The PCC Is 25 Years Strong: A Message From the Editor

This issue marks the 25th anniversary of the *Primary Care Companion for CNS Disorders* and my 20th year as its editor. Looking back, it is a wonder how far we in primary care have come in developing expertise and skills in managing psychiatric aspects of our patients' needs. Looking forward, I am delighted with the breadth of new opportunities for us to improve patient care even further.

In February 1999, J. Sloan Manning, MD, as the PCC's inaugural editor, was motivated by the disconnect between his residency behavioral health training and his lack of skills in treating patients with depressive and related psychiatric illness once in practice.[1] At that time, the US Preventive Services Task Force (USPSTF) recommended against primary care clinicians screening for depression because there was no evidence that this improved patient outcomes, although the potential detrimental side effects of treatment were evident. At that time, selective serotonin reuptake inhibitors (SSRIs) were the vanguard medications in psychiatry, tricyclics were still commonly used, and the monoamine basis for psychiatric treatment prevailed. Most SSRIs were branded, and new ones were on the horizon; 5 years later that there were over a dozen medications in development that would be relevant to our practices impressed me.[2]

Not until June 2002 did the USPSTF find evidence of benefit from depression screening, and care of depression became a recommended part of primary care. I recall a year later meeting with the Massachusetts insurance commissioner on behalf of our state Academy of Family Medicine chapter to seek approval for reimbursement of depression care. At that time, we lived with the catch-22 that as part of preventive care, screening for depression was expected and reimbursed, but if we diagnosed depression, the primary care visit was not reimbursable. Depression care was the purview of psychiatry and, specifically, psychiatric "carve-out" providers who were totally separate from primary care. Descartes would be proud. We railed at the boundaries of the "blood-brain barrier," although we had little skill in integrating patient care across it. For instance, while we did recognize that depression worsened cardiac and possibly diabetic conditions, this was thought to be primarily by leading to patient noncompliance, not embedded in neurophysiologic and endocrinologic mechanisms. To our patients' detriment, each condition was treated as separate and unrelated.

Depression and its management, however, became a gateway for primary care clinicians to learn about additional psychiatric conditions and their care. For instance, most primary care clinicians reported that they never encountered patients with bipolar disease and only rarely saw those with psychosis. We recognized anxiety, but generally considered it a nuisance condition that led to requests for benzodiazepines and frequent visits by patients. We tried to steer clear of patients with personality or substance abuse disorders. Antipsychotics were reserved for the elderly with behavioral problems. There was not much we could do for those with dementing conditions. Not until after the tragedy of 9/11 did we recognize posttraumatic stress disorder or consider trauma as a major contributor to psychiatric conditions. While we recognized family patterns of illness, the complexities of epigenetic modulation of genetic makeup in response to environmental stressors and the possibilities of intervening were insights not yet on the horizon.

While we used the Patient Health Questionnaire–9,[3] the goal of depression care was generally to attain a response—remission was the "stretch goal." Cognitive impairment was often present but not considered treatable, and

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neither it nor problems in functioning were measured. For many clinicians, primary care patients with psychiatric conditions were frustrating, challenging our self-perception of professional competence.

This past year, I attended several psychiatric conferences including the European College of Neuropsychopharmacology and gained perspective on what the future holds. Our technologies for investigation, from imaging and mapping the brain as it functions to tracking and manipulating genetic and epigenetic influences, are astounding. We can literally light up brain pathways and probe living cells as they function. Technologies from mobile in-the-moment assessment and monitoring of mood and function to telehealth tools adopted during the pandemic are changing the ways we manage patients. Insights into the integrated nature of immunologic, neurochemical, and hormonal mechanisms active in most illnesses, including those we label as psychiatric, are opening novel treatment possibilities. We recognize that the blood-brain barrier really is not one, and that microglia and astroglia as well as neurons are residents of the brain with complex interactions with other organs and are potential targets for treatments. Glutaminergic and other neural pathways also have become treatment targets. We are beginning to understand mechanisms by which the gut microbiome communicates with and alters neuro-immunologic processes and treatments that alter these processes. While we have heard of many of these developments in recent years, I was struck by how they have matured to the point that numerous new measurement tools and biomarkers for use in clinical practice are emerging, and over 125 new psychiatric medications are progressing through trials. Treatment of depression in the future may have an attainable goal of improving functioning and well-being, taking effect within hours and fine-tuned to benefit pain, sleep, cardiac, or endocrine comorbidities as well. Close collaboration between primary care and psychiatric clinicians will be essential.

Evaluating these new developments and exploring how to integrate them into daily primary care and psychiatric practice, as well as how to adapt our practices to maximize our patients' well-being will be exciting challenges over the next decades. This will require expanding our scope of practice while adopting new clinical tools, treatments, and practice routines. Sound assessment of the evidence base and learning from the experiences of others will be critical to the successful evolution of personal skill and competence as well as clinical practice. The PCC is committed to providing you with necessary insights and guidance. Essential contributions to this process are your submissions to the PCC and the expertise of our peer reviewers. Their insights often lead to substantial manuscript improvements. We are beholden to them for their acumen and the numerous hours they have invested. I particularly want to recognize the impressive vision of our publisher, John S. Shelton, PhD, who has supported the PCC through the years, and the staff of Physicians Postgraduate Press, Inc., especially our Managing Editor, Sallie L. Gatlin, MA, for assuring its consistent highly professional quality.

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