To explore the challenges and key policy issues of three areas of mental health treatment that have experienced promising advances in recent years, Health Affairs commissioned the following three Perspectives. The subjects include depression and anxiety treatment in the primary care setting, psychiatric pharmacology, and psychiatric rehabilitation.

Treating Depression And Anxiety In The Primary Care Setting
by Leon Eisenberg

There is a considerable gap between the knowledge gained from clinical psychiatric research and the application of that knowledge in the everyday world of general medical practice. Although what we do not know far exceeds what we do know in psychiatry as well as in medicine, there have been considerable advances in our understanding of the psychosocial and biological causes of mental disorders and of the ways of treating them. The effectiveness of treatments for depression and anxiety have been validated by controlled clinical trials. These interventions reduce symptoms and restore personal effectiveness—not for all patients, but for many; not always, but often; not forever, but for substantial periods of time. Yet many patients who could benefit from treatment are not being treated. Why? What can be done? The reasons care fails to be effective are many, but health policy considerations figure prominently among them.

Obviously, psychiatric care is not available to patients who lack access to doctors—that is, to those thirty-eight million Americans without any public or private insurance and to those who are underinsured for mental health care. The nation's failure to correct this injustice shames us all. However, that problem is not specific to mental health, even though it discriminates against psychiatric patients more than against other patients because of the limitations in public mental health services. The issue I address in this essay is the following: Even patients who do have access and who do consult physicians are likely to miss out on care for their mental symptoms.

The gap is found in doctors' offices all over the United States. Psychiatric disorders cause suffering and functional impairment among patients seen in general medical care practices. All too often the source of the patient's complaints is not recognized. When it is, treatment comes from the primary physician. Yet even though depression and anxiety are among the most common problems physicians encounter among outpatients, generalist physicians are poorly trained to diagnose and treat them. Further, the way doctors are reimbursed by third-party payers penalizes the conscientious practitioner who undertakes appropriate clinical management. The result is predictable: Underrecognition and ineffective care persist, despite careful clinical research demonstrating that depression and anxiety can be treated effectively by drugs and psychotherapy.

Leon Eisenberg is Presley Professor of Social Medicine and professor of psychiatry at Harvard Medical School in Boston.
Prevalence

Studies of primary care medical practices find a substantial amount of psychiatric morbidity among patients who consult their doctors. Some present frank psychiatric symptoms; others present complaints for which no identifiable biological cause can be found; still others have symptoms that are out of proportion to their medical conditions. Studies of general practice find rates of diagnosable psychiatric disorders that range from 11 to 36 percent. According to the National Center for Health Statistics, there were 692 million visits to physicians' offices in 1989. If only 11 percent of those visits were for psychiatric disorders, that yields an estimate of more than 75 million physician encounters; if the correct percentage is 36, then the estimate rises to 250 million visits. The policy question is, How many of those encounters are “legitimate” visits to the doctor?

Morbidity

Some data exist to address this question. In one study Kenneth Wells and his colleagues evaluated some 11,000 outpatients enrolled in one of three health care systems at one of three sites. As they enrolled, patients completed screening questionnaires designed to identify depressive disorders. Those whose response scores exceeded a designated value were given a structured diagnostic interview by telephone, designed to identify depression by accepted psychiatric criteria.

The characteristics of patients with current depressive disorders were contrasted with those of patients with one of eight other chronic conditions: hypertension, diabetes, advanced coronary artery disease, angina pectoris, arthritis, back problems, lung problems, or gastrointestinal disorder. On comparisons of physical, social, and role functioning and days in bed, the depressed patients were worse off than the medical patients in seventeen out of twenty-four comparisons. Although patients who met the rigorous official criteria for major depression were more disabled than were those whose depressive symptoms were not severe enough to meet cutoff scores, the symptomatic patients themselves had serious impairment in physical, social, and role functioning—more so than most of the chronically ill patients except those with heart disease. Patients suffering from chronic medical conditions plus depressive symptoms were the worst off.

A research team from Duke University examined the relation between depression and disability in a community sample. Eugene Broadhead and his colleagues carried out a one-year follow-up on some 3,000 individuals who had been diagnosed as having either major or minor depressive disorder in an Epidemiologic Catchment Area study. At follow-up, persons with major depression had a risk of disability four and one-half times greater, and those with minor depression a risk one and one-half times greater, than that of asymptomatic individuals in the community. Because of its greater prevalence, minor depression resulted in 50 percent more disability days than did major depression. The investigators also noted a high frequency of comorbidity between anxiety disorders and depression.

