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Mental Health Delivery in Primary Care: The Perspectives of Primary Care Providers

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Abstract

Purpose.—To explore perspectives of primary care providers (PCPs), including physicians and nurse practitioners (NPs), about delivery of mental health care in primary care settings.

Methods.—We used a qualitative descriptive designed convenience sample of physicians (*N*=12) and NPs (*N*=14) through face-to-face interviews in New York State.

Results.—Three themes emerged: 1) prioritization of patient needs; 2) applicability of mental health care in primary care settings; and 3) physician and NP approaches to mental health care.

Conclusions.—PCPs recognized importance of addressing patients' mental health care needs and barriers in primary care practices.

Keywords

Primary care; mental health; healthcare neglect; acts of omission; care omission

Introduction

An estimated 44.7 million adult Americans have a mental disorder and only 35 million of them receive mental health services (Substance Abuse and Mental Health Services Administration, 2016). Problems with access to mental health professionals, stigmatization surrounding mental illness, and gaps between general medical and specialty mental health services are widely believed to impede the flow of adults into mental health care (de Jacq, Norful, & Larson, 2016; Pahwa, Chatterjee, Tallen & Brekke, 2010). Furthermore, regional shortages of mental health professionals have been exacerbated by geographic

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None.

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maldistribution (Cunningham, 2009) with about 96% of U.S. counties having an insufficient supply of psychiatrists (Thomas, Ellis, Konrad, Holzer, & Morrissey, 2009). Problems with access to specialty mental health care are expected to worsen given that 60% of psychiatrists are over the age of 55 (Association of American Medical Colleges, 2016), and while over the last 20 years, the U.S. population has increased by 37%, the number of psychiatrists has increased by only 12% (Brenner, Balon, & Coverdale, 2017). Yet, alongside widespread problems with access to mental health services, greater social acceptability has reduced attitudinal barriers to seeking and accepting treatment, increasing the need for mental health providers.

Primary care serves an important entry point for patients to access health care services (Starfield, Shi L, & Macinko, 2005). Currently, physicians, nurse practitioners (NPs), and physician assistants provide the bulk of primary care services in the U.S. (U.S. Department of Health and Human Services, 2016). These providers often shoulder the responsibility for diagnosing and treating common mental health disorders (Olfson, Blanco, Wang, Laje, & Correll, 2014). In 2010, 20% of all visits to primary care physicians included depression screening, counseling, a mental health diagnosis or reason for visit, psychotherapy, or provision of psychotropic medications (Cherry, 2014). Primary care physicians also spend more time at clinical visits talking to patients about mental health than biomedical topics (Foo et al., 2017). Likewise, NPs deliver significant amount of mental health services especially to low income and minority populations (Yang,Trinkoff, and Zito, 2017). However, several studies have identified barriers primary care providers (PCPs) face in delivering mental health services such as insufficient resources, inadequate related knowledge, and lack of time (Cooper, Valleley, Polaha, Begeny, & Evans, 2006; Loeb, Bayliss, Binswanger, Candrian & deGruy, 2012). Despite the call for better integration of mental health services in primary care (Crowley & Kirschner, 2015), these barriers may prevent PCPs from delivering mental health services to patients.

Much remains to be learned about delivering mental health services in primary care settings to facilitate efforts to achieve national health policy goals of better integration of mental health services into primary care. The perspectives of PCPs, both physicians and NPs, can provide important insights. The purpose of this qualitative study was to explore mental health delivery in primary care settings from the perspectives of physicians and NPs.

Method

We used qualitative descriptive methods (Sandelowski, 1995a), which are particularly suitable for exploring multiple perspectives and understanding phenomena relevant to practitioners and policymakers (Sandelowski, 2000). The study was part of a larger investigation on primary care and patient safety (Poghosyan et al, 2017; Norful, de Jacq, Carlino & Poghosyan, 2018). It was approved by the Columbia University Medical Center Institutional Review Board.

Sample

We distributed flyers about the study in-person and via email to primary care practices in New York State and recruited a convenience sample of NPs and physicians. Participants

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were eligible if they practiced as a PCP and could speak and understand English. Interested individuals contacted the researchers to determine eligibility and schedule the interview. Using a snowball technique (Kuper, Lingard, & Levinson, 2008), participants also referred colleagues who may be interested in participating.

