care of Patients with Mental Disorders by General Practitioners

Figure V and Table 3 show the distribution of 112,000 patients seen during 1971-72 by private practitioners in Saskatchewan. Altogether general practitioners recorded 99,000 individuals as having a mental disorder. There is a small overlap between psychiatrists and general practitioners -- about 7 percent of the 112,000 patients were seen by both psychiatrists and general practitioners; on the other hand, 77.8 percent (87,000) of the mental disorders recorded by private practitioners were seen only by general practitioners during 1971-72.

Figure VI shows the distribution of 540,886 medical services among the 112,000 patients seen by fee-for-service practitioners during the two-year period. The lefthand side of Figure VI shows the distribution of 112,000 patients; the righthand side the distribution of 540,886 services for mental disorders; the middle set of figures shows the number of medical services per patient during the two year period.

Over three-fourths (77%) of patients had under five services - making up one-fourth (28.1%) of the total medical services for mental disorders during the two-year period. Persons with more than 20 services were 4 percent of the patients but took up 39 percent of the services. Although there is a mean of 4.8 services per patient the distribution is skewed.

Figure VII shows the Lorenz distributions of patients with mental disorders and their associated medical services, for psychiatrists and general practitioners separately. The abscissa shows the cumulative percentage of patients, the ordinate the cumulative percentage of services. One-half of the patients seen by general practitioners took up about 10 percent of their mental health services; one-half of the psychiatrists' patients used about 20 percent of the psychiatrists' services. There is inequality in the utilization of mental health services for both general practitioners' patients and psychiatrists' patients; the proportion of services taken up by a minority of mentally ill persons is actually greater among the general practitioners than among the psychiatrists.

PSYCHOTHERAPY BY GENERAL PRACTITIONERS - NOVA SCOTIA

Figure VIII shows the rate of prepaid psychiatric services from psychiatrists and general practitioners over an eight-year period, fiscal years 1971 through 1978. In Nova Scotia, psychotherapy is defined as:

FIGURE V
PERSONS (N=112,053) WITH DIAGNOSED MENTAL DISORDERS
BY TYPE OF PHYSICIAN - SASKATCHEWAN 1971-72
(From d'Arcy 1976)

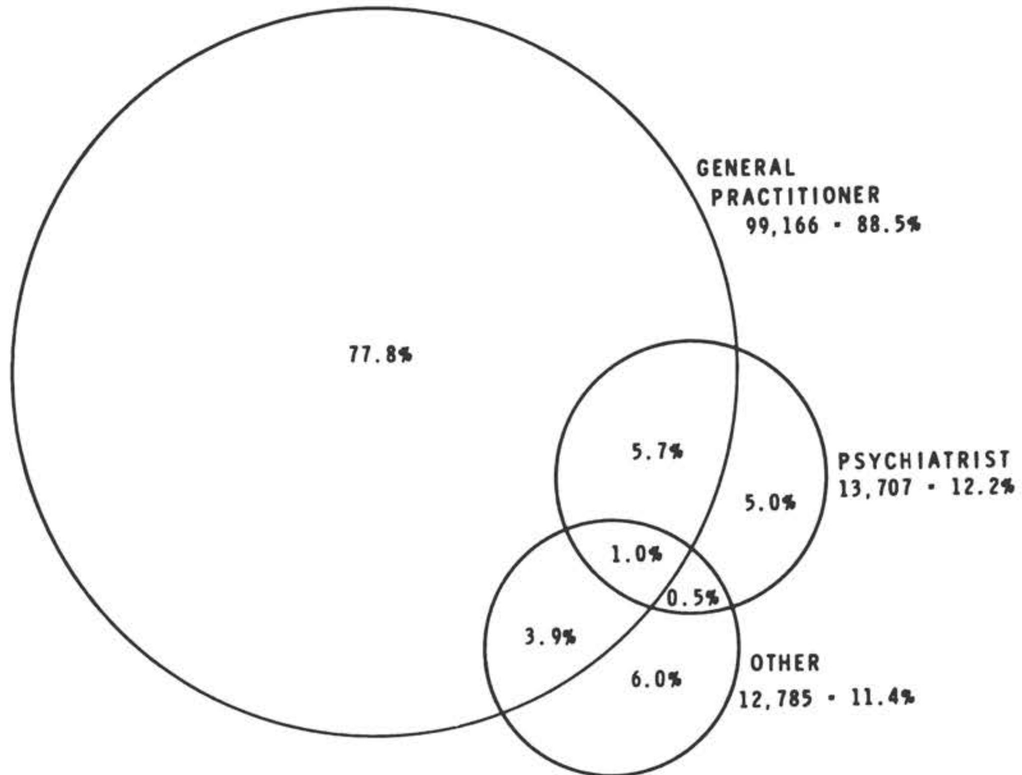


TABLE 3. MEDICAL SERVICES FOR MENTAL DISORDERS, SASKATCHEWAN, 1971-1972

	Patients	Services	Services Per Patient
Total	112,055	540,886	4.8
General Hospital Days (Care by psychiatrist or general practitioner)	8,017	121,301	15.1
Psychiatrists (13,707 patients)			
Treatment interview	7,556	56,596	7.5
First visit	6,335	6,821	1.1
Consultant	4,423	5,854	1.3
Other	8,027	31,686	3.9
General Practitioner (99,166 patients)			
Minor assessment Subsequent visit	57,856	103,545	1.8
Other service	43,878	71,415	1.6
Psychotherapy, counselling	24,130	42,392	1.8
Miscellaneous	28,004	72,326	2.6
Other Service	11,680	28,950	2.5

From d'Arcy, 1976

FIGURE VI

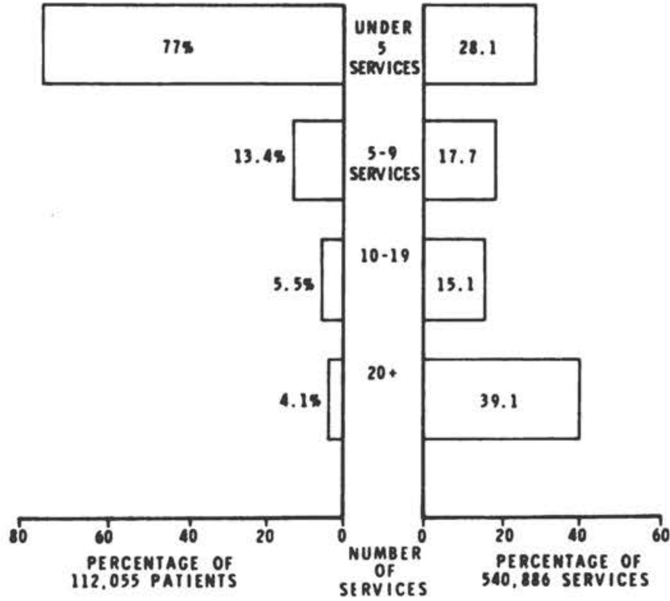


FIGURE VII

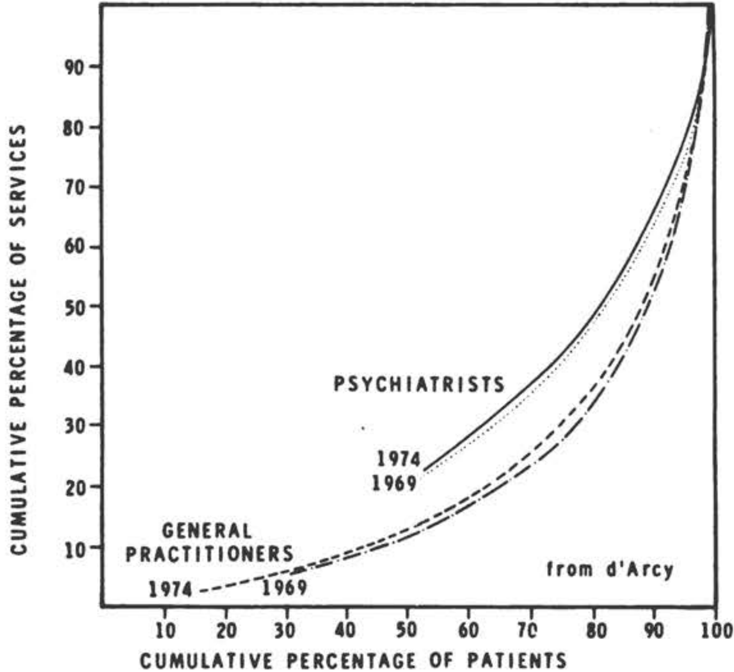
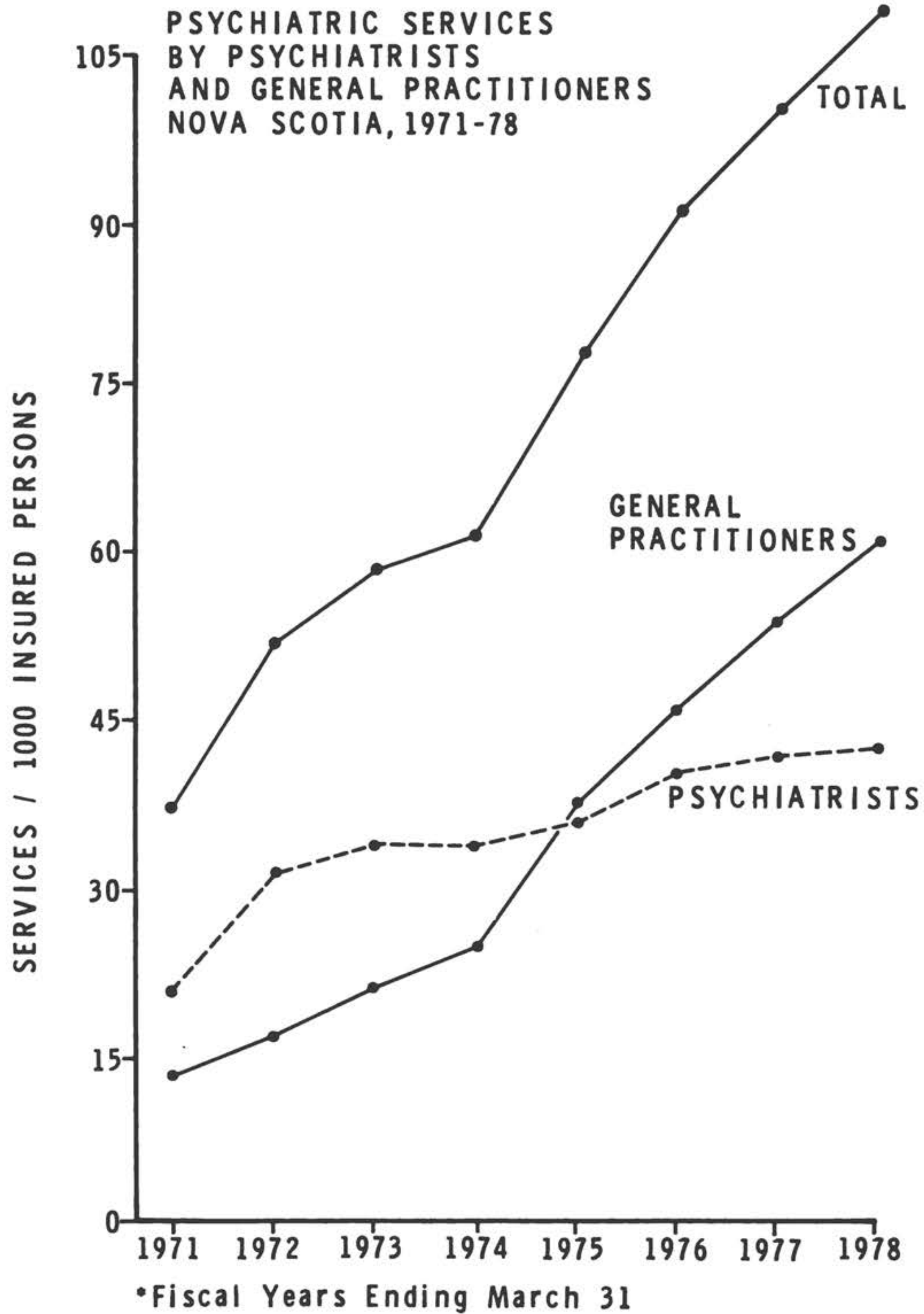


FIGURE VIII



"... any form of treatment for mental illness, behavioural maladaptions and/or other problems that are assumed to be of an emotional nature in which a physician deliberately established a professional relationship with a patient for the purposes of removing, modifying or retarding existing symptoms, of attenuating or reversing disturbed patterns of behaviour and of promoting positive personality growth and development. Accordingly, a psychotherapeutic procedure may be charged for if one-half hour, or major part thereof, has been spent in such treatment of the patient."

The total number of insured medical services increased 185% from 39 per 1,000 in 1971 to 111 per 1,000 in 1978. In relation to the total expenditures for medical services, the costs for psychotherapy increased from 1 percent to 3.5 percent.

In 1974, the services provided by general practitioners increased sharply in association with a change in the fee schedule. In 1974 the fees for counselling and psychotherapy were increased 108 percent for general practitioners and 59 percent for psychiatrists, so that the general practitioner charges for psychotherapy were the same as those of psychiatrists. 25/ (In later years the fee schedules were again changed so that there was a 33% differential between psychiatrists and general practitioners.)

In 1978, approximately 3.5% of the insured population received medical psychotherapy. General practitioners provided 64 psychotherapy services per 1,000; a mean of 1.9 services per patient seen. (If one patient were seen by three different practitioners for psychotherapy, the services would be cumulated for the one patient.) Private psychiatrists provided 45 services per 1,000; a mean of 5.9 services per patient during the year. In addition to the services from private psychiatrists the Nova Scotia mental health clinics provided another 38 psychiatrists' services per 1,000 population, a mean of 4.2 services per patient during the year.

How many general practitioners submit claims for office psychotherapy? Among the 500 general practitioners who earned more than 25,000 dollars from the insurance program during 1977, 30% did not submit any claims for psychotherapy. One-fourth (26%) of the practitioners submitted claims for less than $500 of psychotherapy during the year. The majority of psychotherapy and counselling in general practice was provided by a minority of practitioners. Of the 500 general practitioners, 38 physicians claimed 60 percent of the costs for general practitioner psychotherapy.

CAUTIONS AND CONCERNS

This section describes some concerns these utilization data raise in three areas -- epidemiology; quality assurance/cost containment; and clinical care. These three areas are interrelated since they all involve the questions:

- Who needs treatment? (Person)
- What is the level of care needed? 19/ (Place)
- When is a lesser level of care appropriate? (Time)

Epidemiological Concerns

It is apparent from the literature that physicians vary widely in their recognition of mental disorders; that one condition may be given different names; and that different conditions (mental disorder, emotionality, problems of living, distress, etc.) may be called the same thing. Psychiatric epidemiologists need better methods for identifying and categorizing the kinds of mental "disorders" seen by general practitioners. Shepherd's monograph shows the marked differences in diagnostic composition of cases, among physicians grouped by rate of recognition; the differences between physicians were less apparent in the psychoses and more prominent in the psychosomatic and "other" disorders. 47/

What are the relations between symptoms, syndromes, diagnoses? How can we better define the course and outcome of "mental disorders" with similar symptoms seen in different settings? 52/ Although symptoms may be similar, the course and outcome of alcohol-related problems identified in community surveys differs from that seen in alcohol treatment programs. 6/ The course and outcome of physical disorders seen in different settings also varies. Motulsky has described the different outcomes and symptoms among patients with hereditary spherocytosis and mitral-valve prolapse who are seen in medical practice in comparison to those found in community surveys. 34/ We can no longer assume that persons found in population surveys with symptoms of specific mental disorders will have the same course, complications and outcomes as those mental disorders coming for treatment.

We also need better methods to define the stage and severity of mental disorders. There has been relatively little progress in defining "stage" because of our limited understanding of the natural history of the various mental disorders. "Severity" is highly subjective as yet; 65% of patients seen by private psychiatrists were judged as "serious" in comparison to 19% of patients seen by all specialists. 35/

After we have reduced the variability between practitioners (and even epidemiologists) in diagnosis, after we have better information on course and outcome, after we have better methods for stating complications and severity we can begin to apply Gonnella's staging concept to specific mental disorders, to define different stages on the basis of complications, severity of problems, and potential outcome. 20/ Finally, we can begin to establish "Diagnosis Related Groups," to bring together patients with diverse diagnoses who require common treatment services and should have similar outcomes. 49/

Concerns for Quality Assurance and Cost Containment

The applications of Quality Assurance and Cost Containment methods to psychiatry do not yet compare with their applications to other medical specialities. 43/ How can we justify the cost and assess the quality of care for the 2-4% of patients who use 30-40% of mental health services?

Resource absorption by a small proportion of cases is the concern of psychiatrists as well as economists, as shown by Guideline Number 1 of the Declaration of Hawaii:

> "... the psychiatrist shall serve the best interests of the patient and be also concerned for the common good and a just allocation of Health Resources." 53/

To develop effective mechanisms for Quality Assurance and Cost Containment, we should bear in mind the following: 42/

1) A diagnosis of a mental disorder does not, by itself, justify ambulatory treatment.

A "diagnosis" does not denote a plan of clinical action, nor does it define the person as needing medical care. 26/ By itself, a "diagnosis" is not a disguised prescription for clinical intervention since the usual "diagnosis" does not describe the stage or severity of the disorder, which type of treatment is needed, its duration or frequency, the type of provider or level of care. The need for treatment must be assessed from the nature and severity of the impairment, limitation of function and the potential effectiveness of the treatment proposed. 40/ The American Psychological Association 4/ recognizes that a review model which begins with diagnostic categories is disastrous . . .

> "Instead of starting with diagnosis, one must focus on the objectives of service by authorized providers and the methods used to achieve those objectives in an optimal fashion. Starting from this strategy, empirical norms and other criteria can be developed by peer review operations and from standardized automated, data-processing procedures."

2) Mental disorders must be distinguished from psychological and other emotional responses.

What sorts of disorders involve "feeling sad for at least two weeks?" Who should provide what sort of care for such conditions for how long?

It is as yet difficult to differentiate among:

a) everyday personal reactions to everyday problems; temporary and appropriate adaptations to stress;

b) problems of "emotionality," personality traits, culturally determined behavior; subjective perceptions of "suffering";

c) isolated, psychological and behavioral symptoms and signs;

d) syndromes for which there is good clinical consensus on their nature, severity; and considerable agreement on the type and amount of therapeutic intervention needed, 28/ and

e) conditions, difficulties or syndromes not listed above.

Clinicians are often unable to discern between life crisis and mental disorder. 23/ Of persons with psychiatric diagnoses seen by medical practitioners the majority are suffering from relatively minor ailments which include "problems of living," as well as "medical problems." 10/ We need reliable methods for differentiating these various disorders, situations, behaviors and reactions.

3) The objectives and goals of treatment must be specified.