In a third demonstration of the medical significance of depression, Barry Rovner and colleagues examined 450 consecutive admissions to a nursing home. Research psychiatrists diagnosed one in eight persons as suffering from major depressive disorder; staff physicians recognized few of these cases and treated fewer still. Within twelve months of admission, depressed patients were one and one-half times more likely to die than were nondepressed patients carefully matched for the severity of other medical indicators.

Recognition Of Mental Disorders

Providers’ role. The next question is, Do primary care providers recognize the presence of psychiatric disorders? A number of investigations have addressed this question. Because of differences in criterion measures, estimated rates of failure to detect have
ranged from 45 to 90 percent. Clearly, the diagnostic skills of many generalists are inadequate to the task. Yet these are the only providers of mental health care for most patients.

Reasons that generalists fail to recognize psychiatric disorders are fairly easily pinpointed. One is that current medical education prepares new physicians inadequately to diagnose them. Most schools provide one month of psychiatry during the final two clinical years; that is, less than 5 percent of clinical instruction is devoted to a category of patients who make up 20 to 33 percent of primary care practice. At that, the clerkship is commonly sequestered on an inpatient service with psychotic patients rather than being offered in an ambulatory setting in connection with general medicine. The problem, however, is more than a simple lack of classroom attention. Rather, new physicians are shaped more by the “hidden” curriculum—that is, the values implicitly embodied by what is not taught as well as by what is, by the behavior modeled by the faculty, and by the rewards and admonishments given to students—than by the curriculum’s formal content. The message is clear when the attending physician, becoming impatient with the student who presents a detailed social history, shifts the focus of discussion to the latest lab findings.

**Patients’ role.** The prevailing culture of physicians’ office visits also may contribute to the problem, by socializing patients into underreporting personal distress to their physicians. There appears to be a covert agreement between patients and physicians that physical complaints are the only legitimate tickets of admission to a doctor’s office. In a primary care study in rural counties of California, Mary Jo Good and her colleagues found that only 20 to 30 percent of patients who had experienced emotional distress, family problems, behavioral problems, or sexual dysfunction reported those experiences to their primary care providers. Those patients who are ready to talk about their troubles often find their comments cut short by a doctor who asks the locus of the pain and its characteristics rather than about the circumstances, personal and social, under which it occurs.

Underlying factors. The reasons for underrecognition go well beyond an inadequate medical curriculum and the etiquette of being a proper patient. Many primary care patients somatize their distress; that is, what they are aware of is physical discomfort rather than overt psychological symptoms. If a physician probes their concerns sensitively, most such patients will offer psychosocial attributions; that is, they will acknowledge that personal and family difficulties may have contributed to their medical complaints. But they must be asked, and the doctor must be willing to listen attentively.

Unfortunately, some physicians collude with patients in ignoring psychiatric problems. They harbor doubts that psychiatric disorders are “real” because there are no diagnostic laboratory tests and because the findings are not “objective” in the sense that an x-ray or an electrocardiogram is thought to be. Physicians with negative attitudes toward psychiatry are less likely to recognize depression and anxiety in their patients. Some doctors are reluctant to present a psychiatric diagnosis directly to somatizing patients lest those patients become angry and seek medical care elsewhere. Such patients exist, of course; every doctor has seen them. But physicians fall back on their fear of provoking a hostile reaction, even when it is unlikely, to rationalize their failure to be up front about psychiatric matters. Both physician and patient may be uncomfortable discussing sensitive personal matters; exploring them cakes time, and time is at a premium. To be blunt about it, some doctors are themselves “somatizers;” to them, illness is “real” only when it is associated with verifiable organic pathology.

**Quality of treatment services.** In a general office practice, when a physician recognizes a patient’s need for psychiatric care, the quality of the care provided is likely to be unsatisfactory. Primary care physicians, not mental health specialists, treat patients in these settings; judged against established standards for the treatment of major depressive disorder, the performance of generalists is woefully inadequate. Patients with recurrent unipolar depression are in need of long
term treatment; they require relatively high doses of antidepressants and show additional benefit when interpersonal psychotherapy is combined with drugs. In general medical practice, antidepressant drugs are often prescribed in homeopathic doses; courses of treatment are usually far too brief; and problem-centered psychotherapy is rarely provided despite strong evidence that it is effective. Changing prevailing practice patterns is difficult. Although patients whose psychiatric problems are recognized by their general practitioners are more likely to receive mental health interventions and to have better outcomes, providing feedback to physicians about cases missed does not assure that care will be provided.