Data Collection and Interview Guide

After obtaining consent and demographics, face-to-face interviews in PCP offices were conducted by female primary care NP with PhD degree and experience in qualitative descriptive study designs (Mays & Pope, 2000). We used a semi-structured open-ended interview guide created by following iterative steps (Kallio, Pietilä, Johnson, & Kangasniemi, 2016). PCPs were asked about how they deliver various aspects of mental health care such as “speaking to patients about stress management”, “addressing patients’ emotional needs”, or “counseling patients and their families”. They were also presented with a set of statements about these aspects and asked to read each statement aloud and discuss their thoughts. We used probes such as “tell me more” and “can you give me an example?” to further explore PCPs’ perspectives. We audiotaped and professionally transcribed all interviews. Participants received a $20 gift card.

Data Analysis

We imported qualitative transcripts into NVivo 11 software for analysis (NVivo, 2014). Three researchers (AAN, AG, SC) conducted the content analysis. We identified salient codes; similar codes that clustered together became the source of categories. We interpreted categories to identify themes (Creswell, 2013). Fourth researcher (LP) reviewed all categories and themes. We met weekly to discuss codes, categories and themes. Analysis continued until no new information emerged, an occurrence known as data saturation (Sandelowski, 1995b). We analyzed demographic data with SPSS v24 (IBM SPSS Statistics for Windows, 2016).

To reduce bias and enhance credibility of qualitative methods, we performed member checks (findings were shared with participants to ensure accuracy in interpretation). We enhanced transferability by providing descriptive data about participants. Audit trails documented all study-related decisions (dependability). Lastly, we used reflexivity audit trails to document biases and researchers’ effect on the data (confirmability) (Guba, 1981).

Results

Participant Characteristics

Twelve physicians and 14 NPs participated (Table 1). PCPs worked in private physician practices, university-affiliated clinics, hospital-affiliated practice, and a federally qualified health center (FQHC). The mean age of participants was 43 years and majority of PCPs were female.

Themes

Three themes emerged: 1) prioritization of patient needs; 2) applicability of mental health care in primary care settings; and 3) physician and NP approaches to mental health care.

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Prioritization of patient needs—Participants emphasized the necessity of delivering mental health services in primary care to promote patient health, well-being, and outcomes (e.g., quality of life, readmissions, mortality). Despite this emphasis, both NPs and physicians reported not always addressing patients' mental health needs during visits. This was attributed to patients' multiple concerns and time constraints. One NP stated, "I just feel like I don't always get to address mental health as indepth as I would like to, especially if I'm pressed for time." One hospital-affiliated practice physician noted the difficulty of addressing mental health issues during a visit, "They [patients] are depressed or they have some conditions like obesity. We need to provide them material, counsel them, etc. So, we could do… if we had time." Because of competing priorities, PCPs prioritized more urgent and acute needs, resulting in a lack of routine identification and assessment of anxiety, depression, or other mental health conditions. One NP said, "As a provider, I think you take care of the most urgent needs first, and the less urgent things sort of fall off on that hierarchy list." Similarly, another NP stated "Well, I mean if they're in for strep throat, then there is not going to be (relevance for emotional support)." One physician from a university-affiliated clinic exclaimed "…for a full checkup, we talk about family history and personal history… We don't actually do depression screening, which we should do." Another physician in a hospital-affiliated practice said,

> Briefly you can see whether the patient is depressed. Or any psychological issues and then if you think that there's a need acutely that you can address at the same day but if the patient has a chronic history of depression and they want to talk, we can leave it up to the next visit.

Though PCPs attempted to address certain mental health issues during visits, they faced challenges in allocating sufficient time for such concerns in addition to addressing patients' biomedical concerns. For example, an NP in a private physician practice said, "I don't think we spend enough time with that [mental health] … I'm not sitting there for the time that it would take to give somebody real emotional support." Similarly, another NP from a university-affiliated clinic asserted, "I'm pretty much rushing over psychosocial history… I feel like sometimes I don't have the time to sit there and listen to all of their [patients'] family conflicts." An NP from a private physician practice noted "[On discussing emotional well-being]….I don't always do it. I will take an across the room evaluation myself to do that. That's time consuming." A physician from a FQHC affirmed, "I can't spend 10 minutes with you [patient]. I mean, I could but then I'm already like two hours late." A physician in a hospital-affiliated practice stated, "Well, the omission is going to be the emotional support because, you can't in 10 minutes sit there and hold that person's hand and try to get them through." This lack of available time reported by PCPs to address mental health issues often resulted in PCPs delegating these tasks to other providers.

PCPs often delegated the responsibility of patients' mental health concerns to behavioral health specialists or other team members such as registered nurses (RNs). For example, an NP from a hospital-affiliated practice disclosed, "…what I'm doing is I'm sending them to psychiatry, I'm sending them to social workers, I'm telling them about support groups." One private practice physician affirmed, "We don't give enough emotional support…That's why I put the discharge nurse in…because it's just like, I can't". PCPs struggled addressing

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mental health concerns of their patients due to time constraints coupled with the lack of urgency they associated with mental health issues which prompted them to hand off mental health care to other providers they deemed as better equipped to handle these concerns.

