ABC of mental health

Common mental health problems in primary care

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The size of the problem

Psychiatric symptoms are common in the general population: worry, tiredness, and sleepless nights affect more than half of adults at some time, while as many as one person in seven experiences some form of diagnosable neurotic disorder.

These problems are not confined to Western countries. The World Health Organisation's study of mental disorder in general health care screened over 25 000 people in 14 countries worldwide and assessed 5500 in detail. A quarter had well defined disorders, and a further 9% had subthreshold conditions. The most common disorders were depression (10%), generalised anxiety disorder (8%), and harmful use of alcohol (3%).

Anxiety and depression, often occurring together, are the most prevalent mental disorders in the general population

The 1993 world development report of the World Bank estimated that mental health problems produce 8% of the global burden of disease, a toll greater than that exacted by tuberculosis, cancer, or heart disease. Much of the burden falls on women and young adults.

Not everyone who experiences symptoms consults a general practitioner, but having a mental disorder doubles the likelihood of consultation. About a quarter of patients with probable mental disorder in the general population will consult in any two week period. People with mental disorders consult more frequently than other patients, and almost a quarter of all consultations are attributable to psychiatric morbidity.

Poor outcome is associated with delayed or insufficient initial treatment, more severe illness, older age at onset, comorbid physical illness, and continuing problems with family, marriage, or employment

Mental disorders in primary care

The World Health Organisation's classification of mental disorders for use in primary care pays more attention to the commoner neurotic disorders, while schizophrenia and the other psychoses are classified according to their course.

Mental health problems in primary care

- Emotional symptoms are common but do not necessarily mean that the sufferer has a mental disorder
- Many mood disorders are short lived responses to stresses in peoples' lives such as bereavement
- About 30% of people with no mental disorder suffer from fatigue, and 12% suffer from depressed mood
- Anxiety and depression often occur together
- Mental disorder comprises about 25% of general practice consultations—In Britain up to 80% of referrals to specialist psychiatric services come from primary care

Bereavement

Death of a loved one is a distressing episode in normal human experience. Expression of distress varies greatly between individual people and cultures, but grieving does not constitute mental disorder. The doctor's most appropriate response is compassion and reassurance rather than drug treatment. Night sedation for a few days may be helpful, but oversedation should be avoided. Antidepressants should be reserved for those patients who develop a depressive episode

World Health Organisation's classification* of mental disorders in primary health care

Organic disorders
F00 Dementia
F05 Delirium

Psychoactive substance use
F10 Alcohol use disorder
F11 Drug use disorder
F17.1 Tobacco use

Psychotic disorders
F20 Chronic psychotic disorder
F23 Acute psychotic disorder
F31 Bipolar disorder

Mood, stress related, and anxiety disorders
F32 Depression
F40 Phobic disorder
F41.0 Panic disorder
F41.1 Generalised anxiety
F41.2 Mixed anxiety and depression
F43 Adjustment disorder
F44 Dissociative disorder
F45 Unexplained somatic complaints
F48 Neurasthenia

Physiological disorders
F50 Eating disorders
F51 Sleep disorders
F52 Sexual disorders

Developmental disorders
F70 Mental retardation

Disorders of childhood
F90 Hyperkinetic disorder
F91 Conduct disorder
F98 Enuresis

*ICD-10 (international classification of diseases, 10th edition)

Mood, stress related, and anxiety disorders

Many mood problems are reactions to distressing circumstances (such as bereavement) and resolve spontaneously: patients with such problems benefit from reassurance and time rather than drugs or specialist counselling. About three quarters of patients with new onset neurotic disorders can be expected to recover within a year, but as many as 20% are still symptomatic after three years.

A general practitioner with 2000 patients is likely to see one suicide in a four year period. Recent studies indicate that 15-22% of patients who go on to kill themselves will have seen their general practitioner in the week before their death, and 30-40% will have seen their doctor in the previous month. Those people with past contact with psychiatric services are more likely to contact their family doctor in the period leading up to suicide. An opportunity therefore exists for primary care services to help in preventing suicides, and this may be achieved by improved assessment of suicide risk, liaison with mental health services, and more effective treatment of major depression.

Misuse of psychoactive substances

General practitioners can expect to see patients who misuse all types of substances.

