

Serious Mental Illness in Primary Care: a National Physician Survey



J Gen Intern Med 36(3):833-5
DOI: 10.1007/s11606-020-05950-8
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People with serious mental illnesses (SMIs) like schizophrenia have 2–3 times greater mortality than the overall population due to high rates of poorly controlled medical conditions including cardiovascular disease.¹ Evidence shows sub-optimal care of medical conditions among many people with SMI.² Primary care physicians have an important role to play in improving receipt of guideline-concordant physical healthcare for people with SMI.³ But little is known about PCPs' views on caring for patients with SMI.

METHODS

We surveyed a nationally representative sample of 1000 US physicians identifying as family, internal, or general medicine practitioners using a tailored Dillman method.⁴ A simple random sample of physicians selected from the American Medical Association (AMA) Masterfile were mailed a questionnaire, \$2 incentive, and postage-paid return envelope in February 2019. Non-respondents received identical packets in March, April, June, July, and August 2019. Eligible physicians were those in the original $N = 1000$ sample definitively identified as practicing primary care at the address on file for the entire field period. The instrument ([Appendix](#) in the Electronic Supplementary Material [ESM]) was developed by the study team. The four survey domains are italicized in [Table 2](#) (see [Table 2](#) and [Appendix](#) (ESM) for item wording/responses).

The response rate was 54% (361 returned surveys from 668 eligible physicians). Eligible physicians represented 50 states and responding physicians represented 49 states (WY absent). Twenty-five surveys with > 50% missing data were excluded

from analyses. Response did not differ by specialty, age, sex, degree (MD/DO), or practice type. Chi-squared tests showed that more non-responders (37.2%) than responders (22.1%) were from the south; analyses incorporated weights adjusting for this difference. Data were analyzed descriptively. We used chi-squared tests to compare responses among physicians with versus without onsite mental health and care coordination services. This study was deemed exempt from review by the JHSPH Institutional Review Board.

RESULTS

Respondents' demographic characteristics were similar to PCPs nationally ([Table 1](#)). Over 40% of practices did not perform population health tracking or care coordination; one-third had onsite mental healthcare. Fifty-two percent of PCPs thought that people with SMI want to change their health behaviors ([Table 2](#)). More than three-quarters reported ability to treat physical and mental health symptoms in SMI, but only 40.9% reported ability to treat substance use. Over 70% endorsed joint responsibility with specialty mental health providers for caring for people with SMI. Physicians at clinics with onsite mental health services reported greater ability to provide smoking cessation, mental health, and weight management services ($p < 0.05$; [Appendix Table 1](#) in the ESM). Physicians at clinics with care coordination services were more likely to report need for a health educator and nurse to support care coordination and enhanced reimbursement ($p < 0.05$; [Appendix Table 2](#) in the ESM).

DISCUSSION

The majority of US PCP respondents endorsed joint responsibility for caring for patients with SMI alongside specialty mental health providers, but the population health management and care coordination functions needed for integrated care⁵ were absent from more than 40% of practices. Only 52% of respondents believed that people with SMI wanted to make health behavior change, an attitude at odds with evidence showing people with SMI's desire and ability to lose weight and quit smoking.⁶ Only 41% of PCPs reported that they were able to treat substance use, suggesting a need to bolster capacity to treat this common co-occurring issue in SMI. PCPs with onsite mental health services reported greater ability to deliver

Electronic supplementary material The online version of this article (<https://doi.org/10.1007/s11606-020-05950-8>) contains supplementary material, which is available to authorized users.

Received February 2, 2020

Accepted May 29, 2020

Published online June 10, 2020

Table 1 Characteristics of Primary Care Physician Survey Respondents, 2019 (N = 336)

	Survey respondents	National primary care physician population ¹
Specialty		
Family practice	52.4%	51.5%
Internal medicine	43.2%	44.9%
General practice	4.5%	3.6%
Age		
<35	7.6%	5.7%
35–44	19.1%	22.6%
45–54	29.4%	30.7%
55–64	28.5%	27.3%
65+	15.5%	13.7%
Sex		
Male	58.8%	60.9%
Female	41.2%	39.1%
Region		
South	29.8%	35.6%
West	26.1%	24.6%
Midwest	22.1%	20.9%
Northeast	22.1%	19.0%
Practice type ²		
Group practice	50.9%	Data not available
Solo or two-physician practice	17.5%	Data not available
Government-based practice	11.4%	Data not available
Non-governmental hospital	4.6%	Data not available
Other ³	15.6%	Data not available
Percent of patient panel with bipolar disorder or schizophrenia		
0–10%	79.1%	Data not available
10–20%	17.6%	Data not available
30–40%	2.7%	Data not available
40+%	0.6%	Data not available
Services provided at physician's practice		
Weight management or dietary counseling	81.2%	Data not available
Diabetes education	79.1%	Data not available
Tobacco smoking cessation treatment	77.3%	Data not available
Population health tracking of chronic disease metrics (e.g., HBA1c, flu shots) in the practice's patient panel	58.0%	Data not available
Care coordination for high-need patients	57.4%	Data not available
Onsite mental health treatment services	31.8%	Data not available
Onsite substance use treatment services	19.0%	Data not available
An online patient portal where patients can log-in to see appointments, lab results, etc.	8.2%	Data not available
My practice does not provide any of these services for any patients	5.3%	Data not available

¹Peterson S, McNellis R, Klink K, Meyers D, Bazemore A. *The State of Primary Care in the United States: A Chartbook of Facts and Statistics*. January 2018

²National data on practice type among primary care physicians defined as family, internal, and general medicine physicians is not available

³Includes the following: other—patient care; locum tenens; no classification

services (mental health, smoking cessation, and weight management) involving counseling. PCPs with onsite care coordination reported a higher need for additional coordination supports, perhaps suggesting that practices with care coordination serve high-need patient populations and/or recognition of the value of care coordination.