Applicability of mental health care in primary care settings—PCPs spoke about mental health not falling within the umbrella of primary care or PCPs' scope of practice. For example, an NP stated, "as providers, in internal medicine we see emotional support as a total different entity." A university-affiliated clinic physician said that, "We don't actually do depression screening…it's been decided that it's not really a good use of our time." Though PCPs emphasized the importance of addressing mental health concerns, some did not view it as their responsibility. As addressing mental health concerns was not viewed as falling naturally within their scope of practice, PCPs lacked comfort in providing mental health care.

Certain PCPs reported a lack of comfort when dealing with mental health concerns and were more likely to refer patients outside of primary care when they experience exacerbations. One NP within a private physician practice stated, "We may not feel comfortable with [delivering mental health]. So, when you…see a patient who is depressed…you very quickly refer out." One physician mentioned, "They [patients] want to vent with me and I don't…so it's hard for me to like, 'you're just fine' and just wave my hand." The lack of comfort in addressing mental health concerns partially stemmed from their lack of perceived competence in handling these concerns.

Beyond lack of comfort, sometimes PCPs felt the complexity of the mental conditions warranted referral to a mental health specialist better suited to meet patient's needs. One NP reported that they treat patients based on condition's severity. She explained,

> We do screenings for depression. Mainly depression and anxiety is what we treat here. If anything, more advanced than that [depression and anxiety], we do a referral to our social worker, who can counsel them and engage them in an outpatient psychiatric [clinic].

Similarly, a private practice physician with over 15 years of experience affirmed, "…if they [patients] have an issue about psychiatric medication… You can refer to psychiatrist." Thus, mental health services were often not delivered because of PCPs' perception of mental health not being directly tied to primary care, their general discomfort in dealing with mental health, and their perceived lack of expertise in managing complex mental health conditions.

Physician and NP approaches to mental health care—NPs and physicians mostly reported similar concerns about mental health delivery in primary care. Some differences, however, emerged. NPs spoke about their prior nursing training as shaping how they care for patients and address mental health issues. One hospital-affiliated practice NP said, "…as a nurse, first as a nurse and then as a provider, I try to look at the whole aspect, the emotional concerns of the patients and the families and speaking to the patients about stress management."

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On the other hand, when a physician was probed on reaching out to patients' family members out of patient concerns, the physician replied, "… that would be more sort of a mental health issue rather than a physical issue. And then I reach out to mental health, who often does reach out." NPs were more willing to directly engage with patients' family members while physicians viewed family involvement as a mental health specialist domain.

Both NPs and physicians relied on referrals to mental health specialists, but there were some differences regarding when they determined a referral was needed and the extent of followup after referral. In describing the follow-up, an NP reported, "I made sure … that he [patient] had a psych consult, because … the patient needed outside consult." On the other hand, a physician from a hospital-affiliated practice stated,

> Something as simple as counseling … which is probably the most important in stopping all of the problem, you're not going to get due to the fact you only have 10 minutes. So, you give them [patients] a list of phone numbers to call and you hope that they do it.

This reflects a difference in level of involvement of NPs and physicians in implementing mental health referrals and following up to ensure patients receive specialized services.

Discussion & Conclusions

We explored PCP perspectives on delivering mental health services within primary care practices. Both physicians and NPs emphasized the importance of identifying patients with mental health needs to assure they receive care either in primary care or via referral to specialty mental health. However, mental health is often not viewed as a priority because either it is beyond PCPs' scope of practice or they lack the time due to prioritizing urgent physical needs over mental health needs. Both NPs and physicians reported similar concerns with NPs taking a more active role in coordinating patient care and follow up after referral to specialty mental health services.

The findings of this study reveal several interesting insights. First, although primary care serves as the first point of entry for patients, it appears that practices are not well equipped to identify, care for, or refer patients with more serious mental health issues. According to PCPs, lack of adequate time undermines the delivery of mental health services even when the PCP recognizes the need among patients. This is concerning as patients might leave the clinic with unaddressed mental health needs. Second, even if PCPs refer patients, they often do not follow up regarding the referrals. Thus, it remains unclear if patients receive specialty care. Given the paucity of available mental health providers and that even PCPs have difficulties finding them (Cunningham, 2009), patients might not receive timely services from specialists. Finally, some PCPs mentioned mental health as being beyond their scope of practice. Similar concerns have been raised regarding PCPs being not properly trained to address mental health problems (Agency for Healthcare Research and Quality, 2012).