Most alcohol related problems in general practice affect moderate users (that is, men who drink 21-50 units a week and women who drink 15-35 units), but a fifth of adults consume harmful amounts of alcohol. However, recent surveys suggest that fewer than a quarter of general practitioners routinely ask patients about their drinking habits. Studies in Britain have shown that 15 minutes of advice from a general practitioner may reduce alcohol consumption by as much as 15% and achieve up to a 20% reduction in the number of patients with drink problem.

About half of general practitioners in Britain report seeing users of illicit drugs, and many practices offer advice on reducing the risk of HIV infection, safe sexual behaviour, and on needle exchange programmes.

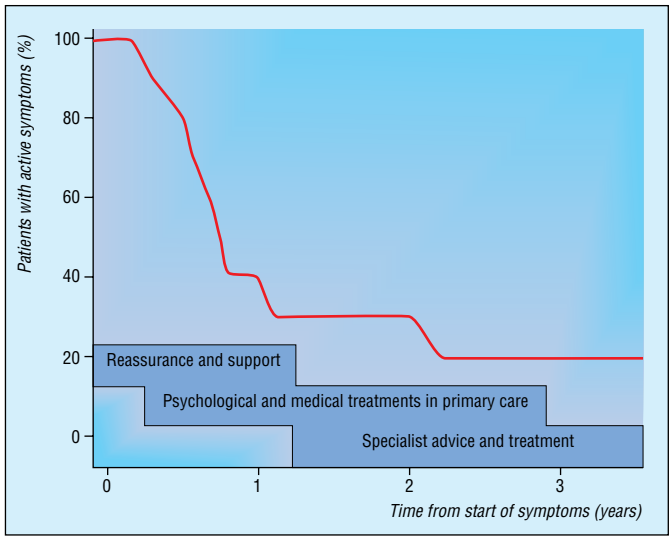
Benzodiazepine dependence has often been highlighted as a particular problem in general practice. Typically, a general practitioner with 2000 patients will have 60 long term users of benzodiazepines, of whom 45 will be aged over 60. Most will be women who have been taking the drug for more than five years. There has been a steady decline in prescribing benzodiazepines over the past decade, much of this being due to better practices within primary care.

Psychotic disorders

The more severe mental disorders (such as bipolar affective disorder and schizophrenia) are relatively uncommon in general practice. Most of these patients will be in contact with specialist services, although as many as a quarter will eventually be discharged back to the care of their family doctor. General practitioners have a particularly important role in the shared care (with specialist services) of these patients—monitoring physical health, long term medication, and compliance with treatment.

Common presentations

Most patients with mental disorders consult their general practitioner with physical rather than psychological complaints. The complaint may be of "feeling tired all the time," poor sleep, or of not coping with day to day events. Other behaviour at presentation may point indirectly to mental health problems. These presentations may initially mislead an unwary doctor, and the mental disorder may go undetected and untreated for several months.

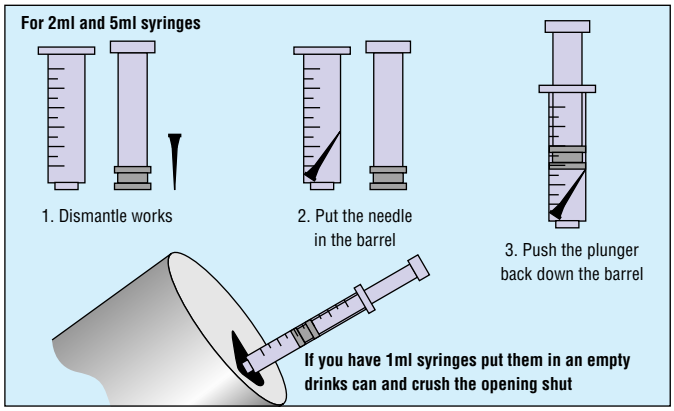


Resolution of new onset neurotic disorders

Factors that should prompt questions about suicide

Especially if patient is male, single, older, isolated, or shows several factors simultaneously

- Previous suicidal thoughts or behaviour
- Marked depressive symptoms
- Misuse of alcohol or illicit drugs
- Longstanding mental illness (including schizophrenia)
- Painful or disabling physical illness
- Recent psychiatric treatment as inpatient
- Self discharge against medical advice
- Previous impulsive behaviour, including self harm
- Legal or criminal proceedings pending (including divorce)
- Family, personal, or social disruption (such as bereavement, marital breakdown, redundancy, eviction)



