Mental health in general practice and primary care

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Mental disorders are recognised as a major public health problem and the management of mental health problems places an increasing burden on health services. A World Health Organization (WHO) study of the global burden of disease assessed that mental disorders make up five of the 10 leading causes of disability worldwide.[1] While the management of these problems takes place predominantly in general practice and primary care settings, historically there has been a reluctance to acknowledge the role and importance of general practitioners and to provide appropriate support for them to deliver effective services. The challenges of providing effective services are particularly marked in countries like New Zealand which until recently had a number of perceived and actual barriers militating against GP involvement in mental health care.

This paper discusses the following issues that have an impact on general practice work with patients who have mental health disorders and psychological problems:

- Prevalence – What do we see?
- Recognition and detection – What do we miss?
- The 'legitimacy' of GP involvement and engagement – What can we do?
- Changing perceptions of mental health problems. A different view of psychiatry and psychological problems.

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The nature and prevalence of common mental health problems

'We are all born mad – Some remain so' – Samuel Beckett, Waiting for Godot

In the general population of New Zealand, as in other Western countries, over one-quarter of the population have had a diagnosable mental disorder in the last six months. Three-quarters of those with a recent mental disorder have attended a health (mainly general practice) service, but only about one-third have sought help for their mental health problem from any agency. One-quarter of those who received any treatment got it from specialist mental health or addiction services, while GPs delivered three-quarters of the treatment for mental disorders.

A WHO study conducted in 15 different centres across 14 countries, found that 24% of general practice attenders had a current mental disorder reaching accepted diagnostic criteria, and another 9% had a sub-threshold disorder (clinically significant symptoms, but not meeting full criteria for ICD-10).[2]

In New Zealand the Mental Health in General Practice (MaGPIe) study assessed the prevalence of common disorders presenting to general practice.[3] Using the Composite International Diagnostic Interview (CIDI), a validated measure of diagnosis, 36% of general practice attenders had one or more of the three most commonly presenting disorders, anxiety, depression or substance use disorder. Figure 1 shows the pattern of these disorders highlighting the importance of mixed and overlapping patterns of symptoms and problems.

Compared with the high prevalence of disorders in the general population, only a small proportion of patients present mental health problems to their doctor as the main reason for their consultation. Four New Zealand studies have found that between 3.1% and 7.6% of patients had a mental health problem as the main presentation at the consultation. The presentation/prevalence gap to general practitioners has been the subject of much discussion and reflects factors relating to doctors, patients and the health system.

Conclusion and implication

- There's a lot of it about.
- Patients have overlapping patterns of symptom and 'disorder'.

Recognition and detection

'GPs miss up to 50% of patients with depression.'

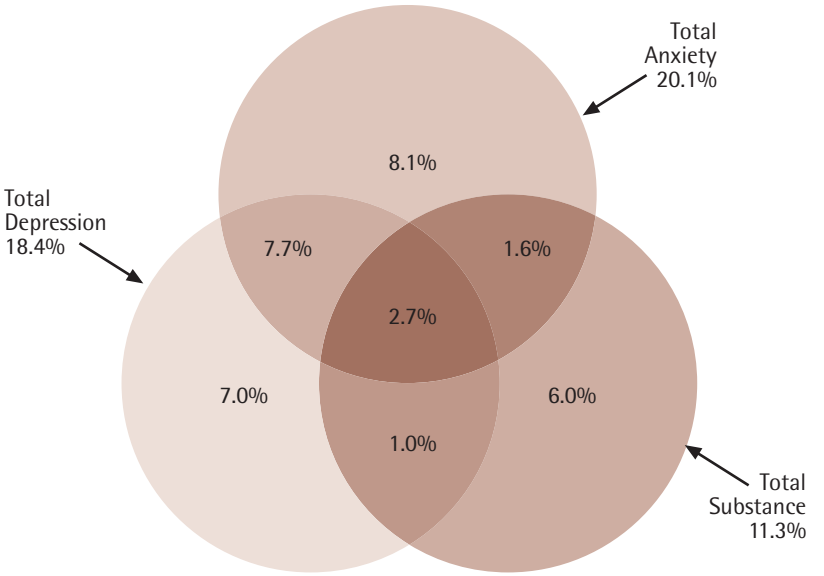
There is continuing debate regarding the effectiveness of the management of common mental health problems in general practice settings. Many studies have reported that general practitioners under-diagnose and under-treat mental disorders, particu-

larly depression.[4] A common response to these findings has been a suggestion that further training and education of practitioners is required and also that screening is an appropriate way of increasing rates of detection. There has also been enthusiasm for the use of screening both in the form of questionnaires and incorporation of specific standard questions into the consultation. The World Health Organization advocates that every patient in primary care should participate in a mental health screening process with the completion of WHO-5 in the waiting room as a standard first step, and recent work from Auckland identified a 'two question' screen as being an effective way to detect the kind of depressive symptomatology that is identified by much longer interview questionnaires.[5]

