

Limitations of “Treatment as Usual” for Mental Health and Substance Use in Primary Care

Because of inadequate access to specialty mental health providers (particularly in-network providers), primary care providers (PCPs) are the **only available source of mental health care for most Americans**.¹ However, PCPs have limited time during patient encounters and are not usually trained or equipped with the necessary tools and resources to provide high-quality mental health care – this leads to poor outcomes for patients.² Although early screening for most medical disorders (e.g., diabetes, heart disease) is standard practice in primary care, screening for mental health problems is much less common.³ This is one key factor which results in most mental illnesses not being diagnosed or treated until eight to ten years after symptoms emerge.⁴ The tragic impact of this delay on children and adolescents is especially harmful.

PCP practices are an integral and successful component of the treatment landscape for many medical disorders (e.g., heart disease) in part because PCPs have established workflows to partner with various types of specialists when medical complexity exceeds what can be effectively managed in primary care. **Mental health care should be no different.** However, since external mental health referrals are challenging and often unsuccessful due to clinician shortages and inadequate insurance networks, mental health partnerships are most effective when integrated directly into primary care. Fortunately, many primary care practices are increasingly adopting a number of methods to increase access to behavioral health including the Collaborative Care Model (CoCM), which is an extensively validated mental health integration protocol that can improve mental health outcomes at scale while also reducing stigma, improving the patient care experience, and reducing total health spending.^{5,6}

Over ninety randomized controlled trials and clinical implementations in large and small practices have demonstrated, across diverse settings, diagnoses, and populations that improved mental health clinical outcomes are achieved in primary care with CoCM⁵⁻⁸. This is because the model uniquely incorporates measurement-based care and population health principles while efficiently leveraging a team of mental health providers to support PCPs. No other approach to integrated mental health care has comparable evidence of improved clinical outcomes.

The data below demonstrates that mental health “treatment as usual” (“TAU”) in primary care, without additional support and resources as provided under CoCM or other integration methods, has minimal beneficial impact on the immense morbidity and mortality of mental health disorders.

- “Only 13% of people diagnosed with a mental health condition receive minimally adequate treatment in a general medical setting; for substance use disorders, that number drops to a dismal 5%.”⁹
- “Numerous studies show that PCPs often do not have the time or resources to provide effective treatment for many behavioral health conditions...Less than 20% of PCPs feel “very prepared” to identify substance use disorders, and most patients with a substance use disorder say their PCP did nothing to address their disorder. **Of the millions of people who receive an antidepressant each year, many do not receive them in sufficient doses or take them for a long enough amount of time to be effective.**”⁹
- “Older adults in particular prefer treatment of mental disorders in primary care – and when they are referred to MH specialists, no more than half complete such a referral.”¹⁰
- A 2007 study found that PCPs only discussed mental health care topics in 22% of patient visits, despite 50% of patient surveys in this study indicating depression. **The study also found that PCPs spend an average of 2-minutes on mental health care needs of elderly patients.**¹¹
- Despite having inadequate access to MH care treatment resources, **“PCPs prescribe 79 percent of antidepressant medications and see 60 percent of people being treated for depression in the United States.”**¹²
- Due to a “lack of regular monitoring and clinical inertia... as few as 20% of patients started on antidepressant medications in usual primary care show substantial clinical improvements.”¹⁰
- **Across all age groups, approximately 45% of people who die by suicide had contact with a PCP within the month before suicide.** This number is even higher for older adults.”¹³
- **A 2017 study estimated that the national primary care depression screening rate was 4.2%.** “African Americans were half as likely to be screened compared with whites, and elderly patients were half as likely to be screened compared with middle-aged patients.”¹⁴
- **Screening alone is important, but without repeated measurement and effective treatment by the primary care team, results are still sub-optimal.** Elucidating this point, Minnesota Community Measurement tracks state-wide outcomes¹⁵:
 - In 2021, 70% of more than 200,000 adults were screened for depression
 - Only 18% achieved depression response over 6 months (12-month figure similar)
 - Only 10% achieved depression remission over 6 months (12-month figure similar)
 - These figures are despite a 45% follow-up rate at 6 months.
 - In 2021, 91.2% of more than 166,000 adolescents were screened for a MH problem
 - Only 14% achieved depression response over 6 months (12-month figure similar)Click or tap here to enter text.
 - Only 7% achieved depression remission over 6 months (12-month figure similar)Click or tap here to enter text.
 - These figures are despite a 43% follow-up rate at 6 months

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