The therapeutic objectives of psychiatric treatment must be specified in advance in order to assess the results of treatment, or the need for modifying the treatment plan. Practitioners vary in their goals for similar patients. 32/ We must be able to identify whether problems for which care is sought by the patient are congruent with those being approached by the practitioner. 48/ Continuation of therapy must be based on whether predetermined clinical goals have been attained. We do not yet have reliable methods for assessing progress in attaining treatment goals.

4) The clinical setting must be considered.

Which types of ambulatory program can provide the appropriate level of care required by a patient? Within the program, what is the appropriate level of provider for the treatment needed by the patient? Out-patient clinics present a range of services not found in private offices. Solo-practitioners provide a continuity and comprehensiveness of care not found in some clinics.

5) Professionally pre-determined screening criteria are essential.

Screening criteria are not meant to be comprehensive or encyclopaedic, but are used to focus attention on circumstances for which problems in justifying admission, continued care, and level of care are most likely, and to identify those cases for whom peer review is indicated. These screening criteria should be: 50/

a) understandable to non-practitioners and require no clinical interpretation;

b) unambigious and reliable;

c) appropriate for the content of the clinical record; and

d) measureable, if at all possible.

6) Cost-containment must use mechanisms which complement "claims review."

Providers must go beyond the claims review perspective of focussing on contractual definition of "eligibility," "provider," "service," "disorder," etc. We need mechanisms which enable professionals to advise the third party payor whether the care of an individual patient, as well as the statistical pattern of care is appropriate, effective, of the "right" amount and of high quality. A cost-containment system for ambulatory care must allow for:

a) conceptual clarification between claims review and other types of review;

b) non-practitioner use of predetermined criteria to select cases for peer review;

c) peer review focussed on specific variations from predetermined criteria;

d) use of reliable nomenclature for differentiating procedures, treatment goals, and patients' psychiatric problems;

e) mechanisms for assessing the level of care needed by the patient in terms of type of provider and type of clinical setting for that provider; and

f) experience-based norms of the course of treatment for defining optimum points for focussed review.

Clinical Concerns

This section describes two concerns for clinical care -- the type and level of care and the "redistributive phenomenon."

There are wide variations in types of treatment and types of provider. 46/ Treatment for mental disorders includes pharmacological or specialized psychological approaches whose nature and effectiveness are well defined and for which the level of requisite training and experience can be specified. 29/ On the other hand, there is suspicion and increasing evidence that personnel varying widely in discipline, training and ideology can perform counselling and psychotherapy with equivalent results. 21/, 51/

It is necessary to classify treatment procedures not only by their duration and frequency, but the necessary level of training and experience of the provider. 18/, 36/ It is not appropriate to have a few procedure codes and reimbursement rates to cover the wide range of psychotherapies and all providers of psychotherapy. Some mental disorders can be cared for by non-psychiatrists or non-physicians. We need to define appropriate levels of care by discipline, training and experience of provider and to distinguish what procedures should be provided by which types of non-psychiatrists, as well as psychiatrists. 51/

The problem is illustrated in the Request for Research Applications (RFA) issued by the National Cancer Institute on February 15, 1979. Since counselling is considered to be potentially effective for cancer patients, projects are requested to show the relationship between specific emotional or psychological problems and specific counselling techniques. (Figure IX). The RFA asked for clear definition of the rationale for matching the problem to the counselling technique and, in addition, enumeration of the special skills, qualifications or experience of the staff required to provide a specific counselling technique for specific emotional psychological problems.

A second problem for clinical care is the redistributive phenomenon. In the development of prepaid health insurance programs, economists are concerned with the redistribution of medical resources from higher to lower income populations. 37/ It is possible however, that including psychiatry in health insurance programs may represent a subsidy to the rich from the poor. 2/,9/,27/,30/

There is some pre-medicare evidence that "upper-class" persons were more likely than "lower-class" persons to remain in prepaid psychiatric treatment. One report from British Columbia found that among married women aged 15-44, covered by the same insurance plan, the 33 residents of upper class areas used twice the amount of psychiatrists' services as did the 51 residents of lower social class areas. 41/

FIGURE IX

SPECIFIC COUNSELLING TECHNIQUE

	1	2	3	4	5	6
A						
B						
C						
D						

SPECIFIC EMOTIONAL OR PSYCHOLOGICAL PROBLEMS

- RATIONALE FOR MATCHING
- ENUMERATE SPECIAL SKILLS, QUALIFICATIONS, OR EXPERIENCE

N.I.H., RFA 15 Feb.1979

Another pre-medicare report 22/ compared the experience of three socio-economic groups who were eligible for similar medical benefits for psychiatric care from general practitioners or psychiatrists during a six month period in Ontario:

a) persons on welfare -- "socially assisted"

b) low-income subscribers whose premium was subsidized ("low-income")

c) "independent" - or non-subsidized subscribers

These three income-groups were continuously enrolled during the study period. The proportion diagnosed as having a mental disorder during the six month period ranged from 4.0% to 5.3% in the various income groups, with socially assisted enrollees having a rate similar to that for non-subsidized ("independent") enrollees.

The distribution of the three groups in general practice was similar to their distribution in the plan; however, socially assisted patients had fewer services than "independent" patients. In psychiatrists' practices, independent insured patients were over-represented -- 50% of psychiatrists' insured patients in comparison to 25% of the insured membership. Socially assisted patients had fewer services from psychiatrists than "independent" insured patients. (Table 4).

TABLE 4. ONTARIO MEDICAL SERVICES INSURANCE PLAN SUBSCRIBERS CONTINUOUS ENROLLMENT

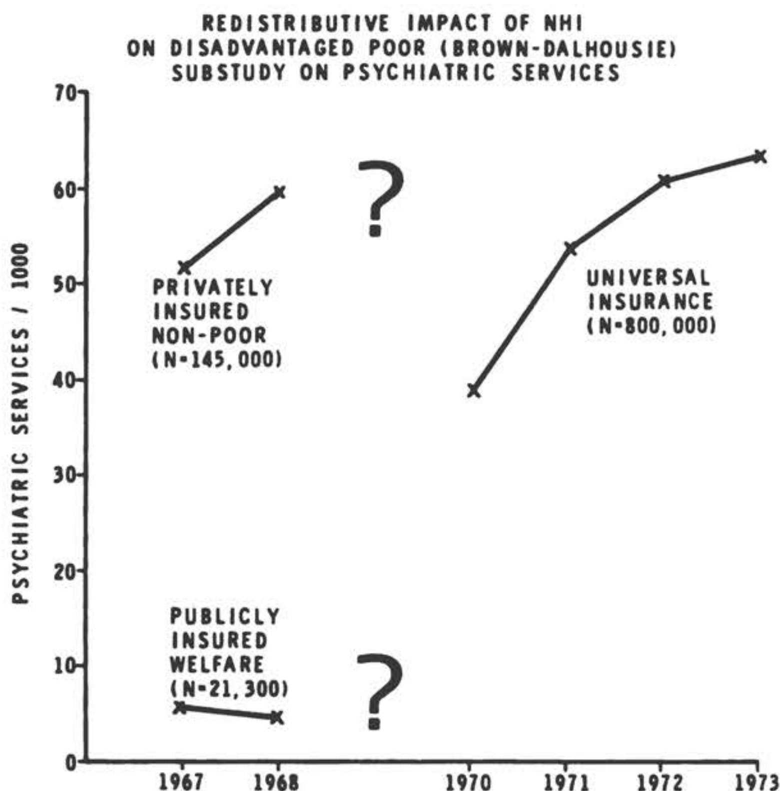
	Socially Assisted	Low Income	Independent
Population Size (thousands)	316	543	312
Percent Distribution	28%	46%	26%
Persons with diagnosis of mental disorder Number (thousands)	17	22	16
Percentage of subscribers	5.3%	4.0%	5.1%
Single Service Claims For Mental Disorders			
Distribution of patients among:			
- general practitioners	34%	42%	24%
- psychiatrists	19%	31%	50%
Average number of services by:			
- general practitioners	3	4	4.5
- psychiatrists	5.5	6.5	8
Multi Service Claims for Mental Disorders (single claims for number of services for a patient during a single month)			
Distribution of patients among:			
- general practitioners	30%	44%	26%
- psychiatrists	19%	31%	50%
Average number of services by:			
- general practitioners	15.5	23.5	26.5
- psychiatrists	12	15	18

From Hanly

A long-term study of the redistributive impact of national health insurance on the utilization of physicians' services is being conducted in Nova Scotia by Murray G. Brown in a project funded by the National Center for Health Services Research. This project is comparing the pre- and post-medicare utilization of two groups -- a group of about 21,000 publicly insured welfare recipients and another group of 145,000 privately insured non-poor persons. The benefits were similar for both groups.

Figure X shows the pre-medicare utilization of psychiatric services for each group: publicly insured welfare recipients received about five psychiatric services per 1,000; privately insured non-poor received 50 services per 1,000. The universal insurance program started with a rate of utilization of psychiatric services less than the privately insured nonpoor were getting four years earlier. Did the poor continue to receive smaller numbers of services, and did the privately insured persons get a larger number of services? A sub-project is now assessing the post-medicare use of psychiatric services by the two groups.

FIGURE X



Agenda for Future Research

We suggest that the topic of this conference, Mental Health Services in Primary Care Settings, be the focus for state-of-the-art conferences on each of the three concerns outlined above:

(a) The epidemiology of mental morbidity in primary practice;

(b) Quality assurance and cost containment methods for mental health services in primary practice; and

(c) Health systems research on mental health services in primary practice.

These proposed state-of-the-art conferences are not meant to produce simplistic answers but are seen as opportunities for defining crucial questions for which our current methodology is adequate, and identifying the questions for which we need better methodology (including data bases).

In focussing on the epidemiology of mental morbidity in primary practice we need to consider the current approaches to case identification; describe the kinds of "problems" they are identifying; and discuss the theoretical rationale of these approaches and their relevance to current patterns of practice and concepts of "medical need." In reviewing our understanding of the natural history of these conditions we should consider the future development of measures of stage, severity and complications. Are we now ready for collaborative or international studies (with NIMH's Diagnostic Interview Schedule and the Research Diagnostic Criteria) or are we still at the stage of the Diagnostic Exercises (WHO; the Anglo-American bilateral Project) where video-taped interviews were used to elicit and assess diagnostic usage and identify the symptoms, signs, and historical features associated with the use of a particular diagnosis? What factors affect whether a primary practitioner defines a patient as having a mental disorder; what determines the need for treatment and what are the practitioner's expectations of course and outcome? What circumstances affect whether the mental symptoms, social context and past history are ignored, diagnosed as a mental disorder, or given an ICD-9 V-code? When are psychosocial circumstances, or "problems which influence the person's health status," considered a current illness and when will they be given a V-code within the ICD-9 classification?

How have current procedures for quality assurance and cost containment been applied to ambulatory mental health care? Do they work? What are the conceptual blocks or missing resources which have made psychiatry falter in applying these methods? How can quality assurance and cost containment approaches be incorporated in teaching and training programs for primary practitioners? How can we

develop definitions and procedures for assessing medical necessity, level of care, and discharge planning for mental morbidity in primary practice? Can attention be re-routed from diagnosis to review problems of management?

The third topic is that of health systems research on mental health services. A recent ADAMHA report 1/ identified health systems research as suffering most from diffuseness of purpose and structure and urged immediate, intense attention on developing better methods of identifying populations in need of service, defining the extent of underservice and acquiring data on utilization and cost across many service settings and financing arrangements. The report urged that immediate priority be given to studies on the utilization and cost of services under current health insurance and projected National Health Insurance plans. Although there is much overlap in content and approach between epidemiology, quality assurance and cost containment, and health systems research, by and large, there has been sparse collaboration by the few researchers in each of these fields. This third conference should consider the reasons for the insularity and seek short-term solutions for enhancing collaborative efforts. An initial focus for such collaborative efforts might be the redistributive effect in prepaid mental health services - is Matthew 25:29 applicable?

CONCLUSIONS

This paper has described the Canadian experience with National Health Insurance prepayment of psychotherapy by primary practitioners, and the implications of these data for epidemiology, quality assurance and cost containment efforts, and for clinical care.

The epidemiologic dimensions of the problem are clearly visible. However, there is far less information on the clinical and economic consequences of prepaid care, and the extent to which utilization can be predicted, demand satisfied, and needs fulfilled. The 1964 Royal Commission project on the extent and results of psychiatric care in Canada 8/ correctly predicted mental hospital use in 1971, but its high-level projection of psychotherapy (0.2 hours per person per year) has now been exceeded in many areas and the divergence is continuing to widen. Both improved understanding and better data are needed to project the needs for medical psychotherapy.

We need to bring together, in a more systematic manner, the skills and resources of epidemiologists and health services researchers in primary practice, as well as in the specialized mental health services. In this way we can bring epidemiology and health services research into the community and clinical settings — out of the closet of research journals.

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MENTAL HEALTH AS AN INTEGRANT OF PRIMARY CARE

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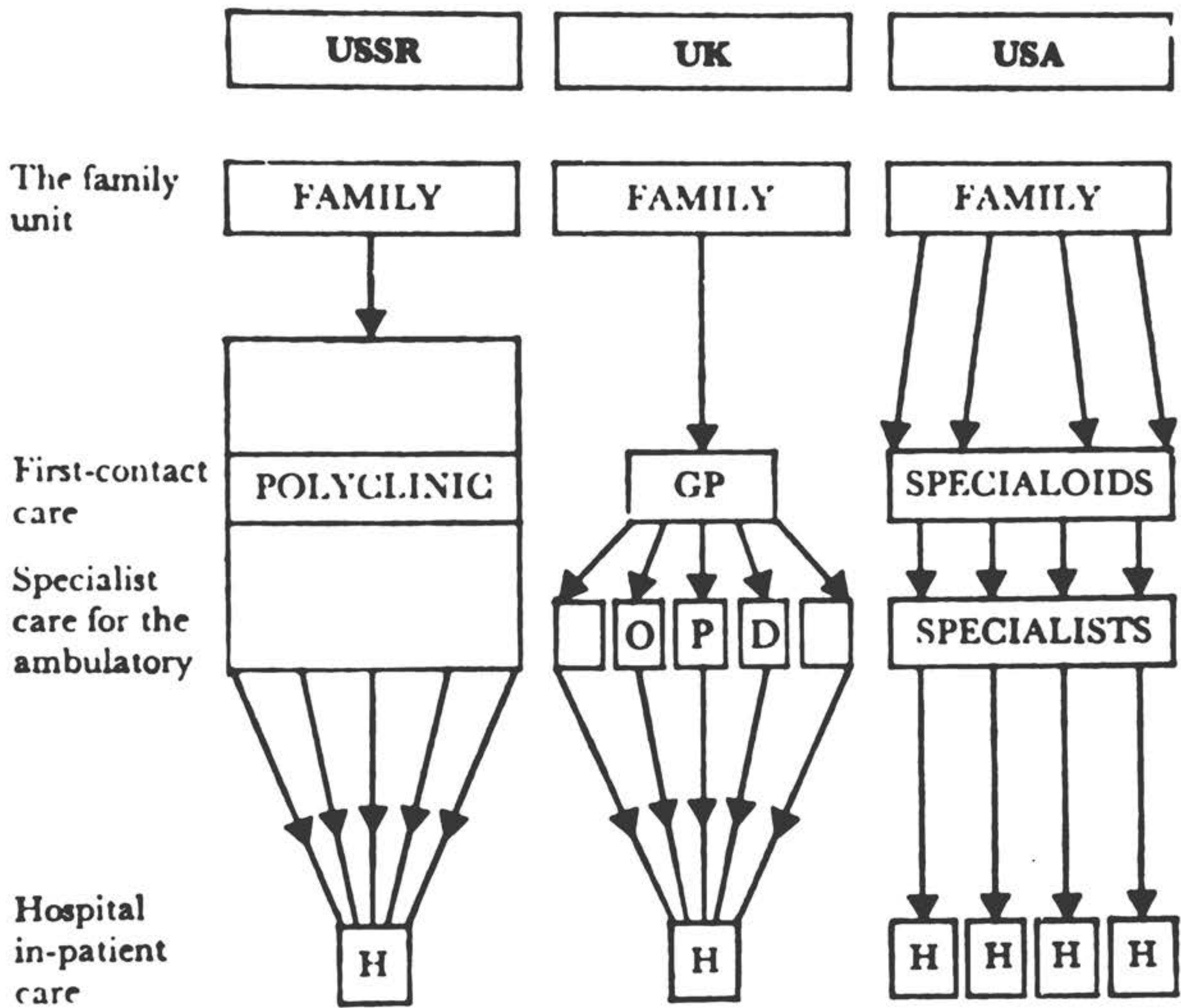
It is now a little over 3 years ago since I visited the National Institute of Mental Health in 1975 as a WHO consultant to assess and report on the status of mental health care systems in the USA, with particular reference to primary care. To implement the various recommendations of my report I urged at that time the close involvement of the Division of Biometry and Epidemiology which, it seemed to me, "would be uniquely placed to provide basic data and a factual underpinning for any proposals to initiate studies as required and to help integrate the effort which may be required in the next phase of the mental health movement." The organization and content of this meeting shows clearly how much progress has already been made by the Division under the leadership first of Dr. Kramer and then of Dr. Regier and how it has already begun to come to grips with many of the issues raised by our own work on the extramural dimensions of mental disorder. From the beginning this was based on the primary care physicians or general practitioners who occupy a central position in the health service structure which differs radically from that prevailing in the two other models encountered in developed countries. 1/ (Figure 1)

In the conditions of the National Health Service the British general practitioner is the physician of first contact, the professional figure who is the gate-keeper to all medical facilities. Furthermore, as he keeps routine records of his consultations, it seemed reasonable to try and assess the amount and the nature of mental disorders with which he is concerned. Accordingly, we initiated a series of studies with this objective in mind. In quantitative terms the most striking result was that a large segment of morbidity, amounting to about one-seventh of all consultations, was attributable or closely related to mental ill-health. 2/

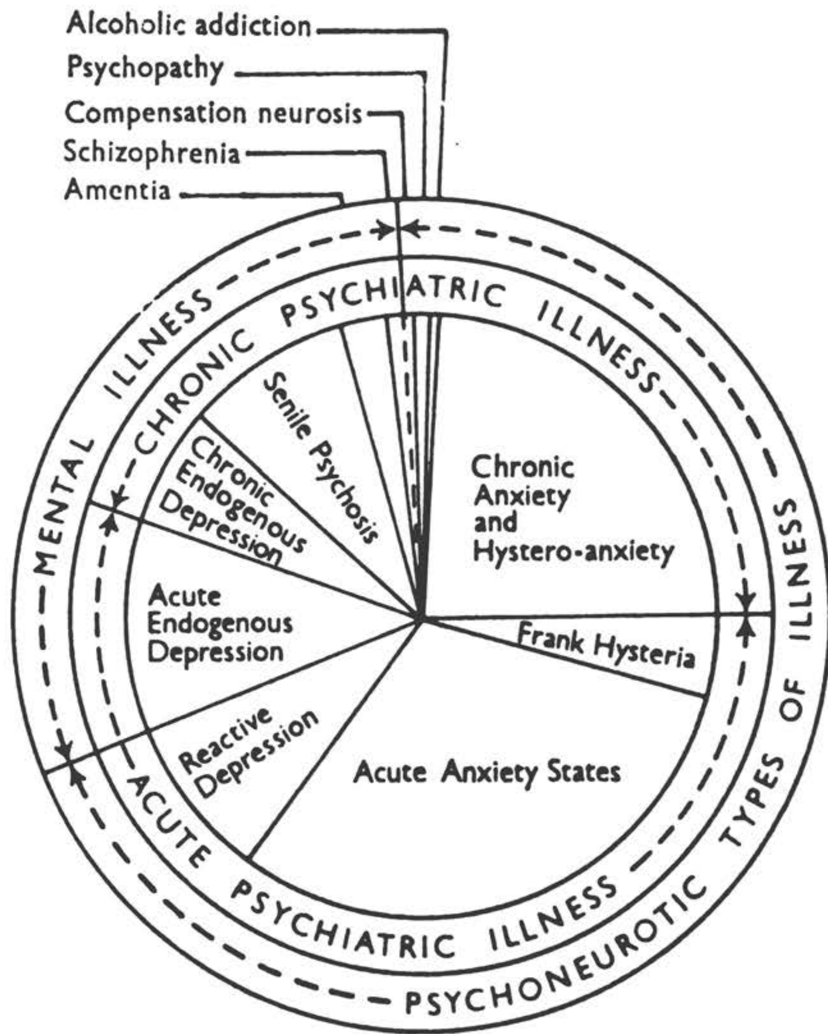
A number of workers have since confirmed the substance of our findings but at the time most of the few people who appreciated their significance appeared to be individual general practitioners with an interest in psychiatry. Here, for example, is an illustration prepared by a well-known British general practitioner, working independently, who analyzed the results of his own activities in the early 1960s. 3/ (Figure 2)

FIGURE 1



A comparison of the flow of medical care in the USSR, UK and USA.