Two systematic reviews however concluded that the routine screening was a costly exercise with little benefit in improving psychosocial outcomes of those with psychiatric disorder managed in non-psychiatric settings.[6]

The assertion that GPs 'miss' 50% of common psychological disorders however may well be an oversimplification of the way that doctors and patients interact in a consultation. In the MaGPIe study, recognition of psychological problems by GPs was largely dependent on how well the doctor knew the patient.[7] While GPs identified psychological symptoms in two-thirds of those deemed to have a disorder using a validated diagnostic tool (the CIDI), if the patient had been seen five or more times in the previous year, 80% were recognised by the GP as having psychological symptoms. If the patient had not been seen in the previous 12 months, only about one-third were recognised. In patients known to the GP, screening would thus identify relatively few new 'cases', whereas in settings where there is little continuity of care screening may become more effective. GP recognition of psychological symptoms in people with a CIDI-diagnosed disorder also varied according to the type of disorder. Whereas GPs identified psychological symptoms in over 70% of patients with either a CIDI-diagnosed anxiety or depressive disorder, only half of the patients with a CIDI-diagnosed substance use disorder were recognised.

Figure 1. Common mental disorders seen in general practice settings



Internationally, there is a resurgence of interest in using primary care to provide mental health services

Recognition and detection of mental health disorders is also dependent on a number of other barriers and facilitators to care. Up to a third of patients with a diagnosable disorder can identify some reason why they found it difficult to disclose problems to their doctor. In the MaGPIe study the commonest reasons for not disclosing were because the patient felt they should be able to deal with the problem themselves or that a GP is not the right person to talk to about psychological problems. Concerns about the doctor's training or competence, or concern over the cost of paying for mental health consultations were expressed much less frequently.

Interventions to improve patient outcomes may be more effective if they foster continuity of care, focus on the problems most likely to be missed such as substance use disorders, take into account high levels of comorbidity of common mental disorders, encourage patient disclosure of psychological issues, and target new or infrequent attenders.[8]

Conclusions and implications

- GPs recognise 80% of patients with psychological problems in patients that they know.
- Barriers to recognition and disclosure include patient feelings that they should deal with problems themselves, and that a GP is not the right person to talk to about mental health issues.
- Screening has resource implications. A cost effective compromise is to screen new and infrequently seen patients and to restrict more routine screening to situations where continuity is not a feature of care such as after-hours or urgent and emergency medical clinics.

Enhancing GP involvement and engagement in mental health work

Historically, system factors have worked against full realisation of GP involvement in helping patients address their mental health problems. In many health systems it is hard to factor in the extra time required to address psychological issues in primary care settings. In countries like New Zealand this is compounded by the financial barriers of fee for service systems.

Internationally, there is a resurgence of interest in using primary care to provide mental health services. In New Zealand the new opportunities offered by the Primary Care Strategy and previously by IPAs and organisations such as Health Care Aotearoa has seen a variety of initiatives developed across the full spectrum of severity of mental health disorder. Besides exploring ways of providing additional resourcing for general practice engagement with mild to moderate mental disorders there have been a number of successful new opportunities to work with those who have severe and enduring mental health problems.

A brief description of an initiative in the Wellington region serves as an example of the way that general practice can enhance its involvement in mental health work.[9]

The community mental health service in Wellington had been under financial pressure and identified significant constraints in effectively managing the volume of consumers under its care. There were long waiting times for access to the service, causing concerns among GPs and the community generally.

It was felt that some mental health consumers deemed to have relatively low clinical needs remained within the specialist service because of barriers to discharge. These barriers included concerns about GP training, communication between primary and secondary care and the fact that out-of-pocket costs would prevent mental health consumers from accessing GP services.

Given the imperatives for change, the Wellington Independent Practice Association (WIPA) and the local hospital organisation agreed to work together and with the Wellington Mental Health Consumers Union (Inc) to develop a new programme of general practice based mental health care. The main structural features of the programme were a new specialist team staff role (the primary care liaison worker), education and support for general practice staff, free GP consultations, and new protocols to improve communication between primary and secondary care. As a result nearly 400 mental health consumers, who had previously received their care from specialist services, use their GP and practice team to receive both mental and physical health care.

An evaluation of the programme interviewed consumers to assess clinical and economic outcomes, and health professionals in both primary and secondary care to gauge acceptability. Clinical outcomes were assessed with a range of standard tools, which were variously designed for measuring either general health status or mental health status. The tools included the Health of the Nation Outcomes Scale (HoNos)15 and the Life Skills Profile (LSP).

