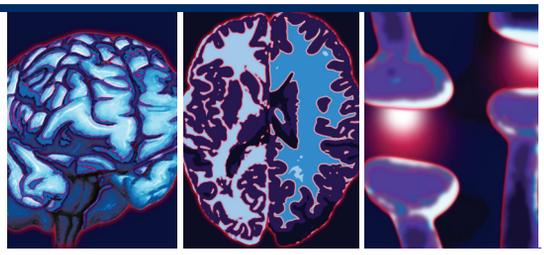
EDITORIAL



Screening for psychiatric disorders: a key to psychiatry's integration with the primary care healthcare system

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"The development of an effective screening program ... is a key opportunity for the re-integration of mental health care into the general medical setting..."

Advocates of universal screening for child psychiatric disorders in primary care overestimate the likelihood that screening programs will deliver mental health care to children with mental health needs. We argue that screening is only effective when carried out by well-trained primary care teams, supported by care co-ordination systems, and when closely linked to a mental health specialty service with resources to handle the patient volume and a commitment to co-ordinating treatment with primary care. The development of an effective screening program composed of these elements is a key opportunity for the re-integration of mental health care into the general medical setting at a time when the Patient Protection and Affordable Care Act in the USA, as well as dominant market forces in the USA and Europe, are producing rapid integration and consolidation of healthcare spending and structure.

Rationale for screening

As the most common, but least recognized, disorders in primary care, mental disorders are prime candidates for survey-based screening. Although mental disorders or related symptoms not meeting the threshold for disorders are reported by parents and primary care clinicians in more than a quarter of all pediatric primary care visits, they continue to be under-recognized by clinicians [1–3,101]. In response, investigators have developed parent- and teen-reported survey instruments for the universal screening of primary care children and adolescents. The idea is that all patients of the appropriate age would be administered a parent or adolescent report tool, usually paper and pencil, in the waiting room. There are now survey instruments with good psychometric properties and many that can be administered by either paper and pencil or computer. These advances have spurred recommendations from professional societies like the

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American Academy of Pediatrics, governmental groups like the US Preventive Services Task Force, and others, to call for routine screening of school-age children for psychiatric morbidity [4,5].

Screening in practice

To design a system for screening in primary care, we need metrics for success. These metrics should be built on two principles. First, the appropriate metrics for regional health services or accountable care organizations (ACOs), the integrated delivery systems proposed in USA healthcare reform, must address the health of covered populations. Second, screening is not simply the administration of an instrument, it is the process of identifying the members of a population with a disorder and connecting them to care. We propose that regional health services or ACOs be evaluated on the proportion of persons with a disorder who become engaged in an appropriate treatment. Minimization of cost and trouble for those who do not have the disorder is also important, but for brevity we only focus on those with the disorder.

When screening is viewed as a process addressing population heath, one discovers that the process has many points of failure. Our experience conducting routine adolescent screening for depression and drug use in a large primary care network is informative [6–8]. First, some teens never have a primary care visit during a given year. For those who did, we employed a computerized screen that was well liked by participating adolescents and clinicians and identified many children previously unrecognized with psychiatric needs. However, roughly half of all teens did not participate in the screening for reasons including literacy problems, teen refusal or lack of guardian consent, or because the clinic staff simply did not administer the screen. Among those who did screen positive, clinicians only referred a small minority to mental health services. Finally, only a fifth of those referred for specialty mental health services actually went to at least one visit in the ensuing 6 months, a number consistent with other studies of referral from primary care. In short, despite having implemented a computerized, psychometrically valid screen in large primary care practices across the city, we succeeded in connecting only a few percent of our population of depressed or substance-abusing youths with care.

This poor performance is not surprising. The practices were staffed by dedicated clinicians, but they were neither accountable for, nor organized to achieve a population health goal.

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Screening & health system transformation

Despite these discouraging results, we believe that current changes in healthcare systems are giving better incentives and building systems that can support successful population screening. The value purchasing movement has created a considerable momentum around the primary care medical home and its tighter links with specialists in co-ordinating care and monitoring outcomes. The patient-centered medical home (PCMH) assigns accountability to the primary care clinician and his/her team for co-ordination and follow through, and comes with the potential for considerable reimbursement in many systems [102]. Specialists that work with the PCMH agree to tight contact and tracking, clear communication around responsibilities towards the patients and the reporting of outcomes.

The interest in PCMH among primary care clinicians and their payors in the USA and the ongoing support of Primary Care Trusts and similar bodies in Europe, are changing practice by emphasizing the coordination role of primary care. This role requires closer linkages between specialists and primary care for referred patients, more effective communication between primary care teams and psychiatrists, and monitoring of services and outcomes for all clinicians. These are precisely the changes that are necessary to make primary care screening effective. The related movement towards ACOs – the use of co-ordinated networks of providers to link care across settings – will further enhance the effectiveness of screening systems between primary care and specialists by incentivizing those practices that are most effective at successful referral and patient improvement.

Action steps

In summary, major quality and financing incentives in the general healthcare arena offer primary care clinicians and psychiatrists new incentives to develop better linkages and referral processes that will provide the successful back end to new screening tools. Mental health specialists, leaders and investigators can expedite these changes through specific actions. First and most importantly, mental health specialists can come together as experts in child symptoms, development and treatment to make unified recommendations about common screening tools for assessment in local primary care practices, common communication tools such as standardized consent for sharing information and

fax back or secure electronic health record or text messaging forms for communicating results. A singular community approach voiced by child specialists is easier to manage within the primary care setting and clearly establishes expectations. Secondly, wherever possible, physical or virtual co-location with primary care clinicians is preferred by patients and greatly increases dose of therapy and return rates. Psychiatrists with the needed flexibility to locate in primary care centers can employ common electronic health records, patient education and office tracking systems, in addition to benefiting from the reduced stigma associated with the primary care clinician's office. Developing a local, regional or statewide child psychiatric consultation system for managing quick questions from primary care screening and psychotropic drug initiation in primary care has also been an important cog in places like Massachusetts [9], Illinois, Minnesota and Ohio. Finally, increasing the role of psychiatrists in design of quality measurement and electronic tools for patient engagement will also greatly enhance the co-ordination of mental health care with general medical services.

All of these recommendations will require the mental health community to speak less as individual professionals or clinics and more as a community of specialists with a focus on specifically addressing the needs of primary care clinicians as the medical home for children. These efforts will ensure that mental health specialists have a greater role in the rapid integration of health and mental health care occurring through market consolidation, health reform incentives and the medical home movement.

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