Whither primary mental health care

William Ferguson MBChB FRNZCGP Dip Obs

William Ferguson has been a GP in Kumeu for 20 years. His main interest is in the integrative and continuing aspects of family health care, for which he found the cornerstones in obstetric care, child development and nutrition and mental health. He has been a senior lecturer in the Post Graduate Department of Obstetrics and Gynaecology at National Women's Hospital, and is currently clinical leader of ProCare's Mental Health Programme.

'I have of late, but wherefore I know not –
Lost all my mirth.
This goodly frame the earth
Seems to me a sterile promontory;
This most excellent canopy the air, look you,
This brave o'erhanging firmament,
This majestical roof fretted with golden fire –
Why, it is no other thing to me
Than a foul and pestilent congregation of vapours.'[1]

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It has been said that for one reason or another only 10% of people suffering from depression receive both timely diagnosis and effective treatment. How would the Prince of Denmark fare in general practice in New Zealand in 2004 if, at the end of a long consultation for a recurring injury (fencing is hell on rotator cuffs), he expressed the above sentiments?

According to the MaGPIe study[2] it is very likely the GP would have recognised an underlying psychological illness, although a full DSM IV diagnosis may be lacking. Furthermore, if the patient had the benefit of a measure of continuity of care and had been seen by the GP a few times previously, then the GP's clinical acumen in this regard is likely to be sharper than any screening test.[3] That inherent perceptiveness of matters psychological in the consultation and the established relationship of trust that exists between a GP and their patient is an excellent foundation stone for the development and expansion of primary mental health services in New Zealand.

Until now we have been somewhat unique in the OECD in that there has been no funded means to address mental health needs in primary care. All funding is targeted to the 3% of the population with the most severe mental illness and is based around secondary services. The 17% of the population that, in any six month period, suffer from mild to moderately severe illness have been left to tough it out (at least until the advent of the PHOs), with funding barriers to access their general practitioner that have been greater than in any other OECD country. This would suggest that not only is a redeployment of funding and resources long overdue, but that damage may have been done by years of neglect.

The MaGPIe study also tells us that more than a third of the patients presenting to us in primary care have had some sort of psychological problem in the last 12 months and it is known that 50% of all psychological presentations in general practice are co-morbid with physical illness. It is also known that any chronic illness such as heart disease, diabetes or cancer virtually doubles the incidence of a co-morbid underlying psychological illness.

It is clear from these figures that good mental health care could easily be identified as the remaining glue that holds family health care together, particularly now that the most important aspects of reproductive health have been removed from primary care. But despite being in the thick of all this, are we delivering to our potential in this aspect of our care, and are we ready to take up the challenges laid down in the PHO environment of meeting the mental health needs of our enrolled populations? How can we grow our capability and our capacity in a way that builds on what works well in the general practice team rather than in a manner that adds to fragmentation and dysfunction?

Let us look briefly at some strengths, weaknesses and opportunities.

Continuity of care, trust and the generalist medical expertise that enables us to think across specialist boundaries are strengths central to general practice. These strengths are not sexy to researchers and bureaucrats seeking simplistic solutions, but nonetheless go a long way to explaining the effectiveness and efficiency that general practice is capable of delivering in primary mental health care. However, the statistic that a mere 10% of patients with depression receive both timely diagnosis and effective treatment attests to a multitude of barriers on both the patients' and the doctors' side.

A major weakness we all face is that both doctors and patients struggle to think across the imaginary fault line that divides mind and body. It exists both in our medical school training and in all conventional western thought, and it interferes with our

understanding of both diagnosis and treatment. An important challenge all health care faces is better integration of physical and mental health care. In saying this, the astute reader can rightly admonish me for recreating the dichotomy! We medicalise things at the slightest provocation. Given that twilight zone of uncertainty of diagnosis or uncertainty of treatment and a waiting room full of patients, we retreat to our bag of familiar tricks with unnecessary lab tests and hasty prescriptions. An opportunity for innovative funders is to recognise that at these moments we need designated extended time to be with the patient as a 'cost-neutral' option for both the doctor and the patient. I am sure that in many instances another 15 minutes of careful consultation time will deliver more diagnostic relevance than any number of laboratory tests, and indeed if at the end of it all a prescription is required, I suspect the patient is more likely to feel disposed to actually take the pills!

If we open the door to this unmet need, what should our role then be? Do we attempt to do it all ourselves? Or do we do the bits we fancy or think important and leave the rest? A current weakness is that generally we have not really thought through all the issues around referral for additional psychological expertise. We need to construct a team we can work with flexibly and with confidence. Research on patient expectations suggests our patients do not expect us to be expert psychotherapists, but they are concerned about the sort of relationship they have with their doctors. *'Don't be nervous about being empathetic. We won't clutch at you like drowning men. We only want you as a doctor'* Kay McKall admonishes us in her excellent and insightful essay.[4] Clearly we need to be experts at the doctor-patient relationship, and we need two attributes in our new team members – the right expertise, at exactly the right time.

In the same way that the patient requires a huge measure of trust to engage with us in the matter of their psychological distress, so also we as GPs need trust in the exact nature and quality of the psychological services that we wish to draw upon. Referral of the complicated psychological problem is of far more importance than the referral of a surgical one. Surgeons have standardised training and do standardised procedures. Do we have the same confidence for someone with a nice pamphlet advertising counselling or psychological services? How familiar are we with the most effective psychological treatment for the conditions we intend to refer, and who has the most expertise in the delivery of those treatment modalities? What quality assurance and evaluation of outcomes do they have in place? Do they see themselves as part of a team approach to primary mental health care?

The second important attribute our new team member must have is timing. In the continuous role we have in our patients' life journey, timing can be critical to efficiency and effectiveness. To quote Iona Heath at the recent College Conference, *'It is by speed and slowness that one slips in among things, that one connects with something else...One takes up or lays down rhythms.'* An appointment for much needed psychological treatment in a secondary services clinic months later is usually not a synchronous part of that rhythm.

I believe it is time the credentialed clinical psychologist came in from the cold and joined, or rejoined, the practice team. I say rejoined because many of you may have forgotten that it was the ground-breaking work in the 1960s of a psychiatrist, a psychologist and a bunch of frazzled GPs, that led to the publication of a book whose insights moulded the philosophical origins of modern general practice.[5] What if effective psychological treatment as an alternative to medication for mild or moderate illness was also a cost-neutral option for our patients? Perhaps we could simply call it the 'Blue Prescription'.

So in treating our Scandinavian Royal who presented with a shoulder strain, the best evidence tells us that the type of treatment (effective psychological treatment modalities or medication) matters less than ensuring it is done properly and then followed up.[6] A meta-analysis of various interventions to improve care of patients with major depression in primary care highlighted follow-up ('case management') as an important hallmark of effective programmes.[7] There is an opportunity here for the practice nurse to expand her role and provide the same meticulous follow-up afforded a patient on anticoagulants, to selected patients with major depression. This will help to ensure treatment adherence, and monitor progress whenever the patient has slipped off the GP's radar screen.

The *'Insiders Guide to Depression'*[4] provides a haunting image of how it feels to be suffering from depression *'the bleakness of the landscape is unimaginable. It is as friendless and alien as a Dali painting.'* In exhorting us to attentive and frequent follow-up the author later adds *'A week is a long time in a Dali landscape. Three weeks are almost unimaginable.'* What are we waiting for?

References

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