The study findings have critical implications for practice, policy, research, and nursing and medical education. Addressing PCP burden and allocating adequate time for mental health concerns requires a comprehensive approach from policymakers, insurers, and health care

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administrators. Some practices have RNs and care managers and delegation of mental health services to them may help meet patients' need. It is important to understand which aspects of mental health care can be delegated to them to reduce PCP burden. For example, a recent qualitative study of PCPs reported that increased RN staffing in primary care yielded increased patient screenings, patient education, and coordination of care and follow up (Norful, Dillon, Ye, & Poghosyan, 2018). In addition, the national trend of implementing Patient-Centered Medical Home (PCMH) models in primary care practices represents a promising development. PCMHs focus on enhancing the core functions of primary care while integrating mental health and delivering care in teams (National Committee for Quality Assurance, 2014; The Joint Commission Accreditation Ambulatory Care, 2011; Croghan & Brown, 2010). A systematic review comparing NP-physician team care to physician-led care showed significant increases in adherence to care guidelines in primary care (Norful, Swords, Marichal, Cho, Poghosyan, 2017). Team-based care may help with adherence to depression screening guidelines and other improvements in the quality of mental health care delivery in primary care. Along with team-based care, care models calling for the integration of primary and mental health services hold great potential. Consistent with the goal of integrating these services, the Health and Human Services awarded nearly $55 million in Affordable Care Act funding to FQHCs for the expansion of mental health services and implementation of integrated care models (U.S. Department of Health & Human Services, 2014). Thus, the study findings can aid such efforts to address challenges in delivering mental health in primary care practices.

As the NP workforce grows, NPs can play a central role in delivering and coordinating mental health in primary care practices (Auerbach, 2012). However, challenges such as restrictive scope of practice regulations in some states that inhibit NP care and prescriptive authority may prevent patients especially racial and ethnic minorities or those covered by Medicaid from receiving timely mental health services (Xue, Ye, Brewer, & Spetz, 2016; Poghosyan et al., 2013). NPs in states with full scope of practice are twice more likely to provide mental health services compared to NPs in states with restricted laws like NY State (Yang et al., 2017). Similarly, psychotropic medication-related visits provided by NPs for patients with mental disorders were more than three times as common in states with full scope of practice than with restricted practice. Removing scope of practice restrictions may improve NPs' effectiveness in delivering mental health care.

Limitations

This study was conducted among a convenience sample of PCPs from one state; PCPs from other states and practices may have different perspectives. The study was also part of a large study on primary care and patient safety; it is possible that we did not explore all concerns related to mental health care delivery by PCPs. This study was qualitative; as such, the findings may not be generalizable. However, we have met the goal of qualitative research in producing credible data by adhering to guidelines for trustworthiness and rigor.

Conclusion

This study examined physicians' and NPs' perspectives about mental health care delivery in primary care. Most PCPs acknowledged the importance of addressing patients' mental

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health needs in primary care; however, they also reported challenges that should be addressed. More research is needed to assess effectiveness of novel care delivery models for managing mental health in primary care.

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Abbreviations.

NP	Nurse Practitioner
PCP	Primary Care Provider
PCMH	Patient-Centered Medical Home
RN	Registered Nurse

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Highlights:

- The study investigated the perspectives of PCPs (nurse practitioners and physicians) on delivering mental health care in primary care settings
- PCP responses suggested lack of emphasis on mental health in primary care settings
- Participants acknowledged importance of mental health care delivery in primary care, but suggested challenges and limitations such as time and scope of practice

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Table 1.

Participant Characteristics

Characteristics	Total (*N* = 26)	NP (*N* = 14)	Physicians (*N* = 12)
Age, years			
Mean (SD)	43.40 (3.1)	41.36 (3.4)	45.78 (2.7)
Sex, no. (%)			
Female	20 (77)	13 (93)	7 (58)
Highest degree, no. (%)			
Master's	5 (19)	5 (36)	-
Post-Master's certificate (NP)	3 (12)	3 (21)	-
Medical degree (MD/DO)	11 (42)	-	11 (92)
Doctorate (PhD/DNP)	7 (27)	6 (43)	1 (8)
Years of experience			
Mean (years)	9.88 (2.1)	7.21 (1.8)	13 (2.4)
Main practice site, no. (%)			
Private physician practice	5 (19)	2 (14)	3 (25)
University-affiliated clinic	11 (42)	5 (36)	6 (50)
Hospital-affiliated practice	9 (35)	7 (50)	2 (17)
Federally qualified health center	1 (4)	-	1 (8)
Geographic location, no. (%)			
Urban	17 (65)	9 (64)	8 (67)
Suburban	8 (31)	5 (36)	3 (25)
Rural	1 (4)	-	1 (8)