FIGURE 2
BREAKDOWN OF PSYCHIATRIC ILLNESS IN AUTHOR'S PRACTICE
FOR PATIENTS CONSULTING IN A COMPLETE YEAR



It is less profitable to dwell on his finer diagnostic categorizations than to underline, first, the relative proportions of acute and chronic illness and of major and minor disease. Secondly, the dominance of mood disorders, which were his particular concern, stands out in this highly schematic picture of depressive disorders. (Figure 3)

While the details may be inaccurate to the point of caricature, the findings nonetheless serve to raise several relevant questions, some relating to the sphere of administration, and others to clinical practice and research.

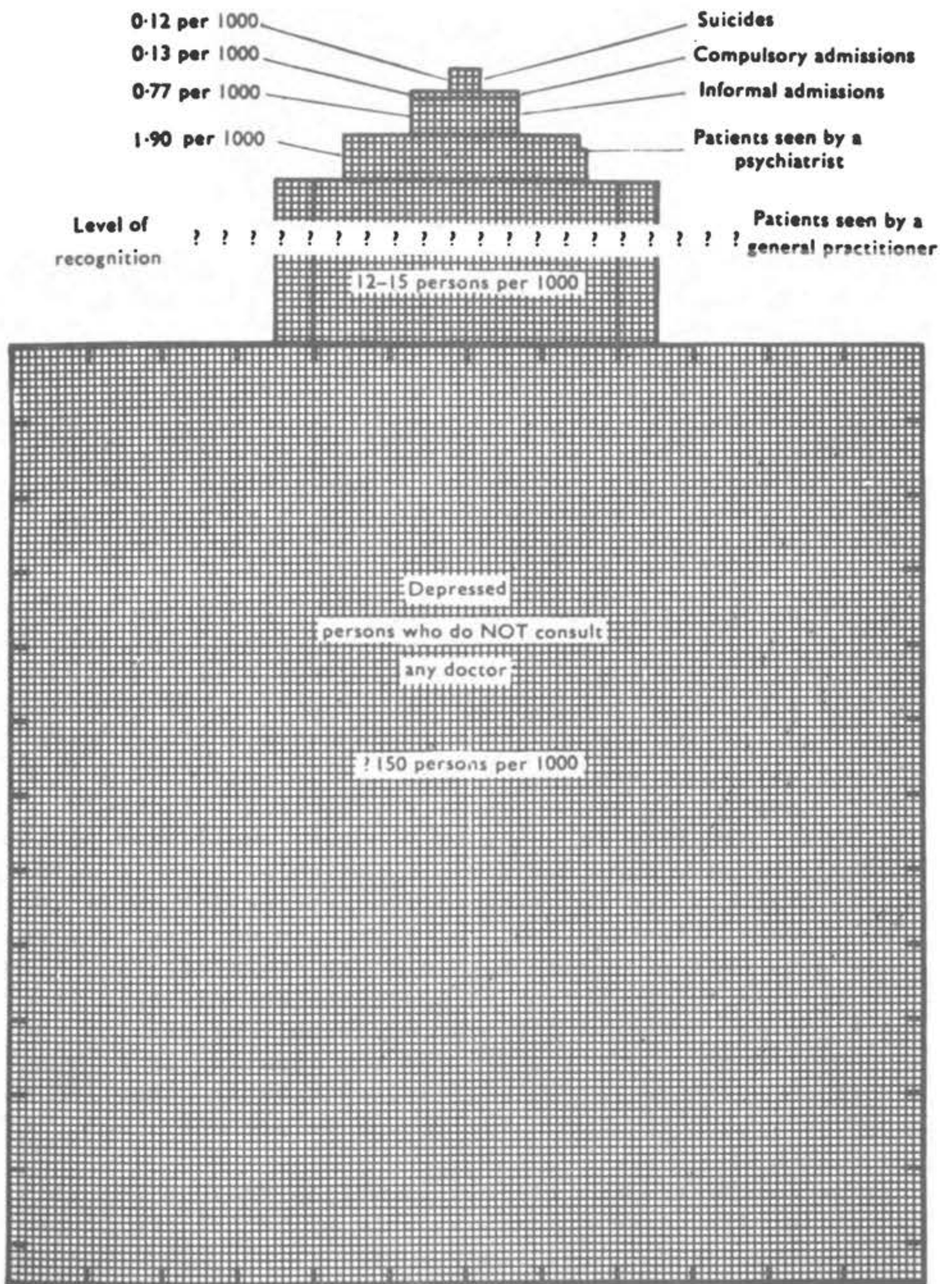
From an administrative standpoint we may look at the figure in terms of cost, of manpower requirements or of educational objectives, all of them necessary prerequisities to rational planning. It is, however, essential for planners to declare their interest if they are not to go astray. A strikingly relevant example of what may happen otherwise was provided in the United Kingdom during the last war when the Ministry of Health sponsored a survey of psychiatric facilities existing in the country. This inquiry was conducted by C.P. Blacker, who used the findings to put forward quantitative proposals for the reorganization of the whole of the national mental health services, including a detailed model plan for a population of a million persons. 4/ Much of the report is eminently sensible and anticipates later provisions of the National Health Service. In respect of the general practitioner service, however, Blacker's assessment led him to recognize the problems but not the angle from which he was observing them:

> "The so-called psychosomatic disability," he wrote, "has been much discussed of late, here and in America; it has even been suggested that as much as a third of all sickness has psychiatric features, the term psychiatric being used to include psychosomatic illness. We can picture to ourselves the effects of clinical attendances if practitioners as a whole came to believe that a third of their patients could be benefited by the attention of psychiatrists. The community contains, as it has always contained, a reservoir of psychosomatic and psychopathic cases; their descent in vast multitudes upon the psychiatric clinics of this country might be caused by nothing more than an alteration of standpoint among general practitioners."

This curious comment reflects an attitude which appears again in his vision of the future relationships between the lofty, seignorial psychiatric specialist and the lowly general practitioner:

> "It is therefore suggested that when the general level of psychiatric knowledge is raised throughout the medical profession by improved teaching methods - or even

FIGURE 3



Scale diagram of the 'iceberg of depression'. One small square = 0·01 persons per 1000 of the home population.

Source: Watts, C.A.H. (1966): Depressive Disorders in the Community. Briston: John Wright.

> before this happy time is reached - it should be the aim of the clinic to send the patient back to his doctor, reporting improvement, at the earliest date reasonable, at the same time furnishing the practitioners with guidance as to how to handle the patient in future."

I am particularly fond of the phrase, "reporting improvement," but the passage as a whole embodies a view of the general practitioner as the doctor who, in the phrase of the late Lord Moran, had fallen off the "specialist ladder." That view is still echoed today. Setting out his views on the organization of psychiatric services, for example, a prominent British social psychiatrist not long ago estimated that three psychiatrists are needed for a population of 60,000 people, in order to care for about 1000 patients during the course of 1 year. He then went on to say: "There will also be about 24 family doctors in the area. These doctors, however, cannot give psychiatrists much help for in our Health Service family doctors are already seeing the bulk of the patients with socioeconomic problems." 5/

A similar perspective has been adopted all too often by clinical psychiatrists, though they peep at the matter through the practitioner's key-hole rather than the planners'. Thus if, in Figure 3, we summate the first four categories, the proportion of depressed patients who come to the attention of a psychiatrist is no more than 2.92/1000 of the general population and no more than 1.8% of all depressed people. In consequence, psychiatrists in their clinical practice are familiar with only a very small band of the depressive spectrum and one, furthermore, which differs in respect of presenting features and in severity from the larger part. Nonetheless, at a recent international conference on depression a well-known European psychiatrist made the following comment: ". . . in possibly as many as 40% to 50% of all patients consulting a general practitioner for any reason whatsoever no organic causes for their symptoms can be found . . . This raises the question as to whether all these patients should be regarded as psychiatric cases and therefore treated by a psychiatrist. The answer is probably 'No'." 6/

It is worth pondering on the two principal reasons for this seemingly willful disregard of the evidence by mental health professionals, as demonstrated by the views I have cited. The first of these reasons, I would suggest, has to do with an understandable reluctance to relinquish what may be termed the psycho-centric perspective, whether this be identified with psychotherapy, psychiatric education, administration or clinical expertise. As such it exemplifies an outlook which is common enough in science as well as other forms of less rational human activity. In all essentials this was described, and even named, as early as 1440 by Nicholas of Cusa who, 20 years before Copernicus' observations, attacked the assumptions of medieval scholarship for the geocentricity of its outlook on the physical universe in a famous tract which he entitled, 'Learned

Ignorance.' Though the present example is rather less momentous, there has been a medieval flavor to the pronouncements of many psychiatrists, not only in their unwillingness to modify their own perspective but also - and this is the second of my two reasons - in their attempt to impose their own conceptual apparatus on the material under study, regardless of its goodness of fit.

The consequences of this variety of learned ignorance reveal themselves most clearly through systems of classification which, au fond, reflect no more than underlying systems of thought. When we started work with general practitioners our first inclination was to employ or adopt the standard International Classification of Diseases. After a very a brief experience of the clinical problems encountered, however, it became apparent that neither the ICD, then in its 7th edition, nor any available alternatives did justice to the situation. Accordingly, we were compelled to construct a more relevant system of our own, designed to meet the needs of the gp's by distinguishing between 'formal' psychiatric illness and what we called 'psychiatric-associated' disorders, thereby anticipating the multiaxial systems which have since been widely compassed to do justice to the health-mental health interface (Figure 4). Using this schema, with all its manifest imperfections, we found that about one-third of recorded psychiatric morbidity had to be classified in this way (Figure 5). Attempting to identify in more detail the content of this heterogeneous category, we found that the 'associated' factors included a wide range of physical disorders on the one hand and of social pathology on the other (Figure 6).

FIGURE 4
CLASSIFICATION OF PSYCHIATRIC CONDITIONS

FORMAL PSYCHIATRIC ILLNESSES

1. PSYCHOSIS	-	schizophrenia, manic depressive psychosis, organic psychosis.
2. MENTAL DEFICIENCY	-	or marked subnormal intelligence.
3. DEMENTIA	-	deterioration of mental powers in excess of normal aging process.
4. NEUROSIS	-	anxiety state; depressive, hysterical, phobic or asthenic reactions; others.
5. PERSONALITY-DISORDER		

PHYSICAL ILLNESSES, OR PHYSICAL SYMPTOMS WITH PSYCHOLOGICAL COMPONENT

6. PHYSICAL ILLNESS 7. PHYSICAL SYMPTOMS	where psychological mechanisms have, in your opinion, been important in the development of the condition.
8. PHYSICAL ILLNESSES 9. PHYSICAL SYMPTOMS	which have, in your opinion, been elaborated or prolonged for psychological reasons.

OTHER PSYCHOLOGICAL OR SOCIAL PROBLEMS

X PSYCHOLOGICAL OR SOCIAL PROBLEMS - please describe in full.

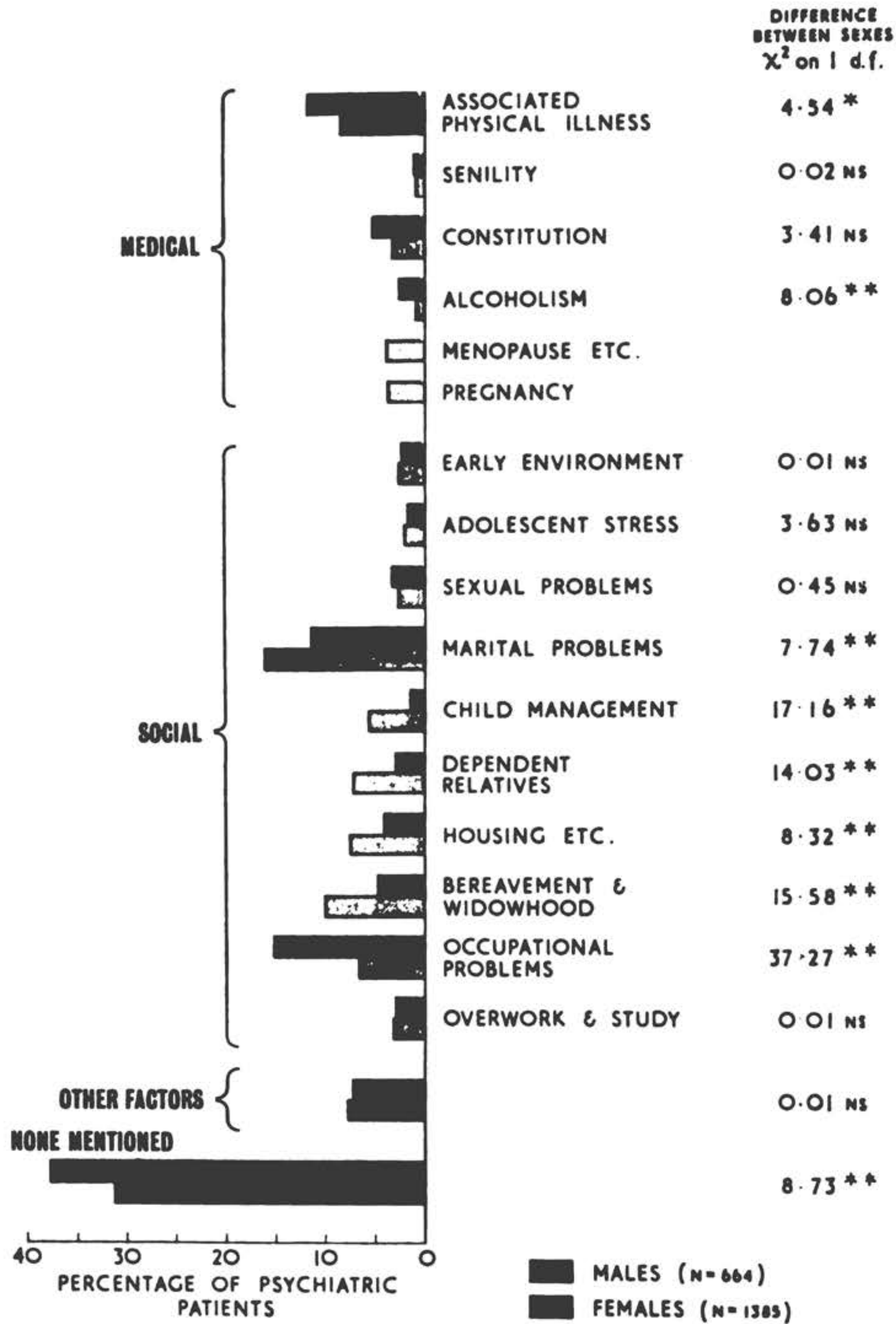
FIGURE 5

PATIENT CONSULTING RATES PER 1,000 AT RISK FOR PSYCHIATRIC MORBIDITY, BY SEX AND DIAGNOSTIC GROUP

DIAGNOSTIC GROUP	MALE	FEMALE	BOTH SEXES
Psychoses	2·7	8·6	5·9
Mental subnormality	1·6	2·9	2·3
Dementia	1·2	1·6	1·4
Neuroses	55·7	116·6	88·5
Personality disorder	7·2	4·0	5·5
Formal psychiatric illness(1)	67·2	131·9	102·1
Psychosomatic conditions	24·5	34·5	29·9
Organic illness with psychiatric overlay	13·1	16·6	15·0
Psychosocial problems	4·6	10·0	7·5
Psychiatric-associated conditions(1) ...	38·6	57·2	48·6
Total psychiatric morbidity(1) ...	97·9	175·0	139·4
Number of patients at risk	6,783	7,914	14,697

(1) These totals cannot be obtained by adding the rates for the relevant diagnostic groups because while a patient may be included in more than one diagnostic group, he will be included only once in the total.

FIGURE 6



The current interest being taken in the health-mental health interface may serve to justify a very brief summary of some of our subsequent work which, it is worth reiterating, grew out of our own data rather than from any theoretical preconceptions. We first attempted to examine the association with physical illness indirectly by identifying a control group of cases reported as being free from any form of mental ill-health. These were compared with patients diagnosed as suffering from psychiatric disorders. Emotional disorder proved to be associated with a high demand for medical care; the patients attended more frequently, exhibiting higher rates of general morbidity and more categories of illness, especially chronic disease. It can, of course, be argued that these findings were largely manifestations of a high demand for medical care attributable to the patients' attitudes to health and that the patients were labelled as neurotic largely because of the frequency of their attendances and the multiplicity of their ailments. Independent data were therefore sought by estimating physical disease among groups scoring high and low on a screening questionnaire, a procedure which yielded similar findings.

Evidence from several other studies pointed in the same direction, but as most of these findings were drawn from investigations directed at other objectives a large-scale independent inquiry was designed to determine directly whether individuals with psychiatric illness did or did not suffer from more physical illness than mentally healthy people. 7/ From a population undergoing a health-screening program subjects between the ages of 40 and 64 were randomly chosen and assessed in four stages: (1) by the completion of a self-administered questionnaire; (2) by a standardized psychiatric interview; (3) by physical screening-tests carried out by trained ancillary staff; and (4) by a physical examination by an independent physician. The subjects with psychiatric disorders were compared with a control group from the same population, matched for age, sex, marital status and social class. The results showed strong presumptive evidence of an association between physical and mental illness in this population, the links being most marked with subjects suffering from cardiovascular and respiratory disease.