Table 2 US Primary Care Physicians' Views Regarding Care for Patients with Serious Mental Illness (N = 336)

	% (95% CI)
<i>Premature mortality and health behavior change in SMI (% agree)¹</i>	
People with SMI are more likely to die prematurely from medical conditions than psychiatric causes.	76.0% (71.0–80.3)
People with SMI can make health behavior change.	74.3% (69.3–78.7)
People with SMI want to make health behavior change.	52.1% (46.6–57.4)
<i>Ability to care for patients with SMI (% able)²</i>	
How would you rate your ability to:	
Treat chronic physical health conditions (e.g., diabetes mellitus) experienced by people with SMI?	93.8% (90.6–95.9)
Communicate with people with SMI?	90.7% (87.1–93.4)
Provide smoking cessation treatment to people with SMI?	79.8% (75.1–83.8)
Treat mental health symptoms experienced by people with SMI?	78.2% (73.4–82.4)
Provide weight management counseling to people with SMI?	77.3% (72.4–81.5)
Treat substance use issues experienced by people with SMI?	40.9% (35.7–46.3)
<i>Responsibility for treating patients with SMI³</i>	
Who should have primary responsibility for treating physical health conditions among people with SMI?	
Primary care physicians	22.6% (18.4–27.5)
Specialty mental health providers	6.6% (4.3–9.8)
Joint responsibility	70.8% (65.6–75.5)
Who should have primary responsibility for addressing tobacco smoking among people with SMI?	
Primary care physicians	22.9% (18.6–27.7)
Specialty mental health providers	5.7% (3.7–8.8)
Joint responsibility	71.4% (66.3–76.1)
Who should have primary responsibility for addressing healthy diet and exercise among people with SMI?	
Primary care physicians	26.7% (22.1–31.7)
Specialty mental health providers	1.2% (0.5–3.3)
Joint responsibility	72.1% (70.0–76.7)
<i>Resources to support care for patients with SMI⁴</i>	
Are there resources that would help you to provide primary care more effectively to people with SMI?	
A health educator trained in working with people with SMI to provide behavioral counseling related to chronic medical conditions (e.g., diabetes education, smoking cessation)	68.6% (63.4–73.4)
A nurse to provide care coordination for patients with SMI (e.g., making appointments, lab follow-up)	63.2% (57.8–68.2)
A higher-than-typical reimbursement rate for providing primary care to people with SMI	47.9% (42.5–53.3)
Training on how to effectively communicate with patients with SMI	44.5% (39.2–49.9)
A lay caregiver to accompany patients with SMI to primary care appointments	43.9% (38.6–49.3)
A nurse to accompany patients with SMI to primary care appointments	30.8% (26.1–36.0)
None of these resources would help me provide primary care to patients with SMI	8.2% (5.6–11.7)

¹Premature mortality and health behavior change in SMI items: Response options included strongly agree, somewhat agree, agree/disagree, somewhat disagree, and strongly disagree. “Strongly agree” and “Somewhat agree” were combined to indicate % agree

²Ability to care for patients with SMI items: Response options included entirely unable, mostly unable, somewhat able, and very able. “Somewhat able” and “Very able” were combined to indicate % able

³Responsibility for treating patients with SMI items: Respondents were asked to choose one option: “primary care physicians,” “specialty mental health providers,” or “joint responsibility”

⁴Resources to support care for patients with SMI items: Respondents were asked to select all that apply from the resources listed

About one-third ($N = 332$) of physicians in the original sample had an incorrect practice status, specialty, or address and were deemed ineligible. While our sample was fairly small, with eligible physicians representing all 50 states but only 660 of 47,701 zip codes, respondents' characteristics were similar to those of PCPs nationally. Our survey did not assess whether PCPs' views on needed resources differed for SMI versus other chronic conditions.

A national sample of US PCPs viewed specialty mental healthcare providers and PCPs as jointly responsible for the health of people with SMI; financing and delivery models that effectively support such shared responsibility are needed.

Emma E. McGinty, PhD, MS¹

Elizabeth M. Stone, MS¹

Gail L. Daumit, MD, MHS²

¹Department of Health Policy and Management,
Johns Hopkins Bloomberg School of Public Health

Baltimore, MD, USA

²Division of General Internal Medicine, Johns
Hopkins School of Medicine,
Baltimore, MD, USA

Corresponding Author: Emma E. McGinty, PhD, MS; Department of Health Policy and Management, Johns Hopkins Bloomberg School of Public Health Baltimore, MD, USA (e-mail: bmcginty@jh.u.edu).

Funding Information Dr. McGinty received support from NIMH grant K01MH106631.

Compliance with Ethical Standards:

This study was deemed exempt from review by the JHSPH Institutional Review Board.

Conflict of Interest: The authors declare that they do not have a conflict of interest.

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