Advice to drug addicts on safe disposal of used needles

Mental disorders presenting with physical complaints

- Coexisting physical and mental disorders that are essentially independent of each other (such as heart disease in a patient suffering from depression)
- Distress due to physical illness (such as anxiety or depression related to a life threatening illness)
- Somatic symptoms of a mental disorder (such as palpitations due to anxiety)
- Chronic somatisation disorders in which patients express hypochondriacal convictions that physical disease is present in the absence of any medical evidence for this
- Common physical complaints include
  - Tiredness, poor sleep, lack of energy
  - Vague aches and pains
  - Worry, tension, inability to relax
  - Poor memory, "Can't cope"

Detecting mental disorder in primary care

Although the bulk of psychiatric morbidity is seen at the primary care level, only a small proportion of cases is referred on to the psychiatric services. In part, this reflects the low rate of detection of mental disorder by general practitioners. Failure to detect mental disorder denies patients potentially effective treatment, and enduring psychological distress has profound effects on patients' capacity to work and enjoy a reasonable quality of life and on their families.

Detection of mental disorder has been shown to reduce the number of subsequent consultations, to shorten the duration of an episode, and to result in far less social impairment in the long term. A doctor's skill in detecting mental disorder has three main components.

Bias towards making psychiatric judgments

Detection of disorder is more likely among doctors who believe that psychological factors play an important role in the aetiology and course of both physical and mental disorder, who express an interest in psychiatric problems, and who believe that mental disorder is an important, legitimate concern of medicine and that mental problems are amenable to treatment.

Vigilance in attending to verbal and non-verbal cues of disorder

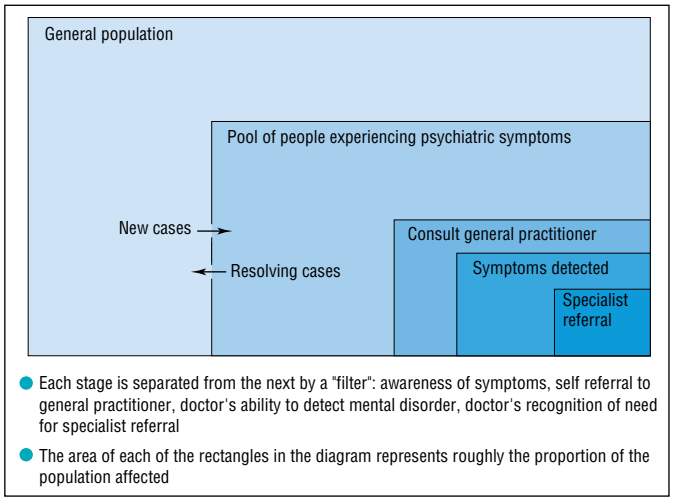
Vigilance reflects the extent to which a doctor actively searches for clues about the presence of mental disorder. Many doctors respond with greater vigilance to groups of patients in whom mental disorder is known to be more prevalent (for example, older, female, widowed or separated patients and those who have often attended the doctor's surgery) but miss disorder in patients who do not match the stereotypes.

Quality of interview and diagnostic skills

Neither high bias nor high vigilance necessarily leads to accurate judgments about the presence of mental disorder (doctors with a high bias might overdiagnose disorders). Diagnostic accuracy is not simply related to experience (the number of years in practice) or to the length of time spent with a patient but is rather related to the style and focus of the interview itself.

Doctors with good accuracy ask more open questions, confirm non-verbal cues detected at interview, and inquire about the family and home life of their patients. Patients with emotional disorder, including those who present with somatic rather than psychological complaints, display both a greater number of and more intense verbal and non-verbal cues of mental disorder when interviewed by doctors with good diagnostic skills.

Doctors with low accuracy display interview behaviours that suppress their patients' expression of emotion (closed questioning, narrow focus on symptoms, abrupt manner), which correspondingly lowers the doctors' chances of correctly identifying a mental problem.