On the other side of the same coin a number of workers, including ourselves, have shown a number of discrete physical conditions to be associated significantly with mental ill-health and at least one large-scale American study has indicated that psychosocial factors must also be considered in this context. This is the work of Shaffer, et al, who investigated a population for disability benefits under the U.S. Social Security Administration's disability program. 8/ These workers made psychiatric assessments of such patients suffering from physical disorders and assessed the mental health of more than 1000 individuals, matched with 14,000 patients attending a medical clinic. The results demonstrated a marked difference between the two groups, furnishing an estimate of up to 44% of individuals with moderate to severe psychoneuroses or personality disorders among the applicants for disability benefit.

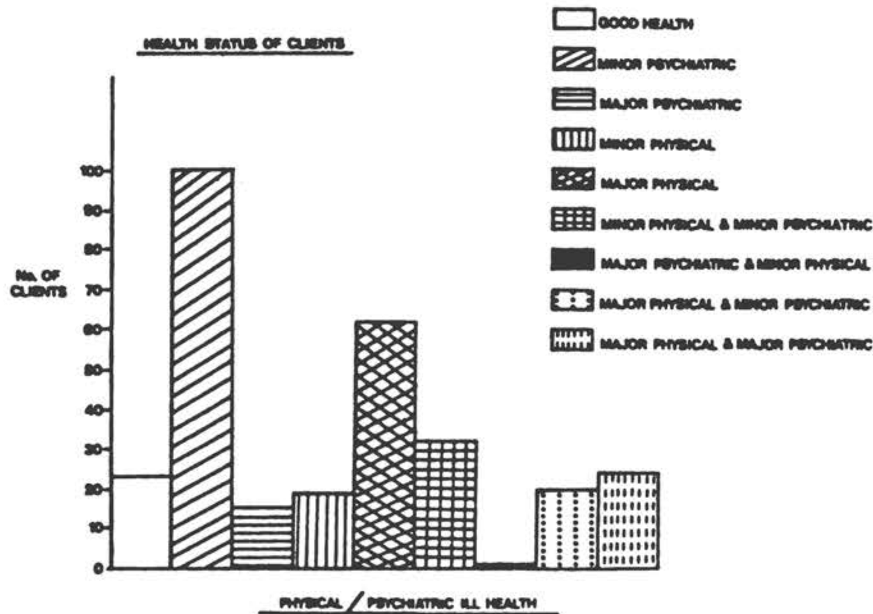
Such findings serve to lead naturally from the physical to the environmental associations of psychiatric morbidity. Some of the links with social pathology have been clarified in recent years by studies concerned with hospitalized mental disorder and mental handicap in relation to its social consequences and social causation. The field has also been cultivated, however, by a host of social investigations of the general population which impinge on normal and abnormal mental states, often unwittingly, through the employments of concepts like 'social malaise' and the fashionable 'subjective social indicators,' incorporating such feeling-states as dissatisfaction, ill-being, unhappiness and annoyance, all of them very close to what the psychiatrist would regard as mood-disorders. 9/

Unfortunately such notions, interesting as they are from the standpoint of theory, need to be operationalized if they are to be employed for empirical research. To our dismay we discovered more than 10 years ago that the necessary spade-work had not been carried out, and so we undertook a number of studies designed to remedy the deficiency. These, in brief, consisted first in constructing and standardizing a Social Schedule to be administered by trained investigators on community populations, focussing on the three broad areas of material conditions, social management or coping, and so-called satisfaction. 10/ It then proved necessary to order and categorize the range of social problems encountered so as to achieve a management classification 11/ which lent itself to the study of various patient groups. With these tools we have been able to examine the social aspects of a variety of clinical conditions.

The findings to date show that at the level of primary care social factors enter so closely into the matrix of what physicians call psychiatric disorders as to justify study both in their own right and on their role as potential pathways for intervention. Figure 7, for example, illustrates the findings on the health status of 300 consecutive patients referred by 8 general practitioners to their attached social workers in the course of their routine clinical practice. 12/ The ratings were made by a medical member of the research-team and demonstrate that the health of the population was generally poor; only seven percent of referrals were without a somatic or a psychiatric diagnosis and more than a quarter were suffering from both mental and physical ill-health. A majority of cases with major psychiatric illness were in the senium, but the bulk of minor mental disorders were presented by married women with family problems and associated mood-disorders.

It has also become clear that the health of those individuals whose primary contacts have been for designated social disorders calls for investigation, and in some of our more recent work we have been examining the health status of individuals who have been referred, or have referred themselves, directly to social agencies as a form of first contact. In one recently completed study, for

FIGURE 7



Source: Corney, R. and Briscoe, M. (1977): Investigation into two different types of attachment schemes. Social Work Today, 9.

example, information has been obtained about all individuals referred over a 3-month period to social workers in two settings -- a large health center run by a group of general practitioners and a local authority area team which is administered by the non-medical social services department. 13/ The information included medical data relating to physical and mental illness of handicap as well as the presenting social problems which led to referral. A substantially high proportion of clients turned out to be assessed as suffering from ill-health, physical or mental or both (Figure 8). Whether they are termed clients or patients these people must evidently be classified in socio-medical or medico-social terms if justice is to be done to their status. The order of the words merely reflects the professional background of the observer.

What, then, are the implications of such findings for the provision of primary care services? In Britain the socio-medical approach to health has been officially recognized by the National Health Service Reorganization Act of 1973 which was followed by a Working Party Report entitled, significantly, "Social Work Support for the Health Service." 14/ In their report the Working Party paid particular attention to the development of social work in the context of general practice and entered a strong plea for experimentation in this field. Our own research, which long antedated the report, has been conducted very much in its spirit.

FIGURE 8

SOCIAL WORKERS' ASSESSMENTS OF CLIENTS' MAJOR PROBLEMS

Category of problem	Intake No.	Intake %	Attachment No.	Attachment %
1) Relationship/Emotional/ mental illness	46	38.7	42	51.1
2) Practical	40	33.6	23	28.1
3) Associated with physical Disability/illness	33	27.7	17	20.8
	119	100	82	100

By attaching a small group of research-oriented social workers to a primary care health-center and a local social service department we have been able to monitor the nature and extent of social pathology encountered in the community, and to examine the means of intervention adopted by the social workers and to evaluate their efficacy.

One prospective study designed to evaluate the therapeutic role of a social worker attached to a metropolitan general practice in the management of chronic neurotic illness has already been reported. 15/ The psychiatric and social status of two matched groups of patients, one attending the practice with a social-worker attachment and the other attending neighboring practices without this facility, were ascertained independently at the beginning and end of a twelve-month period, using standardized interview techniques. A comparison between the outcome of the groups indicated some benefit to patients who had received the experimental service. Although both groups showed a reduction in psychiatric symptoms during the follow-up year, the fall was much more pronounced in the experimental group. At follow-up, 38.0% of the experimental group had been taken off psychotropic drugs, compared with 24.7% of the controls. Continuing medical care and supervision were deemed necessary for 59.8% of the experimental patients, compared with 77.3% of the controls. Similarly, the experimental patients were found to have improved in all main areas of social functioning, whereas the controls showed very little change in this respect at the end of twelve months. Changes in the psychiatric and social-adjustment scores for the two groups were positively correlated.

These findings suggested that social-worker intervention has some therapeutic effect on chronic neurotic illness, at least in some cases, and hence that it is realistic in this context to speak

of social treatment. But what, precisely, is social treatment? Even a cursory glance at the vast social work literature reveals a major split which Dame Eileen Younghusband has identified as:

> ... the conflict between casework and the young radical school of community action. This refers to the knowledge mainly used by caseworkers and that mainly used by community activists. To the latter the unpardonable sin is that casework method is largely based on psychoanalytic theory which causes the caseworker, so they allege, to be primarily concerned with a professional relationship, with the client's unconscious motivation, and with use of the transference in an essentially unequal situation, when what he really needs is help in getting means tested benefits to which he is entitled, or better housing or education or more pay. Conversely, community work draws draws largely on knowledge from sociology and political theory, both of which seem to be active, related to the real world, concerned with how to bring about social change. This is in sharp contrast to dynamic psychology which seems to them anything but dynamic in its social context because it implies that basically human nature is unchanging. 16/

The "casework" concept has tended to dominate the theory and practice of social work in the United States, especially with the large corps of social workers in private practice. It has also been influential in Britain despite the many differences in organizational structure. Yet while its relevance to the needs of the general population have been challenged on theoretical grounds by the advocates of social change neither group has provided empirical evidence to confirm its own claims. As part of our study of chronic neurotic illness it was possible to undertake a detailed analysis of the social worker's activities and to relate these to the client response. 17/

In nearly two-thirds of this sample the social worker's contribution was restricted to helping the patient and his or her family in dealing with practical problems and difficulties, a function for which social workers are specially trained and in which their skills do not overlap to any large extent with those of the psychiatrist. In the remaining one-third she exercised what may be regarded as a quasi-psychotherapeutic function, although here also practical help and support were given in a proportion of cases. The prominence of what has also been called "social brokerage" 18/ rather than traditional "casework" has been detected in other studies which have analyzed social worker activities in general practice. 19/, 20/, 21/, 22/ & 23/.

The specificity of such intervention, however, remains questionable. On the available evidence the most probable explanation of any benefits conferred by the social worker appears to reside in

the way in which her personal activities supplement the resources which she mobilizes and which facilitate a more positive approach by the general practitioner towards a greater awareness of the social orbit of morbidity. Stimson 24/ has pointed out that the global notion of the social element in general practice embraces several themes: the social relationships between doctors and their patients; the awareness of social factors in disease and in illness-behavior; the social causes of disease; the social consequences of disease; social welfare problems; and the socio-psychotherapeutic role of the doctor. The presence of a social worker as part of a primary care team may be expected to catalyze all these activities and so diffuse his or her influence at various points of professional contact.

Finally, I should like to pull my argument together and devote a few words to its implications. On logistical grounds alone it is apparent that the mental health care of the community at large cannot be provided by psychiatric specialists. Our own alternative, advanced 15 years ago and based on epidemiological evidence, was that "the cardinal requirement for improvement of the mental health services . . . is not a large expansion and proliferation of psychiatric agencies, but rather a strengthening of the family doctor in his therapeutic role." 1/ In practice, of course, this emphasis on the primary care system must pay regard to the national variations in the structure of medical organization, but the underlying principle has been endorsed and extended by the conclusion of a World Health Organization report that: "The primary medical care team is the cornerstone of community psychiatry." 25/

This statement is slowly finding favor with good family practitioners, who see the core of their task in their own terms, as exemplified by the comment from a prominent British representative of the Royal College of General Practitioners some years ago: "The first thing a general practitioner has to decide is the relative importance of the emotional and physical factors in his patient's problems. Only the general practitioner approaches the matter quite in this way, and his ability to do so depends on his unique previous knowledge of the patient. Where this knowledge is denied to the doctor, assessment has to be made by more devious and less certain method of evaluating the emotional component by exclusion of the organic. This method of evaluating the emotional component is clumsy. For the 10-20% of selected problems which reach the hospital-based doctor, it is unsuitable and also wasteful of medical resources.

"The organic element is less definable in illness encountered by general practitioners than it is in the selected illness encountered in hospital practice. The emotional element, on the other hand, is relatively more important in general practice." 26/

Today, I suspect this physician would substitute 'psychosocial' for 'emotional' and 'the primary care team' for the 'general practitioner'. He would not, however, modify his conclusions that the

assessment of mental ill-health in its broader sense is a central function of the primary care team, including non-medical members of the caring professions -- the social worker, the health visitor, the mid-wife and the nurse.

But what, then, is the role of the psychiatrists in this situation? Not, I would suggest, necessarily that of other medical specialists -- e.g., the dermatologist or the oto-rhino-laryngologist -- who can lay claim to authority in the diagnosis and treatment of not only the major conditions which come their way in hospital but also the vast mass of minor conditions which can be managed on an extramural basis. Here there is a continuity of expertise to which the psychiatrist cannot lay claim unless he sees himself in the false roles of specialist in psychological hermeneutics or in human engineering or in neurobiological manipulation, all of them self-images which have assumed some prominence in the past 30 years. In such roles his contribution is unlikely to be more than partially relevant to the problems posed by mental ill-health at the level of primary care. An altogether broader-based view of the discipline is required to encompass the presentation of mental ill-health not only as a series of particular clinical states but also as an integral component of much physical sickness on the one hand and much social dysfunction on the other. All too often the good general practitioner knows as much as may be required about his patient's background and domestic circumstances and about the community resources available to him. What he wants above all from his psychiatric colleagues are _facts_ to help better diagnose and manage his own patients _himself_. Which drug should be administered to which patient, in what dosage and for how long? What are the diagnostic criteria he should employ? How efficacious are the available therapeutic measures, whether physical or psycho-social, for the population under his care?

Such basic questions, and their numerous congeners, cannot be answered satisfactorily in the present state of knowledge. They are, however, eminently susceptible to investigation and, in many instances, to _clinical_ investigation, although in a rather different setting from that to which the psychiatrist based in hospital, clinic or office is accustomed. Here, I would suggest, is a logical point of entry for the psychiatrist in search of a necessary if not sufficient role on the primary care scene. Furthermore, as a participant on these terms the mental health professional may become a beneficiary as well as a donor, for the task would surely help restore the holistic concept of the discipline which, though it has receded in recent years, underlay Adolf Meyer's notions of psychobiology which itself reached back to the earlier concept of psychological medicine and, still earlier, to the views of Andrew Wynter on psychiatry in relation to family medicine, expressed more than 100 years ago: "...we are convinced," he wrote in 1875, "that for the good of general medicine,

this particular study of psychological medicine, dealing as it does with so many complex problems should be merged in the general routine of medical practice." 27/ Such a process of integration, or rather of re-integration, would be for the good of not only general medicine but also general psychiatry.

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MANAGEMENT OF EMOTIONALLY DISTURBED PATIENTS IN PRIMARY CARE SETTINGS: A REVIEW OF THE NORTH AMERICAN LITERATURE

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In the role of the health practitioner of first contact, the primary care provider may be in an ideal position to recognize and treat the emotionally disturbed patient. The question emerges as to how the emotionally disturbed patient is managed in the primary care setting. This paper addresses the issue by reviewing a portion of the literature on the subject that was published from 1959 through 1978. North American primary care settings are included in this review. Mental disorder is broadly defined and includes disorders classifiable under Diagnostic and Statistical Manual (DSM-II), as well as problems in living, stress reactions, interpersonal crises, etc.

Before describing the management of emotionally disturbed patients by primary care practitioners, it is important to emphasize that in order to manage those patients, the providers must first identify patients with mental disorder. In their presentations to this conference, Dr. Goldberg and Dr. Hoeper have raised serious questions about the ability of primary care providers to detect mental disorder. The studies reviewed here describe the management techniques for patients who have been identified. The fate of patients with hidden psychiatric morbidity remains unknown. Primary care providers have several choices in the treatment of emotionally ill patients. They can prescribe psychoactive drugs, provide psychotherapy, and/or refer the patient to a mental health specialist. This discussion focuses mainly on the first two options.

Published studies suggest that the prescription of psychotropic drugs is the modal management technique in the primary care setting. Nonpsychiatric physicians use drug threapy in 67 percent of visits by patients with a diagnosis of mental disorder; psychotherapy is used in 22 percent of those visits. 1/ The proportion of primary care patients with emotional disorder receiving a prescription for psychotropic drugs ranges from 29 percent to 79 percent, depending upon the setting. 2/-5/

These rates of psychotropic drug prescribing are averages and thus disguise a wide variation among practitioners at each site. Several authors have reported the types of drugs prescribed. Hesbacher,

et al., studied seven family practices in Philadelphia and found that 55 percent of the patients on psychotherapeutics were receiving anti-anxiety drugs, 19 percent antipsychotic drugs, 16 percent antidepressants, 9 percent sedatives, 1 percent stimulants. 2/ These proportions are very similar to those reported by other investigators. 3/,6/,7/ Patient characteristics (such as age, sex, degree of psychological distress) and provider characteristics (year of medical school graduation, isolation from colleagues) are correlated with the prescribing of psychotropic drugs. 2/,8/,11/

Two researchers have examined to what extent psychotropic drugs are used alone and when drugs and psychotherapy are combined. Fink, et al., report that in the Health Insurance Plan of Greater New York, 57 percent of patients with identified mental disorder were treated by drugs alone. 3/ Rosen, et al., studied five general hospital clinics in Monroe County, New York, and found that physicians used psychoactive drugs alone for 14 percent of patients, a combination of drugs and supportive therapy for 35 percent of those emotionally ill, and supportive therapy, drugs, and suggested environmental change for 10 percent of these patients. 5/ The efficacy of psychoactive drugs alone, compared with psychotherapeutic drugs combined with psychotherapy by the primary care physician, remains unstudied. 1/

In the course of the literature review, few studies were located that addressed the question of the appropriateness or quality of psychotropic drug prescribing by primary care physicians. Data indicate that not every patient prescribed a psychoactive drug suffers from mental disorder. Parry, et al., found that only one-third to one-half of psychotropic drugs were prescribed for a diagnosis of mental disorder. 12/ Psychotropic drugs have also been prescribed for the treatment of obesity, insomnia, cardiovascular disease, musculoskeletal and gastrointestinal problems. The appropriateness of these prescribing patterns has been questioned. Careful monitoring of patients using psychotherapeutics has been urged, given the problems of patient noncompliance and the risk of overdosing or adverse drug reactions. 3/,8/

The studies reviewed point to the need for additional research in the area of the management of emotionally ill patients by primary care physicians prescribing psychotropic drugs. Some of the unresolved issues include: First, when is it appropriate for primary care physicians to prescribe psychotropic drugs? Should every depressed patient receive an antidepressant? Can the primary care physician manage the patient on lithium? Second, are psychotropic drugs efficacious in and of themselves for the primary care patient, or should these drugs be combined with psychotherapy? Carefully controlled clinical trials are needed to answer this question. Third, is the management of psychiatric patients by psychotropic drugs a cost-effective method

compared with other alternatives? Fourth, what is the quality of psychotropic prescribing by the primary care physicians? Are they prescribing the correct type of drug for each type of mental disorder? Are the dosage levels high enough? Are they monitoring patients for compliance of the regimen and observing the potential for abuse? Are they concerned with adverse side effects and drug interactions? Finally, when should patients be referred to psychiatrists for drug therapy?

