Editorial

Tony Townsend has been a general practitioner for 30 years. Although he has dabbled in medical politics, medical ethics, community-based teaching, university-based teaching, quality improvement and assessment, his passion remains clinical general practice. He is currently a full-time general practitioner in Whangamata.

Mental health care in general practice

When the contributions for this issue of the journal started arriving I became aware that I was seeing more patients with acute mental health problems than I had previously seen. Or was I? Perhaps my awareness had been heightened and there was no real increase in the number of patients or perhaps, because I was thinking more about mental health care, patients sensed this and opened up more than they might have done at other times. Perhaps it was simply chance, but in less than a week I saw seven acutely distressed patients.

The first was a young, well-educated woman who was experiencing severe panic episodes resulting in withdrawal and social isolation. It turned out that she was marijuana-dependent. The second was a 25-year-old man who had been depressed for about two years. He had completed a Bachelor degree but then dropped out of university during his Master's and had lost contact with his friends. He was unemployed and spent most of his time doing nothing. He was fixated about his premature balding and was wearing a cap and a hood to cover his androgenic alopecia. Then I saw a 58-year-old woman with a one-year history of low mood, insomnia and suicidal thoughts followed by a 25-year-old woman who had also been depressed for about a year and who was taking paroxetine but was concerned because she was cutting herself. She commented that this was compulsive but afterwards it made her feel much worse. The next day I saw the foster mother of a 17-year-old boy. She had found a screwed-up suicide note in his bedroom and didn't know how to handle this. The week ended with a 33-year-old woman who had been tired for months and found that she was crying easily, didn't want to leave home and had started to send her daughter shopping as she couldn't face going out and a woman who has a long-standing alcohol dependency problem who overdosed on triazolam that she had managed to sneak from her husband who had taken charge of dispensing her medication! In between I saw the usual mix of acute and chronic general practice patients, some of whom also had long-standing mental health issues intertwined with their chronic illness.

What is the point of this? We can all recall similar weeks in our general practice lifetimes when things (patients) seemed to go mad. But that is the point. Patients with mental health problems are common. We listen to them, investigate them to ensure that they are not hypothyroid or demented and we treat them. None of the patients described above were referred despite suicidal thoughts or self-mutilation. The main reason for not referring is not that I believe that I can manage mental health care problems better than anyone else, but simply the reality that if patients with acute mental health problems need help, they need it now. There is little point in sending in a referral that results in an appointment in a week or a month. Unless life is seriously at risk, acute admission does not appear to be an option, although this might be different in other parts of the country. Fortunately every one, except perhaps the marijuana-dependent young woman, rapidly improved by the time they were next seen. The most commonly prescribed medication was an SSRI but I suspect that the decision to acknowledge and talk about their illness was at least as powerful as the drugs I prescribed.

The contributions in this issue of the *NZFP* tend to support the claim that we manage mental health care competently and effectively. Tony Dowell, William Ferguson and John Cosgriff all comment on the MaGPIe study,[1] which has shown that New Zealand GPs are pretty good at identifying psychological problems in their patients and that these problems are very common with about half of all patients identified as experiencing some level of psychological problem during the previous 12 months. This high prevalence is supported by a Belgium study that found that 42.5% of all adult patients had a 'threshold/subthreshold psychiatric disorder'.[2] Although we may experience difficulty in accessing specialist care for our patients who have mental health problems, we are not alone. A survey of more than 6500 US primary care physicians has shown that they face greater hurdles obtaining mental health care services than any other medical services.[3] And that is in the US! The authors comment that primary care is an important entry point for mental health services, yet inadequate referral systems between medical and mental health services may be hampering access.

Attempted suicide appears to be on the increase in New Zealand, particularly among women, but it is interesting to note that the incidence of overdose has decreased while those hospital admissions involving cutting/stabbing and other less common methods has increased.[4] Self-cutting, that is a difficult one; I could have done with Harith Swadi's expertise when listening to the young woman who was telling me about this. Was the paroxetine the cause? Should I increase the dose, switch to another drug or use other strategies to try to help her with this? A little query at the back of my mind wonders whether there is a link between body-image fashion and anorexia nervosa which is now evolving into a link between body piercing and self-mutilation. Certainly, 25 years ago, most of the self-mutilation involved self-inflicted tattoos and I remember spending many hours removing these. The physical and emotional scars of more aggressive self-cutting may not be so easy to erase.

Andrew Darby encourages us to think about what happens to all of those kids that we now have on methylphenidate. Not so long ago I was looking after a family – Mum, Dad and three boys. All of the males took Ritalin and even Mum had taken it on and off although I don't think that she fulfilled the criteria for ADHD. I remember being concerned at one stage as to whether they might be supplying a 'P' lab, but as I got to know them better I became convinced that this was a familial illness. Watching some of our politicians being interviewed on television triggers the thought that adult attention deficit disorder might be quite common in this occupational group but, on the other hand, it might simply be learned behaviour.

John Cosgriff tells us that cognitive behavioural therapy and interpersonal psychotherapy are useful in the management of patients who are moderately depressed, but he also comments that these therapies are not readily available for those who cannot afford private specialist care (that includes almost all of my patients who are depressed). I believe that regular, supportive, patient-centred care by general practitioners helps patients and there is some support for this view from a meta-analysis of randomised controlled trials for the treatment of depression, which showed that remission rates in primary care are at least as high as for those in psychiatric settings.[5]

We have also included two 'reflections' relevant to the theme of mental health care – Guy Pettitt reflecting on compassion and the College motto and Dave McKay on hope in palliative care.

Once again, as with all of our theme issues, we are only able to touch on the topic, but our hope is that this will stimulate readers to reflect and consider their management of patients who have mental health care problems. It is my belief that we are doing well, but that does not mean that we cannot do better.

References

1. MaGPIe Research Group. The nature and prevalence of psychological problems in New Zealand primary healthcare: a report on Mental Health and General Practice Investigation (MaGPIe). NZ Med J 2003 Apr 4;116(1171):U377.
2. Ansseau M, Dierick M, Buntinkx F et al. High prevalence of mental disorders in primary care. J Affect Disord 2004; 78(1):49–55.
3. Trude S, Stoddard JJ. Referral gridlock: primary care physicians and mental health services. J Gen Itern Med 2003;18(6):442-449.
4. Gibb S, Beautrais A. Epidemiology of attempted suicide in Canterbury Province, New Zealand (1993-2002). NZ Med J 2004;117(1205)U1141.
5. Dawson MY, Michalak EE, Waraich P, Anderson JE, Lam RW. Is remission of depressive symptoms in primary care a realistic goal? A meta-analysis. BMC Fam Pract 2004; 5:19.