Consumers reported no deterioration in their clinical condition while under the care of general practitioners, and they were largely satisfied with general practitioner care. Consumers' HoNos and LSP scores were stable after entry to the programme. While general practitioners were initially ambivalent about the programme, they were more supportive after the first 12 months.

Conclusions and implications

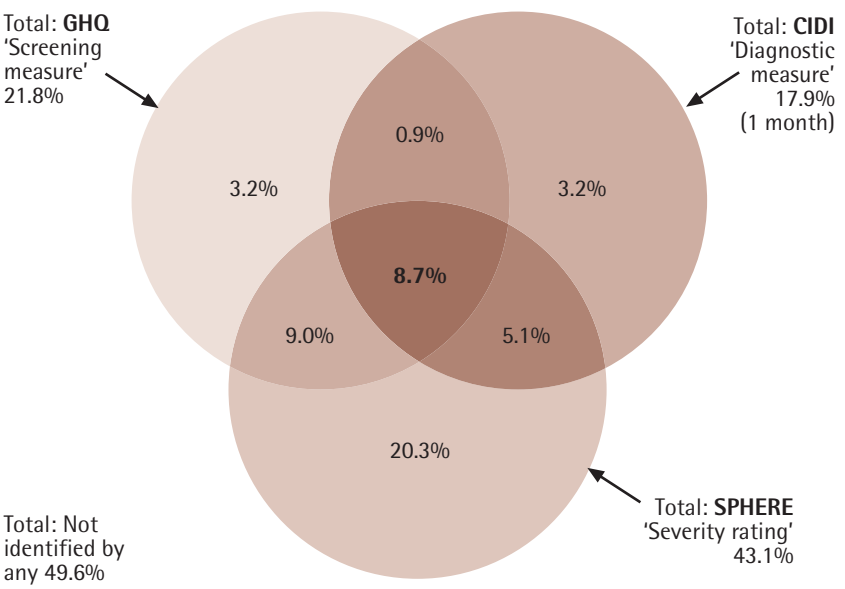
- With carefully designed training and support, general practice can provide high-quality community-based mental health care for consumers with enduring mental health disorders.
- To maintain and sustain such initiatives consumer/patient involvement in mental health initiatives are imperative.

Changing perceptions of mental health problems

'Acting funny but I don't know why' – Hendrix J , Purple Haze

Primary mental health care has developed according to principles and philosophies derived from a special-

Figure 2. Comparison of different psychological assessment tools with the same group of patients.



ist discipline of psychiatry. The 'Diagnostic and Statistical Manual of Mental Disorders (DSM) published by the American Psychiatric Association (APA), for example, is the handbook still used most often in diagnosing mental disorder. While widely accepted among psychiatrists and psychologists the manual has proved controversial in its listing of certain characteristics as mental disorders. The most notorious example is the listing in the DSM-II of homosexuality as a mental disorder; a classification that was removed by vote of the APA in 1973.

This classification and diagnosis of mental health disorders based on secondary care thinking does not fit well into primary care diagnostic and management frameworks, yet often shapes and constrains our clinical thinking. Many of our patients who are distressed or 'act funny' are classified according to predefined criteria that bear little resemblance to patterns of symptoms and disability recognised by a GP. Until recently, for example, there was no classification for the mixed picture of combined anxiety and depression commonly seen in general practice. As an example of the present lack of a suitable 'gold standard', Figure 2 shows the results of comparing GPs' assessment of patients' psychological health in the MaGPIe study using a 5-point scale of severity, with a variety of psychological rating instruments.[10] Patients completed the General Health Questionnaire (GHQ-12), Composite International Diagnostic Interview (CIDI), and Somatic and Psychological Health Report (SPHERE-12). GPs recognised symptoms of psychological disorders in the past 12 months in just over half of those patients. Agreement between GP rates of recognition of mental disorders and diagnostic or symptom rating instruments varied. Only 17% of the patients identified by at least one of the instruments, were identified by all three instruments.

It is not always necessary to make a diagnosis in order to make a management decision, or determine a course of treatment

For many patients, particularly those with mild to moderate severity of problems, it is difficult to know how we decide whether they are a 'case', and whether that case requires treatment. Should we decide the 'casesness' on the basis of a diagnosis, a perceived level of severity or a certain amount of disability?

General practitioners, perhaps uniquely among doctors, are successful in managing uncertainty in clinical practice. It is not always necessary to make a diagnosis in order to make a management decision, or determine a course of treatment. It is important that general practice and primary care develop their own philosophies and management with regard to psychological disorder, which takes uncertainty and our present imperfect understanding of symptoms and disorders into account. What the MaGPIe study has helped to demonstrate is the complexity of recognition and diagnosis of psychological problems in general practice. The Wellington mental health liaison service and similar initiatives in other parts of the country illustrate how general practice, with appropriate support, can provide effective care for those with more severe and enduring mental health problems.

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