The primary care provider also has the option of providing psychotherapy to the emotionally ill patient. The percent of patients with recognized mental disorder who receive some psychotherapy from primary care physicians ranges from 60 percent to 84 percent. 5/,13/,14/ Definition of psychotherapy varied with each setting. In some cases it was defined as "at least one discussion of his or her problem with the physician," while in other studies it was defined as counseling or supportive therapy. Psychotherapy, as it is vaguly defined, may be provided at some time to more than half of the mentally ill patients, but it occurs in only 22 percent of patient visits. 1/

Few data are available concerning the intensity and nature of these psychotherapy sessions. Two studies revealed that more than half of the patients receiving psychotherapy by primary care physicians are seen from one to four times for such therapy. 15/, 16/ Short term crisis therapy seems to be stressed by primary care practitioners. The content of the psychotherapy sessions is largely a mystery, although a few primary physicians provide anecdotal self-reports of how they treat their emotionally ill patients. 15/

Zabarenko and her colleagues at the Staunton Clinic in Pittsburgh observed eight general practitioners in 387 patient visits. They found that physicians were not always actively aware of psychological distress in the patient. 17/ In a later study by these researchers, a psychiatrist observed a family physician for one year and noted that the following lessons could be learned about the management of a primary care patient with mental disorder: First, too many questions may impede the flow of patient information or prematurely terminate the transaction. The family physician should allow the patient to decide how much therapy he or she can tolerate and, finally, every behavior of the patient should be observed and evaluated. 18/

One of the recurring themes in the literature is that formal psychotherapy is difficult to conduct within the context of the primary care setting because of the limited time available to the provider. 4/,19/-21/ Figures from the National Ambulatory Medical Care Survey show that the nonpsychiatric physician averages only 13 minutes per visit with his patients. Several authors have suggested solutions to this, including the 20-minute hour or the 10-minute psychotherapy. 22/,23/

Studies on the outcome of psychotherapy by primary care physicians are practically nonexistent. Fink, et al., found that 36 percent of the patients receiving psychotherapy and 34 percent of their physicians rated the therapy as "very helpful." 3/ Controlled studies of the efficacy of primary care providers' psychotherapy could not be located.

The dearth of research studies in the area of psychotherapy by primary care practitioners leaves many questions unanswered, including the following: What types of patients are best treated by primary care psychotherapy and what types of patients should be referred to psychiatrists? We need controlled, randomized trials to answer this question. What type of psychotherapeutic techniques are appropriate in the primary care setting? What technique is most successful for a given psychiatric diagnosis? Again, we need carefully designed outcome studies. Is it cost effective to provide psychotherapy in the primary care setting? What are the most successful collaboration models for psychiatrists and primary care providers? Experiments in liaison psychiatry and the team approach have been implemented in several delivery sites, but additional studies of these models are needed.

In conclusion, the literature reviewed indicates that the primary care providers do manage emotionally disturbed patients with psychotropic drugs and psychotherapy. However, systematic data on the utilization of these techniques are lacking. One has the impression that drug prescribing and psychotherapy occur in a haphazard way. The works reviewed point to the need for future research and planning in order to effectively deliver mental health services within the primary care setting.

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AN ANNOTATED BIBLIOGRAPHY ON

MANAGEMENT OF EMOTIONALLY DISTURBED PATIENTS IN PRIMARY CARE SETTINGS: A REVIEW OF THE NORTH AMERICAN LITERATURE

Janet Hankin, Ph.D.

The following annotations represent a selection of all articles on the treatment of mental disorder by primary care physicians which were published between 1959 and 1979. The literature search was restricted to articles relating to North American primary care practices. The articles address the problems of psychotherapy and drug prescribing by primary care providers, as well as psychiatric referral. The articles which were chosen for annotation are representative of others published works. Because of space contraints, only a sample of the articles could be annotated. The omission of any given article should not be viewed as judgment about its quality or importance.

Balter, M.B. An analysis of psychotherapeutic drug consumption in the United States. Anglo-American Conference on Drug Abuse: Etiology of Drug Abuse, I, 1973, pp. 58-65.

In 1972, 16 percent of all prescriptions filled were for psychotherapeutic drugs. These 215 million prescriptions were for antipsychotics, anti-anxiety agents, antidepressents, sedatives, hypnotics and stimulants. Forty-four percent of the psychoactive drug prescriptions were for anti-anxiety drugs.

Based on estimates from a national survey of 2,552 persons, 22 percent of American adults used a psychotherapeutic prescription drug. Women and persons over 60 were more likely to use these drugs.

Data from the National Disease and Therapeutic Index indicate that general practitioners account for 50% of all new psychoactive drug therapy. Only one-third of all prescriptions for anti-anxiety drugs were given to patients with a diagnosis of mental disorder. If senility is added to this category of mental disorder, 50 percent of anti-anxiety drug prescriptions were for patients with emotional distress, and 50 percent for patients with physical illness.

Brockway, B.S. Behavioral medicine in family practice: A unifying approach for the assessment and treatment of psychosocial problems. The Journal of Family Practice, 6:545-552, 1978.

Dr. Brockway defines behavioral medicine as "any procedure or set of procedures based on learning theory which is used to assess and treat medical or medically related problems." The family practitioner who is oriented to behavioral medicine sees the patient's psychosocial problems "as a combination of behavior (or skill) deficits or excesses." Once the practitioner defines the problem, s/he must determine: What skills need to be learned to achieve the desired outcome? What factors in the environment maintain the skill deficit or excess? Next, the physician can use a variety of techniques to teach more appropriate behaviors (shaping and modeling, systematic desensitization, biofeedback, assertiveness training). Family practitioners are said to have used these methods to successfully treat persistent vomiting in an infant, headaches, encopresis, enuresis, severe temper tantrums, marital conflict, reactive depression, and primary orgasmic dysfunction. Initial data to determine the appropriate mode of management can be gathered within the constraints of a 20 minute office visit. Behavior treatments tend to succeed in one to six months. Family practitioners can also use behavioral medicine in a preventive way. For example, during prenatal visits, a couple can learn child management skills.

Brown, B.S., Regier, D.A., and Balter, M.B. Key interactions among psychiatric disorders, primary care, and the use of psychoactive drugs. In Brown, B.S. (ed). Clinical Anxiety/Tension in Primary Medicine. Princeton: Excerpta Medica, 1979.

The authors estimate that 60 percent of persons with mental disorder are treated by primary care providers. Of all persons with mental disorder, an estimated 32 million people in a given year, 15 percent see only mental health specialists, 54 percent see only primary care providers, 3 percent use general hospitals or nursing homes, 6 percent use both primary care and mental health providers, and 22 percent go untreated or use resources outside the health care system.

About 5 percent of all patient visits to physicians in office-based practice result in a diagnosis of mental disorder. About half of these visits where a mental disorder diagnosis is received involve psychoneuroses. "Nonpsychiatric physicians account for more than 50 percent of all visits in which a diagnosis of psychiatric disorder is assigned."

Nonpsychiatric physicians employ psychotherapy in 22 percent of visits with a diagnosis of mental disorder, and drug therapy is used at 67 percent of these visits.

The authors call for research to determine which psychiatric disorders are best treated by psychotropic drugs, which disorders require psychotherapy, and when a mixed mode of treatment is needed. Additional research is needed to determine how to divide the responsibility between the primary care physician and the psychiatrist; what is the relative effectiveness of treatment by each type of provider, and the cost effectiveness of the treatment.

Carey, K., and Kogan, W.S. Exploration of factors influencing physician decisions to refer patients for mental health service. Medical Care, 9:55-66, 1971.

The authors asked physicians in the specialties of general practice, medicine, and surgery to describe two patients who were referred to mental health services and two patients with emotional problems who were not referred. Seventy-eight of 92 physicians of the Group Health Cooperative of Puget Sound participated. Data were obtained on 140 patients who had been referred and 125 who were not referred. Patients with acute conditions and those who requested referral were more likely to be referred. The feeling of inability or lack of experience on the part of the physician resulted in a referral. The

"treatment" of mental disorder varied with the specialty: the medical group used diagnostic procedures; the surgical group, placebos; and the general practice group, psychoactive drugs.

Coleman, J.V., and Patrick, D.L., Psychiatry and general health care. American Journal of Public Health, 68:451-457, 1978.

The authors describe a five year experience with the Community Health Center Plan of Greater New Haven, Connecticut. This prepaid group practice integrates mental health services into primary care teams in internal medicine and pediatrics. The mental health clinician is a psychiatric social worker, a psychiatric nurse specialist, or a clinical psychologist. While the primary care providers have the major responsibility for total health care, the mental health clinician acts as a primary care extender. Psychiatrists are available for back-up support.

During a two year period 15.7 percent of the patients seen were diagnosed as suffering from emotional problems (N=2,806). Primary care clinicians alone handled 72 percent of these patients, and mental health clinicians (in addition to primary care providers) treated 28 percent. Mental health clinicians treated 55 percent of patients with chronic emotional problems. The proportion of the following diagnoses were treated by primary care clinicians alone: nonorganic psychoses (54%), anxiety (88%), depression (67%), personality disorders (47%), sexual problems (75%), alcohol problems (80%), durg abuse problems (65%), situational disturbances (70%), social adjustment problems (58%), suicide ideation/attempt (75%). The primary care physicians usually handled medication maintenance, although at times referral to mental health clinicians was necessary to assist the primary care physician to establish the medication regimen.

The authors conclude that this team approach has the major advantage of making the mental health clinician readily available to the primary care provider which can relieve him or her "of the undue, sometimes inordinate pressure of certain persistently demanding patients, usually patients with chronic characterological depressions and borderline states."

Dressler, D.M. The management of emotional crisis by medical practitioners. Journal of the American Medical Women s Association, 28:654-659, 1973.

The person who is unable to handle stress utilizing customary modes of coping frequently consults the physician. The physician can reduce the distress and prevent further deterioration for

patients experiencing emotional crises such as loss of job, financial loss, serious illness, death of a family member.

The physician should first help the patient feel that he "is not 'going crazy' or 'out of control'." The physician should adopt an "accepting, non-judgmental attitude" and be "calm but concerned, flexible but firm, and receptive but involved." The interview should focus on the current problem, rather than delving into the past, and conflicting feelings should be recognized. The physician should help the patient broaden his/her repertoire of coping skills. Family members should be involved in treatment. Medication may be useful in reducing symptomatic distress.

The patient should be seen once or twice a week. When the patient has recovered, the physician should assess the need for follow-up specialized psychiatric care, especially if there is evidence of psychotic or neurotic symptoms, if the patient has a history of recurrent crises, and/or if the patient is interested in a deeper subjective examination.

Fink, R., Goldensohn, S., Shapiro, S., and Dailey, E. Treatment of patients designated by family doctors as having emotional problems. American Journal of Public Health, 57: 1550-1564, 1967.

The authors interviewed physicians at the Jamaica Medical Group of the Health Insurance Plan of Greater New York about 422 patients over 15 years old who were diagnosed as having a mental, psychoneurotic, or personality disorder. Twenty-six patients were referred for a psychiatric consultation. Patients were more likely to be referred if they had a chronic condition, a condition that greatly interfered with life activities, and/or a condition which was thought to improve with psychiatric treatment.

Of all patients with mental disorder, 78 percent received a psychotropic drug and 92 percent had at least one lengthy doctor-patient discussion of the problem. Patients who did not improve with these treatments were more likely to receive a psychiatric referral.

A total of 380 of the 420 patients were interviewed. Among patients with psychoactive drug prescriptions, 46 percent said they were very helpful, 34 percent somewhat helpful, and 20 percent little or no help. Nearly two-thirds of the patients reported that the doctor-patient discussions about their emotional problems were very helpful (34%) or somewhat helpful (30%). Twenty-three percent reported that the discussions were of very little or no help, and 13 percent said they had not had any discussion.

Fisher, J.V., Mason, R.L., and Fisher, J.C. Emotional illness and the family physician. Part II: Management and Treatment. Psychosomatics, 16:107-111,1975.

The authors surveyed 860 family physicians who were members of the Michigan Chapter of the American Academy of General Practice regarding detection and management of emotional illness. Physicians graduating from medical school after 1950 had a tendency to use psychoactive drugs with a lower percentage of their emotionally ill patients than physicians graduating prior to 1950. Physicians graduating before 1950 were more inclined to use tranquilizers and antidepressants with 50 percent or more of their emotionally ill patients than later medical school graduates. About 80 percent of all physicians used advice and reassurance for their mentally ill patients. Physicians graduating after 1950 were more likely than earlier graduates to use psychotherapy with their patients.

Glasser, M. Psychiatry in family practice. Canadian Psychiatric Association Journal, 21:483-488, November, 1976.

The author is a family practitioner who reviewed the charts of all patients he saw between September 1, 1964 and August 1, 1968 (N=4,801). Of these patients, 394 were classified as psychiatrically ill. Beginning in September, 1967, he questioned each returning psychiatric patient about the original complaint. A total of 287 patients identified as psychiatrically ill were evaluated. The remaining 107 psychiatric patients were seen only once and did not return for additional visits. The 287 patients involved in the follow-up study were evaluated in relation to change in symptoms, degree of functional impairment, mental status, level of severity of disease, and any new symptoms. The majority of patients were also rated by a psychologist. Nearly three quarters of the patients were diagnosed as neurotic; 11 percent had adjustment reactions; and the remainder were psychotics, drug and alcohol addicts, or suffered from character disorders.

The author used therapy that was "eclectic, at times being supportive and fostering catharsis, while on other occasions being directive and offering interpretations of behaviour." Twenty-six patients were referred to mental health specialists. Most patients were seen by the family practitioner only five times, and none more than twenty-two. There were no significant differences in improvement rates for the patients treated by the mental health specialists versus those treated by the family practitioner. At the time of follow-up, 74 percent of the patients were judged to be better, 20 percent neutral, and 6 percent worse.

Greco, R.S. Psychiatry in everyday medical practice. Psychiatry in Medicine, 3:303-309, 1972.

The author participated in Balint-type training sessions at the University of Pittsburg Medical School. He became convinced that "every doctor-patient transaction has a workable psychotherapeutic aspect." He provides several examples in the discussion. When the patient presents him/herself to the physician without specific complaints (e.g., for routine physical exams), the physician should take this opportunity to practice preventive psychiatry. When the patients present an unorganized illness, symptoms are presented, and the physician can work to organize the illness and restore the patient's balance.

In an organized illness, the patient and doctor agree on a diagnosis, and the physician can treat the problem directly.

Hesbacher, P., Rickels, K., Rial, W.Y., Segal, A., and Zamostein, B.B. Psychotropic drug prescription in family practice. Comprehensive Psychiatry, 17:607-615, 1976.

The authors surveyed 1,190 patients seen in seven family practices from March to September, 1970. Of these patients, 48.2 percent were experiencing emotional problems currently or had suffered from emotional problems during the past two years. Among patients with emotional disorder, 50.4 percent had received a psychotropic drug prescription within the past two years. Twenty-nine percent of the emotionally ill patients were taking psychotropic drugs at the time of the survey. All patients completed the Hopkins Symptom Checklist (HSCL) at the time of their visit.

The authors found a general trend that the scores were highest for patients with emotional problems currently on drugs, lower for patients with emotional problems who were previously on drugs, followed by patients with emotional problems who were never on drugs, and the lowest for patients without emotional problems.

The patients who had been prescribed drugs in the past two years were most likely to receive anti-anxiety drugs (55 percent of all patients prescribed psychoactive drugs) followed by anti-psychotic drugs (19%), antidepressants (16%), sedatives (9%), and stimulants (1%).

Ketai, R. Family practitioners' knowledge about treatment of depressive illness. Journal of the American Medical Association, 235:2600-2603, 1976.

Ketai chose 227 family practitioners attending a seminar at the University of Michigan Medical Center as his subjects. Before the physicians heard a lecture on psychotropic drugs, they completed a multiple choice examination on the prescribing of psychotropic drugs. The answers of the physicians were compared with those of seventeen psychiatrists. The greatest discrepancy between the family practitioners and psychiatrists occurred for depressive illness.

Nearly 27 percent of the family practitioners were unaware of how best to treat a depressed patient with severe anxiety and agitation. One-fourth of the family practitioners would begin treatment with tricyclics at too low a dose, while 9% at much too high a dose. Thirty-nine percent of the family practitioners would not raise the tricyclic dose to acceptable and proper levels.

The author concludes that family practitioners should be taught how to use tricyclic antidepressants. He recommends a starting dose of imipramine hydrochloride or amitriptyline hydrochloride of 75 mg/day which should be raised to at least 150 mg/day within a few days. Some patients require dosage levels of 200-250 mg/day. A trial of two to three weeks at therapeutic levels is needed before determining that the drug is ineffective.

Kiely, W.F. Psychotherapy for the family physician. American Family Practice, 3:87-91, 1971

The author suggests that family practitioners practice suppressive and supportive psychotherapy, aiming toward intrapsychic equilibrium, rather than reorganizing the personality. Kiely suggests that while the initial visits may last from 30-60 minutes, follow-up visits of 15-20 minutes are adequate.

The family physician can begin the interview with simple questions like, "How have things been going generally?" or "I have the feeling that you've been working under a good deal of tension." However, the physician should avoid asking too many questions and using technical terms. Kiely argues that the physician should focus on current feelings and symptoms, rather than delving into the past. The family physician should avoid: provoking anxiety in the patient, showing judgmental attitudes, creating a hostile reaction to the physician, and confronting the patient.

Locke, B.Z., Finucane, D.L., and Hassler, F. Emotionally disturbed patients under care of private nonpsychiatric physicians. American Psychiatric Association: Psychiatric Research Report, 22:235-248, 1967.

Seventy-nine general practitioners out of 107 in Prince Georges County, Maryland, kept records on patients seen in one week during February-July, 1964. A total of 7,814 patients were included. Physicians identified 7 percent of the sample as emotionally ill (9 percent of those white and 15 years of age or older). Physicians provided the following types of care to patients with mental disorder: suggested psychiatric care or counseling (25% of patients), gave supportive therapy (59%), suggested environmental or social change (19%), prescribed drugs for the psychiatric problem (60%), suggested referral to other agencies or persons (6%), suggested other recommendations or other therapy (5%), none of the above (8%).*

Locke, B.Z., Krantz, G., and Kramer, M. Psychiatric need and demand in a prepaid group practice program. American Journal of Public Health. 56:895-904, 1966.

All patients aged 15 and over seen at the Group Health Association (Washington, D.C.) in the Departments of Internal Medicine, Pediatrics, Allergy, and Dermatology during a 3 1/2 month period were included, N=6,104. Nearly 15 percent of the patients seen had a mental or emotional problem. Seventy-five percent of these patients were treated with psychoactive drugs, 63 percent received counseling, and 17 percent were referred for outside psychiatric help. For another 18 percent of patients who were not referred, the physician wanted to recommend additional treatment, but was reluctant to do so because s/he felt that the patient would find it unacceptable or too costly.

Ornstein, P.H., and Goldberg, A. Psychoanalysis and medicine. II. Contributions to the psychology of medical practice. Diseases of the Nervous System, 34:277-283, 1973.

The authors describe two techniques of psychotherapy that can be used by the primary care physician. The long interview (or focal psychotherapy) focuses on the patient's life situation and personality. The physician spends most of the time listening in order to uncover: the problem that caused the illness, the effects of the patient's behavior on others, unconscious conflicting motives, and the conflict which is at the root of the problem.

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*Percentages add to more than 100% because patients could receive more than one type of care.