Problems In Primary Care Practice

Psychiatric disorders are underrecognized and undertreated more often because of the social characteristics of primary care practice than because of failings of primary care physicians. Indeed, family physicians themselves lament the barriers to adequate care. What is it about primary care practice that causes this situation?

Classification problems. The first difficulty is professional: Official psychiatric categories are unsuitable for use with patients seen in general medical practice. Those categories were developed to describe patients who had passed through a series of screens before arriving at the psychiatric clinic. David Goldberg and Richard Gater have illustrated just how skewed that population sample is. They estimate that one in four of the patients attending a British general practice suffer from one of the common mental disorders: “becoming anxious, distressed or depressed.” The general practitioner (GP) recognizes only about 40 percent of that group; that is, the GP identifies one in ten patients as having psychosocial problems. Of that number, only 20 percent—that is, two out of one hundred GP attenders—are treated by mental health workers. Yet it is on that unrepresentative subsample that the official classification scheme has been based.

Studies of psychiatric problems among primary care patients have a long tradition in the United Kingdom, where they were begun by Michael Shepherd; they have been pursued by a generation of students he has trained at the Maudsley Hospital in London. Studies undertaken in the United States have generated remarkably similar findings. James Barrett and colleagues examined patients seen in general office practice and found that many of them simply do not fit into the specialist’s nomenclature; mixed states of depression and anxiety are common. These researchers believe that there is a need for a “purpose-built” classification of disorders so that general medical patients can be sorted out and treated more effectively.

Adapting treatment for the primary care setting. The second quandary is clinical; namely, evaluating the efficacy of the customary psychopharmacological treatments when they are applied in the primary care context. One would believe that major depression would be as responsive to drugs in the generalist’s as in the specialist’s office. However, antidepressant drugs often must be taken for several weeks before they work; side effects are prominent well before relief is obtained. The patient, unless strongly motivated, may become discouraged and stop taking the medication before a full therapeutic dose has been applied. Also, it is less clear that antidepressant drugs work as well for mild depression as they do for major depression.

In contrast, psychiatrists provide care to a subset of patients who remain after poorly motivated patients have dropped out during the referral process; their patients have accepted the diagnosis of depression and are eager for help. Unmotivated patients remain with primary care physicians; their poor compliance may contribute to the physician’s unsatisfactory prescribing record. This cannot, however, be the whole story. Using medication effectively, whether for diabetes or for depression, is based on much more than simply filling in a prescription blank. Counseling the patient on the nature of the problem, the pros and cons of the treatment options, the risks and relative sig-
nificance of the several side effects, and the importance of active participation in decision making and follow-through are keys to the success of drug prescribing. Some generalists give these steps short shrift.

The importance of time. The third obstacle, and the one most difficult to remedy in the current health policy climate, lies in the “ecology” of primary care practice. Its economics are based on seeing as many patients as possible because the payment per visit is relatively small—certainly small in comparison to specialist fees. Physician/patient encounters last from three to twenty minutes at most and average six or seven minutes. Office design and space management emphasize relatively rapid processing of patients.

However, management strategies for patients with depression and anxiety are time-and labor-intensive. There are no shortcuts in assessing psychiatric status. Attentive listening is a key ingredient in diagnosis and treatment. Also, the patient has to be educated about the meaning of the illness and the available treatment options, their benefits, and their limitations. Adherence to medication is bound to be poor unless physician and patient work together to monitor side effects and dosages. These goals cannot be accomplished in a six- or seven-minute encounter. Useful as antidepressants are, counseling methods such as interpersonal psychotherapy and cognitive behavior therapy, whose effectiveness has been demonstrated in randomized controlled trials, are essential to enhance social function and to minimize recurrence. Psychological interventions are even more essential for the treatment of anxiety. Undue reliance on drugs is associated with dependency and iatrogenic (treatment-induced) illness. Such complications are particularly worrisome among elderly patients. Given these complexities, appropriate clinical management demands time.

Reimbursement perversities. But time is precisely what family practitioners do not have if they are to meet the official quota for the number of patients seen per clinic session. The already intolerable time press is being made worse by perpetuating reimbursement policies that undervalue cognitive services. Gastroenterologists and cardiologists are paid at rates five to ten times higher when they pass an endoscope or thread a catheter than when they invest the time to take a thorough history, perform a careful physical examination, and counsel a patient. The payment scheme has functioned as if it had been designed to transform gastrointestinal specialists into endoscopists and heart specialists into “catheterologists,” a point long noted and long ignored. The US Department of Health and Human Services (HHS) regularly announces that the nation needs more generalists and fewer specialists; yet the department continues to use a fee-for-service schedule, which reinforces the very practice it laments.

