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Addressing Trauma and Stress in the COVID-19 Pandemic: Challenges and the Promise of Integrated Primary Care

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Behavioral health needs around the world were substantial and largely unmet prior to the COVID-19 pandemic (Kazdin & Blase, 2011; R. C. Kessler et al., 2009). However, projected increases in trauma [(e.g., Posttraumatic Stress Disorder (PTSD) and Posttraumatic Stress Syndrome (PTSS)] and related concerns during and after this pandemic will continue to burden a healthcare system that is ill-prepared to address the needs of the "whole person." The prevalence of PTSD, PTSS, and overall behavioral health needs are likely to increase in the United States (US) post-COVID-19 due to more individuals-including frontline healthcare providers-having increased exposure to trauma-related events (Hamilton, 2020; Lai et al., 2020; Lee et al., 2007).

Primary care has been described as the "de facto" mental health system in the US (R. Kessler & Stafford, 2008) and recent estimates of prevalence rates of PTSD in primary care range from 2% to 39.1% (Greene, Neria, & Gross, 2016). Integration of behavioral health clinicians (BHCs; e.g., psychologists, licensed clinical social workers) into primary care settings has been a critical step in addressing the dearth of behavioral healthcare around the world (Kazdin, 2018). Integrated BHCs bolster the capacity of primary care teams to better care for the biopsychosocial needs of the population they serve.

The Primary Care Behavioral Health (PCBH) model of integrated care (Robinson & Reiter, 2016) adds BHCs to the primary care team to enhance the team's ability to treat and manage its patient population. BHCs provide additional help to patients for improving chronic disease outcomes (e.g., diabetes, chronic pain), making lifestyle changes (e.g., quitting smoking, weight management, medication adherence) and addressing mental health care (e.g., anxiety, substance use disorders; (Bridges et al., 2015; Bryan, Corso, Corso, Kanzler, et al., 2012; Bryan, Corso, Corso, Morrow, et al., 2012; Bryan, Morrow, & Kanzler Appolonio, 2009; Corso et al., 2012; Robinson & Reiter, 2016).

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Notably, patients with PTSD and PTSS and functional impairment can be remitted with a brief, evidence-based protocol in a PCBH model of care (Cigrang et al., 2017). PCBH also works well in a trauma-informed primary care framework, which assumes all patients have experienced trauma and encourages an organizational shift that emphasizes respect and appropriate responses to trauma in the health care context (e.g., shifting from "what's wrong with this person?" to "what has happened to this person?")(Harris & Fallot, 2001). This approach may include increasing behavioral health treatment access to patients with trauma-related issues (Green et al., 2016; Green et al., 2015), which is especially important for patients who are also health care workers, who may be reluctant to seek out specialty psychological services due to stigma or length of treatment (Gerber, 2019; Sendler, Rutkowska, & Makara-Studzinska, 2016).

Increasing access to behavioral healthcare is a hallmark of PCBH (Ogbeide, Landoll, Nielsen, & Kanzler, 2018), and the COVID-19 pandemic has certainly challenged this capability. Integrated BHCs around the globe have risen to the challenge of delivering primary care alongside their primary care provider colleagues during these unprecedented times. Rapid adaptations and changes to reimbursement rules by federal and commercial insurance companies have led to innovations whereby primary care is now frequently delivered via telephone and video calls through telehealth (AAFP, 2020; Smith et al., 2020). Patients who have access to phones with adequate minutes, video teleconferencing capabilities and/or internet with adequate bandwidth, can benefit from these innovations during shelter-in-place orders, quarantines, and infections (Zhou et al., 2020).

However, the most vulnerable members in our communities continue to struggle to access behavioral healthcare during this pandemic due to lack of access to reliable telephone use and affordable and consistent high-speed internet (O'Dowd, 2018). Pre-pandemic literature abounds with evidence of how social and economic determinants are the real drivers of health and well-being (Artiga & Hinton, 2019). Notably, an alarming health disparity has emerged as evidence indicates African Americans and Hispanic/Latinx populations suffer more morbidity and mortality due to the SARS-CoV-2 virus than other racial groups (Lahut, 2020; Mays & Newman, 2020), partly due to long-standing health disparities and inequitable socioeconomic factors (Jordan & O'ppel Jr., 2020; Newkirk II, 2020). The gap between patients with and without resources has only widened during the COVID-19 crisis and is a specific problem integrated primary care settings must grapple with in their efforts to provide accessible care.

An additional challenge for integrated primary care during this pandemic is continuity of treatment for patients who are receiving a protocolized course of care. For example, brief PTSD treatment in primary care involves modified imaginal exposures and in-vivo exposures (Cigrang et al., 2017). Engaging in in-vivo exposure planning with patients becomes complex due to stay-at-home mandates as well as patients adhering to physical and social distancing. While telehealth delivery of techniques such as in-vivo exposure was less effective than in person(Gros, Yoder, Tuerk, Lozano, & Acierno, 2011), other findings suggest telecommunication-based delivery of trauma-related treatment did not negatively impact outcomes despite expression of low confidence from patients (Price & Gros, 2014). This is promising and may be of specific importance for underserved populations who may

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have limited experience with telecommunication for psychological treatment. The COVID-19 pandemic, with recommended physical and social distancing, has reinforced a previously identified issue, that more research is needed to understand best methods for modifying protocols for delivery using technology (Yuen et al., 2015).

Patients with trauma histories often present to primary care with myriad physical and psychological complaints (Doherty & Gaughran, 2014) and primary care clinics will continue to be the front door for accessing trauma-related treatment in the US healthcare system. Now is the time to bolster primary care teams with behavioral health colleagues to meet these mounting concerns. Although there are challenges to integration, we have witnessed in this pandemic how quickly sweeping and meaningful changes can be made to ensure access to necessary healthcare, such as modifications to reimbursement arrangements, HIPAA policies, and treatment delivery methods. Integrated primary care teams will undoubtedly prove to be essential in meeting the needs of our communities, first responders and healthcare workers who will be suffering the effects of this pandemic for years to come.

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