However, the long interview is time consuming, so an alternative technique, the ten minute psychotherapy or "flash" may be used. The flash is empathetic understanding and "requires as a fine tuning-in, a briefly sustained intense identification with the patient that leads to a knowledge about him which doctor and patient silently share for the benefit of the patient."

Raft, D. How to refer a reluctant patient to a psychiatrist. American Family Physician, 7:109-114, 1973.

Psychiatric referral is more difficult when the family physician has a negative attitude to psychiatry and transmits these feelings to the patient. Sometimes the referral is made because the physician is disappointed or angry with the patient who presents a physical symptom for which no organic base can be found.

Even when the family physician does make a psychiatric referral, the patient may be reluctant to cooperate. Many patients fear emotional illness or want to avoid exploring deep feelings. The family physician should exploit the doctor-patient relationship when s/he recommends psychiatric consultation. Some patients feel abandoned by the family physician when a psychiatric referral is made. The physician needs to reassure the patient that s/he will not be neglected. "The physician may simply have to refuse further investigation unless the patient will follow his advice to see a psychiatrist."

Rosen, B.M., Locke, B.Z., Goldberg, I.D., and Babigian, H.M. Identification of emotional disturbance in patients seen in general medical clinics. Hospital and Community Psychiatry, 23:364-370, 1972.

The authors studied patients seen in one month at four outpatient general medical clinics. Another clinic with a small case load reported on patients seen during two months. The clinics represented 5 of 6 outpatient general medical clinics in Monroe County, New York. A total of 1,413 patients aged 15 and older were studied.

Twenty-two percent of the patients were diagnosed by their physicians as suffering from mental disorder. The types of treatment provided included: supportive therapy (31% of patients); drug prescriptions (14%); environmental changes suggested (1%); supportive therapy and drugs (35%); supportive therapy and environmental changes (8%); therapy, drugs, and environmental change (10%).

Shortell, S.M., and Daniel, R.S. Referral relationships between internists and psychiatrists in fee-for-service practice: An empirical examination. Medical Care, 12:229-240, 1974.

The authors interviewed 127 internists practicing in the northern suburbs of Chicago. During a one month period 0.9 percent of all patients seen were referred to psychiatrists. Internists over 50 years old, those in practice 20 years or more, solo practitioners, board certified, and those without a subspecialty had higher rates of psychiatric referral. Depression, followed by anxiety and neurosis were the most frequent reasons for psychiatric referral. Alcoholics were least likely to be referred to psychiatrists. The internists were generally satisfied with their patterns.

Scaramella, T.J. Management of depression and anxiety in primary care practice. Primary Care, 4:67-77, 1977.

The author argues that patients with anxiety syndromes "are more manageable and respond better to therapy when they are treated by their family doctor." These patients are reluctant to see a psychiatrist. The family doctor should work to alleviate the patient's fears by reassurance and understanding. Specific case examples are presented which illustrate management techniques. Patients with anxiety states should be referred to psychiatrists when: 1) neither patient nor physician can identify the source of stress or conflict, 2) patient fails to follow or benfit from primary care physician's treatment after three months, 3) patient expresses strong interest in psychotherapy, or 4) patient's personality makes it difficult for him/her to cooperate with primary care physician. The author presents techniques to overcome a patient's resistance to psychiatric referral.

The primary care physician can provide treatment for depressed patients in a majority of cases. Depressive disorder is usually characterized by low spirits, sleep disturbance, somatic complaints, and inability to function effectively. The primary care physician should: 1) identify for the patient what is wrong; 2) explore the factors in the patient's life which may be contributing to the depression; 3) explain to the patient that somatic complaints, feelings of hopelessness and pessimism are part of the depression; 4) while acknowledging the symptoms, do not promote the use of symptoms to avoid life events; 5) measure the extent of depression by having the patient complete a depression inventory; 6) ask about self-destructive thoughts; and 7) Outline a specific treatment plan. Patients should receive a psychiatric consultation and/or referral if patient shows signs of psychosis, strong suicidal intentions,

previous episodes of mania, poor response to treatment after three months, patient has a depressive life style, or patient requests to see a psychiatrist.

Smith, J.A. Office psychotherapy in family medicine. American Family Physician, 2:80-84, 1970.

The author describes the symptoms, course, and treatment of anxiety by the family practitioner. Anxious patients may have acute episodes with autonomic symptoms such as cardiac palpitations, vertigo, dry mouth, and diffuse perspiration. The onset may be sudden and accompanied by intense fear and an urge to escape. After the acute episode, the patient may continue to complain about nausea, urinary frequency, vertigo, blurred vision, insomnia, palpitations, cardiac awareness, tinnitus, or cold hands and feet.

The typical treatment of anxiety is to assure that patient that s/he does not have a dread disease. The physician should be careful about the content of both verbal and nonverbal communication. The physician should ask questions about the true cause of the patient's complaint, and should de-emphasize the importance of physical complaints. Patients with severe anxiety should receive an anti-anxiety agent.

Zabarenko, R.N., Merenstein, J.; and Zabarenko, L. Teaching psychological medicine in the family practice office. Journal of the American Medical Association, 218:392-396, 1971.

The authors describe an educational experiment where a psychiatrist served as a preceptor for a family physician. The physician learned not to make a rigid distinction between organic and psychiatric disease and realized the importance of seeing the total patient. It is important not to impede the flow of patient information by asking too many questions. Every behavior of the patient should be observed (gestures, body language, banter). The physician learned to recognize major but hidden syndromes, especially depression. He learned that is was not wise to force the patient to accept the fact that no organic disease is present.

APPENDIX A

INSTITUTE OF MEDICINE

An Invitational Conference:
The Provision of Mental Health Services
in Primary Care Settings

National Academy of Sciences
Washington, D.C.

April 2-3, 1979

AGENDA

Monday, April 2

2101 Constitution Avenue, N.W.
National Academy of Sciences
Lecture Room

8:00 a.m.	Registration
8:45 a.m.	Welcome David A. Hamburg, M.D. President, Institute of Medicine
9:00 a.m.	Opening Remarks Herbert Pardes, M.D. Director, National Institute of Mental Health
9:15 a.m.	Merle Cunningham, M.D. Bureau of Community Health Services Health Services Administration
9:20 a.m.	Policy Issues on Provision of Mental Health Services in Primary Care Settings: A Federal View Gerald L. Klerman, M.D. Administrator, Alcohol, Drug Abuse, and Mental Health Administration
9:45 a.m	Discussion

10:00 a.m.	Coffee Break
10:15 a.m.	Nature and Scope of Mental Health Problems in Primary Care Darrel Regier, M.D. Division of Biometry and Epidemiology National Institute of Mental Health
10:35 a.m.	Questions
10:45 a.m.	Delivering Mental Health Services in Primary Care Settings: Some Successful Models Chairman: Jonathan Borus, M.D. Massachusetts General Hospital Neighborhood Health Center Model Barbara Burns, Ph.D. Primary Care Research Section Applied Biometrics Research Branch, NIMH Mental Health in a Fee-for-Service Pediatric Practice Lawrence Pakula, M.D. Timonium, Maryland Treatment of Emotional Problems by Primary Physicians in an HMO Jules Coleman, M.D. Community Health Center Plan New Haven, Connecticut
11:45 a.m.	Discussion
12:15 p.m.	Lunch -- NAS Refectory
1:15 p.m.	Identification and Management of Mental Health Problems in Primary Care Settings Chairman: David A. Hamburg, M.D. Training of Family Physicians in Mental Health Skills: Implications of Recent Research David Goldberg, M.D. University of Manchester England

Observations on the Impact of Psychiatric
Disorder upon Primary Medical Care
Edwin Hoeper, M.D.
Marshfield Clinic
Marshfield, Wisconsin

Literature Review on Management of Emotionally
Disturbed Patients in Primary Care Settings
Janet Hankin, Ph.D.
Johns Hopkins Health Services Research
and Development Center

Suicide Prevention by Family Physicians:
Opportunities and Limitations
Thomas Madden, M.D.
Department of Preventive Medicine
Rush-Presbyterian -- St. Lukes Medical Center
Chicago, Illinois

2:30 p.m. Discussion

3:00 p.m. Coffee Break

3:15 p.m. Issues in Training, Organizational
Structure and Financing

Chairman: Steven Sharfstein, M.D.
Division of Mental Health Service
Programs
National Institute of Mental Health

The Primary Care Physician: Mental Health Skills
Robert Lawrence, M.D.
Harvard Medical School

The Role of the Psychiatrist in the Primary Care
Setting: Issues and Problems
Alan Jacobson, M.D.
Joslin Clinic
Boston, Massachusetts

Reimbursement for Mental Health Services
in Primary Care Settings
Alexander Richman, M.D. in collaboration
with Murray G. Brown, Ph.D. and
Vernon Hicks, M.D.
Dalhousie University
Halifax, Nova Scotia

	Problems in Analyzing the Cost-Offset in Providing Mental Health Services in Primary Care Settings Herbert Schlesinger, Ph.D. in collaboration Emily Mumford, Ph.D. and Gene V. Glass, Ph.D. University of Colorado Medical School Denver, Colorado
4:40 p.m	Discussion
5:00 p.m. - 7:00 p.m.	Reception -- Great Hall

Tuesday, April 3

8:30 a.m.	Plenary Session -- Lecture Room Introductory Remarks -- David A. Hamburg, M.D.
	Mental Health as an Integrant of Primary Care Michael Shepherd, M.D. Professor of Epidemiological Psychiatry Institute of Psychiatry University of London
9:30 a.m.	Workshops
	Group A Chair: A. Alan Fischer, M.D. Rapporteur: Fredric Solomon, M.D.
	Group B Chair: Lisbeth Schorr Rapporteur: William Lybrand, Ph.D.
	Group C Chair: Barbara Starfield, M.D. Rapporteur: Elena Nightingale, M.D.
12:30 p.m.	Lunch -- NAS Refectory
1:30 p.m.	Workshop Summaries -- Lecture Room
2:00 p.m.	Panel: Future Directions in Coordination of Mental Health Services and Primary Care
	Julius Richmond, M.D. Assistant Secretary for Health Department of Health, Education and Welfare
	Gerald Klerman, M.D. Administrator, Alcohol, Drug Abuse and Mental Health Administration, DHEW

	George Lythcott, M.D. Administrator Health Services Administration, DHEW
3:00 p.m.	Discussion — Final Remarks
3:30 p.m.	Adjourn

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APPENDIX B

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Mental Health Services in General Health Care: Summary of the Invitational Conference on the Provision of Mental Health Services in Primary Care Settings, April 2,
http://www.nap.edu/catalog.php?record_id=21495

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APPENDIX C

POSTSCRIPTS

In accordance with the original conference design, participants in the April 2-3 meeting were encouraged to submit written follow-up comments within 30 days. The following were selected to highlight several of the principal themes concerning mental health services in general health care.

(1) Advantages of Coordinated Mental Health and General Health Care.

Albert J. Solnit, M.D.:

. . . The major advantage of bringing together primary and mental health care knowledge and personnel is the primary and secondary preventive impact on the continuity of effective care for patients. This concept also implies that patients who need tertiary care (e.g., those with schizophrenia, sustained depressive conditions, etc.) should be referred to mental health specialists who are competent to evaluate and treat such patients, often with the collaboration of the primary health care provider.

When primary physicians and their teams include preventive mental health knowledge and techniques in their repertoire, the care of patients should be increasingly humanized. Moreover, such health care should assure more effective continuity of care and opportunities to maximize primary and secondary prevention of physical and mental health conditions.

Mack Lipkin, Jr., M.D.:

The goal of integrated primary health care and mental health service can be justified on humanistic grounds, the grounds of caring. However, additional data argue for such integration. First, the nature of disease and illness phenomena is that they are, in fact, integrated. Second, a significant majority of the cases, ranging from 30 to 80%, according to criteria and study, involve psychological as well as disease issues. Third, a subset of cases, in our experience 4% (visits in an HMO), require integrated care. Failure to provide such in these cases leads to increased costs, decreased satisfaction, and occasionally unnecessary morbidity and mortality.

Barbara Starfield, M.D., M.P.H.

(By coincidence, at the time of the conference Dr. Starfield was just completing an epidemiological study of psychosocial and psychosomatic disorders in pediatric case loads. The psychosocial disorders, including learning disabilities and behavioral dysfunctions, have become increasingly prevalent; together with psychosomatic disorders, they are present in about 20% of pediatric cases. She has applied the term "the new morbidity" to this phenomenon. An abstract follows of her unpublished report, "The Prevalence of Psychosocial and Psychosomatic Diagnoses among Children in Primary Care Facilities.")

The Prevalence of Psychosocial and Psychosomatic Diagnoses Among Children in Primary Care Facilities

(Abstract)

In this study in seven primary care facilities, the proportion of children recognized as having psychosocial problems was much higher than generally assumed. Although there was great variability among the facilities the prevalence was at least 5% and as much as 15% except in the hospital teaching facilities where it was much lower. The prevalence was higher in children in poor families. The variability among facilities was much less for psychosomatic problems, which were diagnosed in 8-10% of children. The variability in diagnosis of psychosocial problems is most likely a result of differences in the extent to which different practitioners recognize this type of problem.

For both types of problems, but especially for psychosocial ones, the proportion of visits with the diagnoses was much less than the proportion of children with them, so that the management of these problems was not associated with a relatively large number of visits. Available evidence suggests that individuals with unresolved psychosocial problems make more than their share of visits for other diagnoses. Therefore, management of psychosocial problems in primary care should reduce overall utilization.

The findings of this study have implications for the content of educational programs for primary care practice and are pertinent to current debate over policy concerning reimbursement and benefit packages.

(2) Organizational Issues.

Gordon H. Deckert, M.D., F.A.C.P.:

I certainly agree with the data that the majority of the mentally ill are cared for in primary care settings. Beyond this I tend to believe that the majority of these patients will be taken care of by primary care physicians and in settings where being able to implement the model of a team of mental health professionals working with primary care physicians is unlikely. This is a point I want to emphasize since most of the presentations tended to come from individuals working in the large metropolitan areas of the northeast coast and metropolitan areas of California. The vast majority of primary care physicians in this country work in settings where it will not be possible in the next five years or even ten years to place well-trained mental health professionals. Hence, it will not be enough with this new initiative to focus on the training of mental professionals to work in primary care settings. In many instances (I would daresay even most instances) the delivery will have to come from primary care physicians themselves.

Stephen King, M.D.:

The British contribution /to the Conference/ . . . pointed dramatically to the difficulties inherent in attempts to effectively integrate the private fee-for-service system extant in the United States.

There is a significant rapidly growing system of care directly supported by ADAMHA and HSA. In Region IV alone, the Bureau of of Community Health Services supports approximately 300 projects at a cost of $200,000,000 which along with 500+ NHSC provider assignees is providing medical care to 3,000,000 people. This resource could easily be galvanized with an effective operational linkage with the CMHC's. Such a model would cause by its effect a great deal more to happen, even in the private sector. It should not cost more dollars to integrate these programs locally -- providing single point access and point responsibility for catchment area populations were to be established.

Primary care resources and CMH resources tend to care for very different populations of people. The information presented at the conference would tend to support the hypothesis that the nature of clinical needs of these two populations are different, suggesting to me that some scrutiny of the purposes of the various programs is warranted.

It is my impression that a major contribution to the present schism arises at the legislation/congressional level. The present legislation is increasingly undergirding a conceptual isolation of the programs, especially in the mental health area. The constituency

is particularly turf jealous. Also, along this line is the lack of attention to the issue by the planning legislation (93-641). Actually the HSA boards and staff as well as the State Health Coordinating Committees and the State Health Planning Development Agencies are not oriented toward mental health programs.

There are many instances of effective program integration in the field (other than in the private sector) often established in the face of bureaucratic indifference. These are always, I think, the result of assertive and immaginative local leadership.

. . . I would like to assume that it is in the vested self interest of all that there be integration of these elements of care, and further, that this care must be available to all to be effective. When this integration and access are assured, they are accomplished in the field, in an arena which is most distant from those arenas of academia and research and which is often buffeted by unthinking administrative policy decisions by the responsible agencies.

There is in truth no discernible national health policy which speaks to the importance of the complete human being, of an organism needing care, a policy which is oriented toward effective coordination of available resources over which we have control.

Jeffry L. Houpt, M.D.:

The problem begins with the term "primary care" medicine. It tends to imply that we are talking about the integration of mental health services with primary care physicians as opposed to other nonpsychiatric physicians who provide primary care medicine. I think it is important to keep in mind that primary care physicians are only one group of physicians with whom we need to be concerned. I make this point because I left the conference concerned that we support a pluralistic system and think about ways of integrating mental health services with the internists, surgeons, pediatricians, and obstetricians/gynecologists who also practice primary care medicine.

If we are going to take a flexible approach to this particular subject, we cannot pattern ourselves completely after the British system. Under their system, all people see the generalist first before seeing a specialist. Mental health services are provided by the "G.P.," or on occasion with the assistance of a social worker. Recommendations are rather one-sided for such a model: (1) better education for primary care physicians in psychiatric management and (2) attempting to strengthen referral for severe psychopathology.

While such an approach is clearly viable, and in some areas the only reasonable approach, I'd like to keep alive (1) the notion of integrated <u>multi-specialty</u> clinics or offices for providing

primary care medicine and (2) the notion that mental health professionals can provide some of these services. I would suggest that the mental health services provided to nonpsychiatric physicians by mental health professionals be described in terms of two broad areas of function: a first category whereby mental health professionals provide direct service to patients, and a second category called liaison functions or indirect services whereby mental health personnel provide service to the nonpsychiatric physician or other members of the health care team. Liaison functions would include such things as providing support, advice, or teaching.

The essence of my ideas are that we provide a flexible system. Both primary care physicians and multi-specialty groups could be developed to meet the need for general medical care. Programs could be developed to utilize mental health professionals in providing direct and indirect services to either the primary care physician or the multi-specialty group. There is no need to force such a hard line of distinction between "primary care" and secondary care when it comes to providing mental health services.

George J. Cohen, M.D.:

Comparing three systems of provision of mental health services in primary care settings, I think it is important to indicate the intensity of those mental health services as well as procedural factors. In my score of years in private practice my approach was very similar to Dr. Pakula's, i.e., essentially preventive, with anticipatory guidance based on normal stages of child development and my assessment of both the child's and the parents' temperaments. In addition there were many times when either the family or I would feel a need for counseling regarding behavior problems. This was usually set up at an after hour session for which a separate charge was generated. Fortunately in a largely middle class practice most families are able to afford this cost out of pocket.