The American Medical Association’s (AMA’s) latest economic report notes that the income of surgeons was 2.3 times that of general practitioners in 1990. The surprise is that any medical students, since they all can read, opt for primary care fields. Once they enter practice, these dedicated physicians face ineluctable pressures to speed up the rate at which they process patients, as unit reimbursement falls behind the rate of inflation. Let me not be misunderstood: Doctors do not face starvation, even those at the lower end of the medical pay scale. But why do we persist in imposing economic penalties on what almost all agree to be the needed ingredients in our health care system: personalized, low-tech, psychosocially sensitive primary care medicine?

Steps Toward Improving Care

What is to be done to improve the care given to medical patients with psychosocial distress? No single solution will suffice. Practitioners need retraining; health policies, reformulation. Continuing medical education. The answer does not lie in referral to mental health specialists; there are simply too few, most clustered in cities, their services often not covered by insurance. Any realistic hope of change must rest on improving the quality of care in the general medical sector. Pa-
None of this will happen unless primary care practitioners are paid adequately for time devoted to counseling. Obviously, logging time provides no assurance that the time has been well spent. Mechanisms to assess the quality of psychosocial care will be essential. However, the challenge of designing sensitive and specific quality assurance applies throughout current medical and surgical practice; it is not limited to psychological interventions. Reimbursing adequately for time will increase costs in the primary care sector, certainly so in the short term. Can the nation afford the additional costs? Can patients—and we all fall into that class at one time or another—afford not to have care when they need it?

Recognition and management of psychosocial problems may lead to cost offsets by reducing inappropriate use of other medical and surgical care.33 My argument, however, does not rest on the claim of economic benefit, which is at best uncertain.36 Rather, the effectiveness of health care should become the primary criterion for health policy. My principal contention is that making it possible for internists and family physicians to provide appropriate psychiatric interventions will diminish suffering by addressing the sources of distress in the patients they serve.

At The Threshold Of Health Reform

When federal pressure managed to bring specialists and generalists to the same table to discuss the principles of redistributing reimbursement among medical specialties so as to bring about greater equity, the compromises in the resource-based relative value scale (RBRVS) necessitated by the competing constituencies limited its effects to adjustments at the margins. Specialists are still angry at the challenge to their right to earn all they can; generalists are disillusioned by how far actual effects are from what was promised to them. The RBRVS has produced no substantive change in incomes at the bottom of the earnings scale.

We stand at the threshold of major health system reform; cost escalation has
become a chain reaction. And implosion threatens. In my view, it is essential that we begin the planning now for the terms under which mental health care should be included under whatever reform program is adopted, although only a national health insurance system can provide a real solution to questions of equity and cost. The basic principle must be that mental illnesses should be treated like all other medical illnesses, for both short-term and long-term care. Even with that principle in place, it will be necessary to design special outreach services for the chronically mentally ill who barely survive at the margins of society and lack the capacity to take advantage of services that are ostensibly available to them.

Some will argue that this is a counsel of perfection, desirable but unattainable at a time when the focus is on cost and not quality of care and when I myself have argued that cost is driving reform. Yet, if we do not build in access to mental health care at a juncture when the system is being shaped for years to come, we condemn ourselves to playing catch-up ball—a game we cannot win. Opting to gamble for large stakes at the risk of sacrificing modest but more likely winnings is necessarily a judgment call.

Rudolf Klein has contrasted the “optimizing, rationalizing” model of the decision-making process in government with the “satisficing” model.1 The latter is based on a course of action that is “good enough:” cautious, incremental, and based on compromises dictated by competing constituencies. In the case of U.S. health care policy, those constituencies include the AMA, the independent (and competing) specialty societies, HHS, the Office of Management and Budget, civil servants in the federal bureaucracy, regional and state health authorities, and public opinion (more accurately, what politicians think is public opinion), among others. To paraphrase Klein, there is the risk of being too cautious and missing an opportunity for improvement, or a converse risk of underestimating resistance to reform and alienating those in a position to carry out that reform. In my view, the time is now to insist on parity. I do not think I underestimate Klein’s “frictional costs;” they will be overbalanced in the struggle for fundamental reform.

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NOTES


7. Schulberg and Bums, “Mental Disorders in Primary Care,” and J. Ormel et al., “Recognition, Management, and Outcome of Psychosocial Disorders in Primary Care: A Naturalistic Follow-up Study,” Archives of General Psychiatry 35 (1978): 685–693.


20. Shapiro et al., “Utilization of Health and Mental Health Services.”