At Children's /National Children's Medical Center, Washington, D.C./, both in the past few years in my full-time work in the Outpatient Department and in my 17 years of working in the Lead Poisoning Clinic, a different set of circumstances prevails. In the general Medical Clinic we try to encourage the residents to do some anticipatory guidance especially when the children are in for health check-ups. In addition there is a steady flow of youngsters with the usual childhood behavior problems and habit disorders such as bed wetting, school phobias, and somatic or functional complaints, e.g., headaches, abdominal pains. Here again we encourage the residents to look beyond the symptoms and to identify situational or emotional factors. This however is often done on a somewhat scatter shot basis because the attending physician cannot work with each and every resident with each and every patient. However, as patients are discussed in follow-up and as charts are reviewed, these questions

often surface even if the resident has not requested a consultation initially. In our Lead Poisoning Pica Clinic which has not been absorbed into the general Medical Clinic team structure, I supervised both pediatric and psychiatric residents. As we saw each of our children with Pica and/or lead poisoning, our approach was to encourage the residents to take a holistic approach to the child, his family and their environment while the psychiatry resident served either as a consultative resource for deeper emotional difficulties or as a leader of discussions with the parents regarding anticipatory guidance and situational adjustment.

A third model is in Mobile Medical Care, our volunteer clinic for low-income persons in Montgomery County /Maryland/, where we have both medical and mental health personnel working in the same clinic. There consultation is available on a face to face professional basis, and the medical and mental health records are available in the same jacket; any professional can see what another has been accomplishing in his work with the patient.

In all of these settings one of the most important things is a relationship between the primary care health person and the mental health person. This means the primary physician must choose mental health experts with whom he can work comfortably, as well as open communication in both directions. In private practice this was frequently difficult, especially if the patient went to a mental health clinic or other agency where there was often great reluctance to reveal any information to the referring physician. However, the private mental health consultant was usually able and willing by phone to render such information. In the Children's Hospital clinic setting such personal contact is available, but the primary physician must often be pushed to take advantage of it, and often will refer the patient to the psychiatry clinic but not follow-up on the patient. The presence of both the mental health and the medical health workers at the same time at the same place at Mobile Medical Care obviates some of this difficulty.

Alan M. Jacobson, M.D.;

Funding was, is, and will be a major stumbling block to the reasonable policy of bringing psychiatry and primary care practice into at least shouting distance. The use of categorical monies for linkage grants is a useful first step, but should be tested in other settings besides neighborhood health centers and HMO's. I could envision social workers, trained and supervised by liaison psychiatrists and funded by linkage grants to CMHC's, approaching private general practices located in the catchment area.

A second approach could take advantage of the Blue Cross reimbursement policy already in place whereby hospitals build into physician outpatient fees the cost of social work time. This could

be expanded to Blue Shield coverage for private practices which employ social workers and could even be used for psychiatric supervision and consultation time. Direct psychiatric treatment would be funded by current methods.

Thomas Madden, M.D.:

Because of the absence of a universal primary care service in the U.S.A. there exist large areas where both physical and mental health care are lacking. It seemed to me that the Conference gave very little attention to this specific problem, although its existence is probably the main reason for such a conference being necessary at this time. These needs are made acute by what is happening in many individual States. For what appear to be purely fiscal reasons, rather than the beneficent effect of modern therapeutics or a fashionable concern for "community care," old long-stay Victorian units are being systematically emptied out. They are not attractive or suitable places for mental health care, they promote chronicity, they often provide the worst of care and have the least* skilled and the least rewarded staffs; but it is certain that in the community, facilities for care are usually lacking and the receiving community is often quite unprepared and unwilling, both in terms of arrangements and attitude, to receive or welcome. (*I throw no stones. It is the same at home.)

An important priority will be the need for half-way houses, protected living and working environments, hostels, etc; and let us hope once again that such facilities will not all or even mostly be sited in the old and decaying neighborhoods; for in both countries the attitude seems to prevail that areas which have become habituated to tolerating anything may be allowed to tolerate everything.

Having said all this, I would not welcome special units, teams, solutions for immediate need without considering what might be their effect 5 to 10 years ahead. If such are set up, their existence must not later be used as justification for saying that there is no need for primary care, for a supply of family doctors, for example.

(3) Provider Roles and Skills.

Carolyn B. Robinowitz, M.D.:

. . . Certain issues of quality should be studied and addressed. There are implications about quality programs related to those sixty million prescriptions of Valium yearly, as well as the accuracy of diagnosis and appropriateness of certain management plans of referral patterns.

. . . While I realize that this is both simplistic and obvious, I continue be appalled at how little attention is paid to quality or to what needs to be taught. There is a tendency in making family medicine a legitimate specialty to require that family physicians know everything that their specialist counterparts do in each area. While any educator can recognize that it would be impossible to teach and learn all this material in a three year residency program, we often behave as though we expect it of the primary care physician. Therein, I think, lies one of the major problems for the long-term viability of the field. I do worry that in our concern to develop specialist primary care practitioners capable of intervening early, promoting health education and responsibility for patients' health care and providing continuous skilled and long-term care, we may also set up demands for someone who has more knowledge and skill than it is possible for anyone to have. By making these demands (or creating these expectations in the public's mind), we are setting up the possibility of major disappointment with the real limits of the field. This disenchantment may then cause the pendulum to swing back the other way and lose support for what should be a growing and necessary field. On the other hand, the practitioner who has the sense of needing to do more and be all things to all people and experiences constant frustration in meeting this challenge may end up being a "drop-out" to enter a specialty in which knowledge and skills seem more circumscribed.

Gordon Deckert, M.D., F.A.C.P.:

First, primary care physicians in my experience do _not_ hesitate to ask me for "help" in dealing with patients in their practice. I do not find them nearly as resistant as they are often portrayed. However, in the main their first query pertains to patients with psychosomatic disorders. Their second concern usually is how to deal with the psychological responses of patients to illness, in short to what we would call adjustment reactions. _After_ these questions come questions relative to the management of patients with mental illness, as defined in the Conference (that is, anxiety reactions, the depressive spectrum, schizophrenia and thought disorders, alcohol and drug problems). Depending upon the study, 25% to 30% of patient visits to primary care physicians fall into this latter

category. The priorities of primary care physicians must be considered when we approach them and by emphasis they have not been the priorities of the Conference, in my opinion.

In my experience, primary care physicians do not need to be convinced that a large share of their practice falls into the arena of what I call "psychological medicine." The skeptical physicians are those in health sciences centers. What primary care physicians in practice are skeptical about relates to the quality and practicality of the offerings from the mental health professions. From long experience they have discovered that most continuing education programs or educational approaches to them tend not to be very practical or helpful within the context of their particular practice. I am really quite convinced that physicians in practice are much more sensitive to the problems in their practice than the data would indicate but like most physicians they tend to record information and make diagnoses in categories for which they feel they can offer some assistance. In many instances they simply do not know how to be helpful to certain categories of patients with psychological problems.

Thomas Madden, M.D.:

It is necessary to examine and draw conclusions from the work of Darrell Regier and his colleagues. Their work shows that, in much the same way as the ubiquitous GP of the United Kingdom system, the primary care doctors of the U.S.A., be they internists, pediatricians, ob/gynecologists, old-style G.P.s or the new generation of family doctors working the community (the latter, I believe, with more skill due to better preparation for the task), _are_ providing a service accounting for the majority of requirements, in those areas at least where such doctors are to be found. They are in fact handling a major part of the mental illness in the community and providing continuing care in those more serious cases, in which specialist doctors and institutions are only episodically involved.

It is important to examine what help, what resources, what further training these physicians need.

. . . With regard to 'feeling unwell,' whether expressed in somatic or psychiatric symptomatology, a well-known study in the Guy's area (Wadsworth, Butterfield and Blaney, 1971), showed that, in a borough regarded as well-served by family doctors, local authority and hospital services, only 5% of a survey sample reported no complaints in the 14 day period prior to being questioned: _complaints for which for the most part they had not considered it necessary to consult any doctor_. While this and similar enquiries have encouraged speculation as to undiscovered illness which it would be desirable to treat, they have not been held to indicate that all symptoms require referral and that there is no place for reasonable self-management.

. . I observe that many sections of the U.S. public have increasingly come to seek medical and specialist advice by self-referral; and that this public may need to learn from a new generation of primary care (and here I think particularly of family) doctors to accept the advantage of having a continuing and independent advisor. They may need to be educated to the idea (and still more to accepting in practice) that many problems do not require a physician at all. This they may learn from members of the primary care team, each with their own skills, their own daily schedules, whether in office or home nursing, in obstetrics, in health education, in social work or in data collection and management. From personal experience of working in this manner, I believe that many of these professionals do many things much better than doctors. A recent article (NEJM 298, Jan. 19, 1978, pp. 130-135) suggests that in the home management of acute pediatric illness by telephone, nurse practitioners performed significantly better than either house officers or practicing pediatricians . . .

Morris B. Parloff, Ph.D.

One of the most useful services that the mental health practitioner might provide to his PCP colleagues is to reassure them that it's OK for the PCPs not to hold themselves totally responsible for the "total" care -- physical and mental -- of all of their patients. The stresses associated with accepting society's wish that the physician be omnipotent and omniscient are enormous. The physician's willingness to be seduced into accepting this role requires "treatment." Acceptance of such responsibility represents a potential danger to the mental health of the physician and to his/her patients. The physician who truly subscribes to the injunction to treat the "whole person" unassisted must be dissuaded from the vision of the doctor as family practitioner, which is best left to the movie and video screen rather than to "real life."

The hard-earned wisdom that permitted the ancient Greek gods to give up being physicians must not elude modern physicians, who appear to wish to fill what they mistakenly believe is a job vacancy.

. . . What was made clear is the fact that primary care providers (PCP) are often the first professional clinicians to encounter evidences of an emotional or developmental problem in their patients. What is less clear, however, is the nature of the assumptions and motivations that underlie the decisions by most such practitioners to undertake to "treat" these problems by themselves rather than to refer relevant cases to mental health specialists.

The proportion of diagnosed psychiatric disorders currently treated by nonpsychiatrically trained physicians is frighteningly large with estimates ranging from 54 percent (Regier) to 72 percent (J. Coleman). The credibility of these figures is lessened by the fact that the diagnoses were made by the self-same nonpsychiatrically trained physicians. . .

. . Whether the non-mental-health-trained physician does in fact treat mental disorders in such grand numbers is of less concern to me than the fact that such practitioners believe that they are doing so and are quite willing to continue to do so. The basis for their apparent reluctance to make referrals to mental health specialists was only touched on but not adequately discussed. As a consequence it is not clear that what may appear to be a problem for the mental health practitioners is thought to be one by the PCP.

. . . An assumption that was little challenged was that the nonmedically but fully trained mental health practitioner was to be assigned less credibility as a reimbursement-eligible therapist than the medically trained practitioner who was essentially unschooled in the field of mental health practice. An interesting rationale was offered for this distinction and one for which the nonmedical practitioner may have to bear some responsibility. The nomedical mental health practitioners have, rightly or wrongly, become identified with the kookier forms of "psychotherapy," such as nude marathons, encounter groups, body therapies, meditation, yoga, primal therapy, biofeedback, etc. Physicians, on the other hand — even if they participate in such practices — are sustained by the authority of their profession and their acknowledged ability to dispense serious medications and to make somatic interventions. Society has long delegated to the physician the authority to treat and to heal the ill. Nonphysicians who elect to define the consumers of their services as "clients" rather than "patients" and who prefer to conceptualize the problems to be treated as "problems in living" rather than evidences of ill health may indeed have jeopardized their eligibility under current narrow interpretations of health insurance.

Implicit in this issue is the identification of the medical practitioner with the goal of amelioration and cure of disorders and the nonmedical with the goals of enhancing and optimizing functioning. The professions may be moving toward a division of turf that may not yet be recognized by its memberships.

Moreover, the distinction is not supported by available research for there appears to be no quantitative or qualitative difference in effects of psychotherapy attributable to differences among the professions represented in the field of mental health.

Alan Jacobson, M.D.:

Another major obstacle is the "guild." It was not addressed directly but certainly lies behind much discussion and probably should be considered if not openly discussed. Do psychiatrists want social workers between them and the patients? Do they want to be auxiliary to GPs? Is there a choice?

Jean Johnson. M.S.N., Ph.D.:

. . . There is general agreement that the primary purpose of medical care is the diagnosis and treatment of pathology. Primary health care includes something more that the diagnosis of pathology and its treatment. The "something more" that the public expects of primary health care includes assistance with establishing and maintaining behaviors congruent with prevention of illness, coping with illness and disability, and problem solving throughout the life span . . .

The orientations and methods appropriate for medical care may be inappropriate for the "something more" component of primary care. Because of the knowledge gained through years of education and training, the physician is allowed to make decisions about the health state of the patient and recommend treatment in an authoritative manner. That role is what the public expects from physicians, and they are allowed to maintain authoritative power over aspects of people's lives as long as they are perceived as trustworthy and benevolent. The authoritative approach is inappropriate for the "something more" components of primary care. Those components require that the responsibility for decisions and actions lie with the patient. The health care provider's role is one of assisting patients to make decisions and maintain behaviors so that they achieve their goals and experience satisfaction. The divergent expectations of roles makes it unrealistic to expect physicians and patients to alternate between the two orientations. One might expect that many physicians would maintain the orientation and methods that are central to their primary purpose when delivering the "something more" component of primary care . . . Physicians' discomfort with peoples' dependency on them for non-medical but health related aspects of their lives and peoples' lack of satisfaction with the help they received may have contributed to the decline of the practice of generalized medicine.

The "something more" component of primary care has always been a part of nursing and recently it has become central to much of the practice of nursing. Primary health care is an area of specialization for nurses with the highest practice degree (Masters) in nursing at this time. There are a number of nurses who are prepared to collaborate with physicians in the delivery of primary health care. Collaborative practices exist and reports of demonstration of the effectiveness of such practices are in the literature. Many believe that the goals of primary health care can be achieved by nurse-physician collaboration but that the relationship between the health care providers must be collegial rather than nurses being subservient. Barriers to growth of a collaborative model for providing health care include inter- and intraprofessional rivalry, professional practice acts which prevent nurses from being responsible for the full scope of their practice, policies with respect to reimbursement for services, and government policy and practices with respect to

support of health manpower training. If the barriers could be overcome, both the quantity and quality of nurses prepared to enter into collaborative primary care practice would rapidly increase. Some assurance of employment suitable to one's preparation would attract nurses to the nursing specialty of primary health care. Quality of the educational programs would increase as the role of nurses in the delivery of primary health care became more uniform.

(4) Education and Training.

Carolyn Robinowitz, M.D.:

One particular problem which I think needs much more detailed attention is the issue of education and quality. These are not simple turf issues as who should teach what, or how much or for what proportion of the curriculum, but a way of clarifying the very specific behavioral goals and objectives and what it is we hope the primary care practitioner will be able to do. It may be simplistic to talk about interviewing skills for communication, yet these are minimally taught in pediatrics and rarely, if ever in internal medicine, at least on the graduate level. In family medicine programs there is more attention to interviewing, but sometimes the basic behavioral scientists who present information about patient-doctor relationships and interviewing skills neglect to provide the particular kinds of tie-ins to clinical service delivery.

Phenomenology is another important topic. The practitioner needs to have some understanding of signs and symptoms, certain behaviors and constellations of behavior which lend themselves to clinical pictures and diagnoses, with implications for treatment, not only of emotional illness per se, but also to ascertain how the patient will deal with the disability of illness. This goes beyond self-awareness -- important and needed as it is — and the kinds of attitudes that support empathy, and includes a much stronger scientific knowledge base and ability to apply the data collected. This approach has implications beyond diagnostic nomenclature to treatment plans. While ideally we would hope the primary practitioner could manage as many of the problems of his or her patients as possible, in reality we do not expect primary care givers to choose to, or for that matter even be able to, manage all of the emotional complaints of their patients. Consequently, referral takes high priority. Practitioners should know the limits or level of their competence and ability to treat and when to refer. Some of the referrals may be for consultation and assistance in management with the implication and expectation that the patient remains theirs for management of both the emotional and physical illness. In other cases the referral will be for the management of the emotional illness per se. The practitioner should have sufficient knowledge and skill to make this referral in a way that supports the likelihood of the referral being followed (that is the patient actually seeing the psychiatrist), and that it be done in a way that facilitates whatever evaluation and treatment needs to take place. This, to my way of thinking, is one of the most difficult skills to learn. Perhaps some of its difficulty lies in the discomfort many primary care physicians feel with any referrals. Not only does referral imply that they've failed — that is that they can't handle something themselves -- but there may be the stigma or discomfort in terms of the practitioners' understanding of mental illness with a sense of futility and hopelessness aboout outcome.

Obviously this involves attitudes and stereotypes as well as knowledge; but if we teach for increased diagnostic skills and sensitivity, we have to expect case-finding will also produce a higher number of referrals for more specialized care.

Last but not least, they will need to know and understand the various aspects of treatment. There is a wealth of literature about use of drugs, their side-effects and interactions with other medications. This is vital and often neglected even by primary care physicians. In addition, they need to develop skills in techniques of psychotherapy or counseling, and also some notion that these techniques are learned over a long period of time (for example most graduate psychiatrists learn psychotherapy over many years); they should be encouraged to develop some kind of peer (or more formalized) supervision of this skill.

. . . We need to deal with not only core curriculum or training experiences in residency, important as they are, but whole medical school experience and more appropriate role-modeling (keeping in mind that most research on role models demonstrates the high degree of importance of negative role models). Social issues with impact on medical care and implications for funding, training, and practice patterns need to be assessed in light of current economic realities.

. . . In this we should consider what the unique or particular capabilities of the psychiatrist are or address the real differences between physician/clinician and behavioral scientist.

This is not to say that there is no place for behavioral scientists, but in many cases, less clinically trained mental health personnel are used to provide teaching or care at less cost. In some cases they provide excellent training or service; in others they form poor role models for the primary physician who does not learn to integrate mental health principles into ongoing practice activities or who never understands the interrelationshps between psyche and soma, the appropriateness of multi-disciplinary approaches such as pain management, psychosomatic disease, concomitant and other medical diseases and so forth.

Neil J. Elgee, M.D.:

(1) Teach the teachers (per David Goldberg) . . .

(2) Teach psychosocial diagnosis to medical students, primary care doctors, nurse practitioners, physician associates, all in training and in continuing education.

(3) Emphasize diagnosis and treatment of depression.

(4) Emphasize the pharmacology of psychiatric medications.

George J. Cohen, M.D.

One area that we did not touch in depth was the education of the primary care providers. There was some concern that too much of the emphasis, both medically and psychiatrically, is on the inpatient rather than the outpatient. Another concern is that there is so much information available in both fields that the student at whatever level can feel overwhelmed. Educational methods are important to consider and perhaps advice from educators might be of help. I think all of us recognize that the acquisition of skills requires both observation and a great amount of practice under supervision. Hopefully more and more of this is occurring in medical schools as well as in residencies, with continuing experience in following an emotional problem from presentation until resolution under close supervision and counseling from an experienced therapist. A certain amount of basic didactic material is essential as are group discussions and the personal experience with consultation and collaborative efforts between the mental and medical health people.

Gordon H. Deckert, M.D., F.A.C.P.

I am on the receiving end of a constant stream of complaints about mental health professionals, especially psychiatrists, even from those physicians in areas surrounded by a plethora of psychiatric or mental health professional talent. The central theme of their complaint is that most psychiatrists, overwhelmingly most psychologists, and certainly most psychiatric social workers simply do not know how to work in a primary care setting. Many of them have made the observation that national policy has even discouraged the training of individuals toward this end. There has been an attempt through policy to train mental health professionals to work in community mental health centers, in other designated mental health facilities but <u>not</u> conjointly with physicians in the general health care delivery system. This complaint and this problem as viewed by primary care physicians must be kept in mind as we work toward the training of psychiatrists, psychologists, and social workers. In my view, there must be an emphasis for training these mental health professionals in the context of primary care sites. Psychiatrists and psychologists will not learn how to work effectively with primary care physicians simply from assignments to inpatient units, outpatient psychiatry clinics or community mental health centers.

. . . My final series of comments relates to the <u>training of primary care physicians</u>. I have met with considerable success in this regard, at least in terms of receptivity . . . There are certain themes that I have found useful in approaching primary care physicians. I will outline a few of these in this letter. Perhaps most essential to convey, at least in my experience, is a certain <u>conceptual task</u>. Primary care physicians have been captured, to use a concept from physiology, by the stimulus response specific model which indeed has captured most of medical education. Psycho-

logical medicine cannot be practiced with this model in mind. Rather, one must use the individual response specific model. In my experience, until this concept is thoroughly grasped by my workshop attendees, they will continue to ask such unscientific questions as "How do you treat depression?", "How do you treat anxiety reactions?", etc. Once they grasp that we do have something specific to offer in terms of process when one approaches a specific kind of patient who presents with a specific constellation of findings, we are off and running. The next major theme is the perceptual task. By this I mean that many physicians simply do not see the evidence for primary emotions in the fact in front of their face. They are much better at hearing evidence but they are relatively unskilled visually. They are in the situation of not seeing data and hence not making the precise diagnosis and hence not treating certain patients effectively. They would be in a similar situation with other patients if they did not feel the enlarged liver or did not hear the presystolic rumble or did not notice the elevated white count in a lab report. I'm not speculating in making this observation. Many physicians simply do not see subtle evidence for anger in women or fear and/or sadness in men. The educational experience of most medical students in most medical schools and certainly in most primary care residencies is such that they do not discover the recognition rules taught them by their culture, rules which they brought to medical school or to postgraduate residencies or whatever. Finally, unless one can bring some model for therapeutic intervention all of the above comes to naught. I have evolved a model of therapeutic intervention which I call "The Therapeutic Sequence" which seems very helpful in didactic sessions with primary care physicians. This is all outlined in a chapter on "Interviewing Techniques" in the latest Textbook of Family Practice published by Saunders and edited by Conn and Rakel.

Morris B. Parloff, Ph.D.:

An oft-repeated "solution" was that of providing the physician with additional training, but there was no agreement on what the physician was to be trained to do. Recommendations ranged from providing broader training in the behavioral and social sciences (presumably to promote a more humanistic approach to patients); improving diagnostic skills to permit the physician to undertake triage in determining whether the patient's problems required specialized attention; or enabling the physician, independently, to provide effective treatment of the full spectrum of emotional disorders.

In my view it would indeed be appropriate for physicians in the course of early academic training to receive information which might permit them to differentiate among the following classes of problems: 1. those problems that will improve over time with or without formal psychiatric intervention (e.g., crisis reactions, sadness rather than

depressions, phobias in young children, etc.), 2. problems which require treatment lest the condition worsen or the patient become more vulnerable to stresses, and 3. problems which are best treated by the PCP or other non-mental health professionals lest the fact of referral act to confirm the patients' fears that they are suffering from pathological processes when in fact they are confronted with everyday problems of "normalcy" or "existential problems of living."

Mack Lipkin, Jr., M.D.:

Teaching about integrated care is presently difficult. In Rochester, despite the presence of a nationally recognized group with a charismatic leader, the impact on the overall organization of care has been extremely variable. For the most part, trainees in this institution behave predominantly in ways similar to the prevailing biotechnical culture.

Our analysis of this problem leads to the following conclusion. In order to affect behavior (as opposed to lip service ideology) of trainees, the important behavioral levers which control their behavior must be managed. Most significant is the role of the practice culture. Here, the role model concept is useful, but errors have been made in recognizing who the role models are. The attending physician is one. However, in the tertiary hospital, the housestaff themselves provide their own role models. Students, as well, look up to the housestaff. Thus it is our belief that a role model cascade is necessary in which a core group of those capable of producing integrated care influence housestaff and attendings, as well as students.

Learning in this area is difficult because the concepts are complex and painful; exhausting psychological effort is involved in applying them; and, at present, the prevailing disease oriented culture is not hospitable. To counter these deterrents, trainees need to experience positive integration oriented learning at each level of their growth.

What is needed, then, is a cascade of role models -- a critical mass of model professionals, people who believe in and can cogently practice integrated care. As well, model services are needed which prove, in their structure, belief in integrated care. Both model professionals and model services must stem from a conceptual framework in which the case for integrated care is clear and convincing. This then must also reach the curriculum and every clinical teaching service. This is seldom a priority, as services stem from analytic discipline and integration stresses synthesis.

Government roles in relationship to development of an integrated conceptual framework, curriculum, model services and model professionals can be multifaceted. Centers of excellence are needed to train teachers.

Money is needed for research in the applied issues of integration of care and the underlying basic scientific issues. Money with strings attached in terms of training and service formation could be very helpful in providing opportunities for those with skills in this area to achieve some potency in the presently biotechnically dominated teaching institutions. Especially needed is career support for mid-level persons in this area, since otherwise they must get support from other kinds of activities.

. . . Finally, the notion of the great potential marginal gain in this area was mentioned. At this point in history, relatively small investments in centers of excellence, training of teachers, and creation and study of model services can well be expected to produce large gains relative to the costs. This is a major argument for well-targeted government support, at this time, for study of integration of care.

Thomas A. Madden, M.D.:

Primary care providers: helping the helpers

The resolution of these problems does not require (as some speakers seemed to imply) investigations into "Who should provide?", or even "How well do the present providers perform?" (although this is a very interesting subject), or into "What types of new institution will be needed?" Even to set out in such a direction may imply that one has in effect already concluded that the present primary care doctors ought not to continue to do the job, a decision which defies both logic and experience elsewhere. The question ought rather to be: How may they be helped to do it better?

I do not write as an English family doctor, when I say: Begin with the primary care doctors that you have. This is certainly the least costly and most practical way to go. Whatever the present inadequacies of provision and cover, solving one problem in health is often the way to solving more. Hence the long-term answer in the mental health sphere is precisely the same as that for any other aspect of health: the provision of adequate primary care for all areas and the training of physicians and other professionals for this work.

This continues to have implications for the medical schools in training (and far better than heretofore) the future primary care doctor and in assuring a proper supply of such doctors to the communities. Our workshop particularly emphasized the need for medical studies to include: (1) the patient in the family context and (2) the patient in the community.

Alan M. Jacobson, M.D.:

The move toward primary care oriented psychiatry, in whatever form this takes, necessitates a shift in the ego ideal of psychiatry and therefore a restructuring of psychiatric training. If, to paraphrase the Bauhaus expression (Form follows function), training follows money, policy recommendations should encourage NIMH stipends for primary care psychiatrist training either as part of the general residency or as fellowships in PGY 4 and 5.

(5) Quality of Care Issues.

Morris B. Parloff, Ph.D.:

Quality of Care and Professional Affiliation

It seemed odd to me that so little interest was expressed by either the primary care provider or the psychiatrist in determining the quality of mental health services which, according to claims, are being so promiscuously and effectively provided by the nonpsychiatrically trained physician in treatment sessions limited to 13-20 minutes each.

There also appeared to be no enthusiasm for the notion that research be undertaken to assess the quality of care offered by the PCP by comparing the relative effectiveness of the PCP and the mental health specialist in treating specified classes of emotional problems.

While the psychiatrists seemed to be excessively modest in commending to their medical colleagues the value of specialized mental health training, they appeared considerably less diffident with regard to their special competence relative to their nonmedically trained mental health practitioner associates.

Evidence of the Effectiveness of Psychotherapy

In casting about for evidence of the efficacy of psychotherapy, a rather oblique set of data were presented, intended presumably to impress the PCPs and the authors of potential health insurance legislation. The evidence presented was not that the specialized practice of psychotherapy is demonstrably effective in ameliorating the discomfort of the patient and enhancing his/her functioning, but rather that psychotherapy provides a cure for excessive utilization of medical facilities. While the evidence is clear that some emotionally disturbed patients make excessive use of medical facilities and that appropriate psychiatric care may reduce such inappropriate drains on medical resources, this fact appeared to be less impressive to private practitioners and physicians working in community mental health clinics than to those in HMOs.

Concern about the patient's welfare requires that the patient be provided appropriate medical care rather than simply less medical care. The persistent efforts to justify mental health services on the equivocal evidence of cost-offset is not only unpersuasive but promises to be ill-advised. Costs should continue to be of lessor priority at this stage of the field's development than evidence regarding the quality of care provided.

Neil J. Elgee, M.D.:

My main concern is that we seem to be implicitly accepting as a given, in the administrative and political context, the complete

whole undifferentiated spectrum of "psychiatric services" -- like buying and administering a package. . . I am not persuaded that an analytic hour with an M.D. represents quality. In Camelot, it is true, I would be in favor of everything we discussed and everybody's program. I fear, however, if we promote undifferentiated psychosocial services, we may fail to get much of anything at all or may dilute the good with the undifferentiated. As of my present reading of the situation, I would want to concentrate.

George J. Cohen, M.D.:

Certainly as we all agreed there is a gut feeling that most of us have and which is often expressed by patients that attention to emotional areas is really important and helpful. Evaluating modes of delivering such care is difficult, first, in establishing criteria for diagnosis and treatment methods, second, in recognizing cultural variance, third, in finding some sort of control population to compare against the treatment population in terms of attitudes and outcomes. Which outcome item to use is another concern. The number of visits for non-psychiatric complaints was shown to have many many flaws. If we don't consider the variation in training, experience and interest of the primary and mental health therapists, comparisons are virtually impossible. Another important item to consider is the initial state of physical and mental health of the patient and whether an increase or decrease in utilization is a goal.

(6) Research Needs.

Neil J. Elgee, M.D.:

/I would/ support research in all aspects of psychosocial disease. Justification for wholesale delivery of therapeutic interventions is not yet persuasive and should remain in the research arena.

Vincent J. Felitti, M.D.

. . . It is clear that a pluralistic system is already in place — the relationship of psychiatry to primary care already exists in the solo practice sector, in HMO's, in university settings, and in group practices. We don't need to know what to do, we are already doing it. What we need is to know what works best and where to allocate future resources.

I was quite disappointed during the meeting to see that there was so little interest in studying the outcome of the integration of psychiatric services into primary care settings. . . A number of important questions need to be answered and the HMO setting provides a unique opportunity to do this because for the first time a large closed system is available in which the complex ramifications of psychotherapy can be studied. The simple fact of having a unified medical chart serving all specialties is a sudden, significant advantage.

Should entry into the psychiatric system be patient determined or only by referral from a provider? Should it be passive, or should an outreach program be used? What types of therapists are most cost effective? Are social workers, psychologists, and psychiatrists interchangeable as psychotherapists or not? How should triage be done and by whom? What types of therapy are affordable and demonstrably effective? What should be the limit on duration of therapy? There is a small amount of significant information (e.g., Malan, D., Archives of General Psychiatry, November 1976) indicating that a one time visit may be significantly beneficial. What measures of effectiveness of therapy do we have? Two issues need to be addressed here. The first is the effectiveness of therapy to the patient and the second is the effectiveness of therapy to the overall system. Does effective psychotherapy decrease perverse medical utilization? Does ineffective psychotherapy increase it? Clearly outcome studies are not only difficult, but resisted. Some of the difficulties, and none of the resistance, may have been reduced by Hans Strupp of Vanderbilt University who had an important article out recently. He describes using a tripartite system which makes diagnostic use of those very issues that had always been a source of disagreement and confusion in the past.

For the first time a major undertaking is underway relating psychiatric treatment to general medical care. If, in a flurry of goodwill and good intent, the outcome of this is not studied we shall have missed a golden opportunity.

Thomas A. Madden, M.D.:

. . . I consider it important NOT to devote research funds to the development of ever more sensitive indices of personal misery and dysfunction, such as might tend to show that 90% of the population 'could do with' brief or longer psychotherapy (however defined). To follow such a direction would be betrayal of those in need, when so many serious problems, untouched let alone unsolved, abound in so many countries and here.

. . . In the sphere of research, it is necessary not merely to look at what specialists think primary care doctors ought to do, patently cannot do or do badly; but at the subtly acquired skills which many excellent family doctors may have evolved, intuitively rather than by Balint seminars, and from experience; a product of continuity of care, familiarity and human involvement. At the Institute of Psychiatry, such an approach has been made by Dr. Norma Raynes, a sociologist and anthropologist who has developed interesting techniques of direct observation. (In publication)

. . . In any comparison of the results of therapy by drugs, with or without psychotherapy, it is necessary to look at a much more important and complex dimension, that of the patient's coping resources; to build into the enquiry, however difficult, some measure of the patient's position in the social network as a factor strengthening individual resources and chances of recovery. In the wider sense, this means family, friends and neighbors, even the members of the primary care team or lay counselors. As it happens, there is work precisely on the topic of post infarction career and the use of lay counselors. A useful reference is Angela Finlayson's "Social Networks as Coping Resources" (Social Science and Medicine, Vol 10, pp 97-103, Pergamon Press, Great Britain, 1976).

Need, not entrenched interest, skillful lobbying or special pleading should determine priority. With such obvious and gross needs, to some of which I have alluded, one would not want to encourage inquiry into, say, the wide range of normal mood changes reported as pathology by hypersensitive surveys.

In research, as the whole volume of Michael Shepherd's work and his talk to the Conference reveal, the cooperation of teaching hospital and practicing community doctors becomes a two-way process. The learned institute acquires a population for its study which is not selected, hospital-based. (In this case, it was the Maudsley

doctors who first acknowledged the existence of a very large and ill-defined 'psycho-social' group of patients known to G.P.s but not at that time to hospitals.) Conversely, I believe that every G.P. who has participated in any part of that work, now over many years, has thereby sharpened perception and skill in management.

Alan M. Jacobson, M.D.:

Offset is a dangerous outcome variable for psychiatric research in primary care settings. I would instead suggest funding for replication of Goldberg's and Shepherd's intervention studies in U.S. settings. Outcome variables developed for these and recent U.S. psychotherapy outcome studies offer a variety of measures which could be used in addition to offset of medical utilization.

Morris B. Parloff, M.D.:

A major concern of the conferees appeared to be service delivery and providing some advocacy for the alleged advantages of particular delivery systems such as neighborhood centers, CMHCs, HMOs, private practice, group practice, team functions, etc. This all appears to be predicated on the belief that knowledge regarding the efficacy of the techniques to be delivered has already been well established. Little attention was paid to the prior question of establishing the efficacy of treatment techniques under ideal conditions. This step is prerequisite to any research which attempts to establish the adequacy of the treatment delivery systems since such research confounds efficacy of treatment with adequacy of delivery.

Mack Lipkin, Jr., M.D.:

Research concerning integrated aspects of care has been touched on in the conference. However, certain issues were not focused on with depth. One of these is the need for greater clarity about the underlying conceptual models or paradigms being employed. Second is the need for meaningful population-based studies with a problem (as opposed to diagnostic) orientation. Third, there is a need for outcome measures which measure goals of care systems in contrast to present haphazard specialty-based goals or the equally mindless body count approach.

(7) Social Support Systems.

Marie Killilea

Although the importance of supportive others in times of crisis has been recognized for many years, the use of personal and social networks in health and mental health clinical practice and research, and in the design of services, is a relatively new occurrence.

Social support systems include naturally occuring helping networks which often seem to be invisible because they are so much a part of the fabric of our lives. Help is given and received outside the structure of human services agencies. This help is based on a commitment of reciprocity and exchange, e.g., within the family; in kin and friendship networks; in neighborhood helping networks. In addition to these fluid, unbounded networks, there are more organized structures of informal social support, e.g., self-help groups such as Alcoholics Anonymous; person-to-person mutual aid such as Widow-to-Widow programs; cross-age helping programs such as Foster Grandparents; peer-oriented helping programs such as school peer counseling activities; alternative community service programs such as hospices and shelters for battered families.

These social support systems are inherently sensitive to cultural and subcultural variations and build on preferred patterns on help seeking and help accepting.

Many community institutions which have other objectives as their primary mission in society also have important social support functions; e.g., the workplace, the church, the school, and the medical care institution.

Operational definitions of social support include Sidney Cobb's: that social support is information that tells a person that he/she is loved, valued and is part of a network of communication and mutual obligation; and Gerald Caplan's: that support systems are attachments between individuals, and between individuals and groups, that a) promote emotional mastery; b) offer guidance about the field of relevant forces, expectable problems, and methods of dealing with them; and c) provide feedback about behavior which validates identity and fosters improved competence. The processes of social support have emotional, cognitive, and instrumental components.

Several reviews of research studies, including the Task Panel Report on Community Support Systems of the President's Commission on Mental Health, have found that the cumulative evidence suggests that social support may play a major role in modifying the deleterious health effects of stress, in influencing the use of health services, and in affecting other aspects of health behavior such as adherence

to medical regimens. Underlying these studies are several alternative hypotheses: that social support has a direct effect on health; that social support provides a buffer against the effects of high stress; or, that social support has a mediating effect which stimulates the development of coping strategies and promotes mastery.

The evidence from these studies, and the new questions raised by them, points to directions for the future. There is a need: to develop the research base, and to experiment with pilot and demonstration projects on the relation of social support, stress, health and the utilization of health and mental health services.

In the United States, the family is the chief decision-maker about health care and the major purchaser of health services, rather than government which essentially is only a payer for medical services rendered. The lay referral network (how people get to services) and the lay treatment network (including self-care; mutual help groups and other social support systems; and the wide variety of community institutions that are not labeled or identified in our society as health care institutions, but which may be very much involved in health promotion, health maintenance and even, at times, health services delivery) should be topics on the agenda to be seriously considered when we are thinking about the future. While there are not at the present time many models of the medical care system stimulating the development of social and community support systems, where they are absent, to address pressing health care needs, some examples do exist and should be further explored. With the prospect of national health insurance, the necessity of finding effective ways to link health and mental health services with effective social and community support systems becomes of crucial importance.

APPENDIX D

Institute of Medicine Staff

Delores Parron, Ph.D. -- (Conference Coordinator)
Associate Director, Division of Mental Health and Behavioral Medicine

Fredric Solomon, M.D. -- Director, Division of Mental Health and Behavioral Medicine

Elena Nightingale, M.D. -- Director, Division of Health Promotion Disease Prevention

Naomi Hudson, Secretary, Division of Mental Health and Behavioral Medicine

Susan Egerter, Research Associate, Division of Mental Health and Behavioral Medicine

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