Stages on the pathway to care

Problems suggesting an underlying mental health problem

Presenting problems

- Seemingly inappropriate requests for urgent attention (appointments, home visits)
- Increased frequency of consultation or requests for tests
- Unexpected or disproportionate outbursts during consultation (tears, anger)
- Excessive anxiety about another family member (child, elderly relative) or presenting a relative as the patient

Recurring problems

- Frequent consultations, "thick notes"
- Unstable relationships or frequent breakdowns in relationships
- Distressing or deteriorating social circumstances (eviction, redundancy, squalor)—Poverty may not cause mental disorder, but it can increase vulnerability and reduce the ability to tolerate symptoms

Factors determining the detection of mental disorder

Patient factors

- Nature of presentation (somatic presentation less likely to be detected)
- Severity of disorder (more severe problems more likely to be detected)
- History of psychiatric problems known to general practitioner
- Relatively high frequency of recent consultations

General practitioner factors

- Positive attitude to mental disorder and psychiatric patients
- Interest and knowledge of mental disorder
- "Bias" in assessment
- Interview skills—Doctors who are better at detection
  - Make early eye contact
  - Clarify presenting complaint
  - Avoid "checklist" questioning
  - Ask more "open" and clarifying questions
  - Spend less time talking and interrupt less
  - Seem less rushed
  - Show empathy
  - Are sensitive to emotional, verbal, and non-verbal cues

Managing mental disorder in primary care

Direct care

Any member of a primary care team may encounter patients with mental health problems and require advice and guidance. A general practitioner's role will include supervising other staff as well as directly managing such patients by means of drugs or psychological treatments.

In Britain most psychotropic drugs are prescribed by general practitioners, and most moderate anxiety and depressive disorders are entirely and successfully managed in primary care

Although there is insufficient time in the average consultation to undertake formal psychological interventions, many general practitioners who are good at detecting disorder also use psychotherapeutic and counselling techniques to the benefit of patients. Some use double or extended consultations for this purpose. Several studies have found specific interventions by general practitioners to be highly effective.

Other effective interventions include explaining the rationale for treatments, negotiating compliance, checking that advice and treatment are understood, and providing straightforward psychosocial advice on managing distress.

Patient characteristics influencing general practitioner's decision to refer

- Male sex
- Younger age
- Severe disorder
- Experience of separation in early life
- Associated misuse of alcohol or drugs
- Suicide attempt or suicidal ideation
- Social problems
- Inappropriate responses to medical attention

Specialised services in primary care

About a third of general practices in England and Wales have psychological treatment services, most provided by trained counsellors. While there is a wide range of professional backgrounds and therapeutic skills from which to choose, most are based on "non-directive" approaches and psychoanalytical methods. The efficacy of generic counselling (the most common arrangement in primary care) is far from certain as it lacks a strong research base.

We believe that priority should be given to employing staff who can offer treatments of proved efficacy. In primary care cognitive and behavioural therapies are efficient and effective, with proved value in treating depression, generalised anxiety, phobic anxiety (both generalised disorders such as agoraphobia as well as specific fears), obsessive-compulsive disorder, stress related disorder, sexual dysfunction, and the addictive disorders. Nurse behaviour therapists are specifically trained in these techniques but are still relatively few in number. Most clinical psychologists will also be familiar with these interventions.

Effective interventions by general practitioners

- Most moderate anxiety and depressive disorders are managed successfully in primary care
- Brief structured counselling by general practitioner is as effective as anxiolytic drug in generalised anxiety disorder
- No difference in outcome between acute neurotic patients managed by generic community psychiatric nurse or by general practitioner
- Fifteen minutes' advice from general practitioner is effective in aiding reduction of alcohol consumption
- Advice on reducing risk of HIV infection through safe sexual behaviour or needle exchange programmes
- Further examples of general practitioner interventions
  Teaching relaxation techniques
  Supporting use of self help techniques in neurotic disorders
  Supervising withdrawal from alcohol
  Monitoring depot medication
  Operating shared care protocols with local community mental health services

Psychological treatments in primary care settings

Treatment	Practitioner	Programme	Use
Cognitive-behavioural therapy	Nurse therapist or clinical psychologist	6-12 sessions	Effective in depression, generalised and phobic anxiety, obsessive-compulsive disorder, and stress related disorders
Generic counselling using non-directive or psychodynamic methods	Qualified counsellor	Open ended	Used in variety of neurotic disorders Effectiveness not proved
Long term outreach support Case management and other specialist interventions	Community psychiatric nurse	Long term	Effective in patients with severe mental illness Best provided in association with specialist mental health services

Community psychiatric nurses have provided an important link with local specialist mental health services, but their role is controversial. As specialist psychiatric services focus on the needs of patients with severe mental illness, there have been moves to equip community psychiatric nurses with specialised treatment skills for the long term management of this group of patients. These skills include problem orientated case management, family psychoeducation, and psychological interventions aimed at improving compliance (adherence) with medication and coping with persistent psychotic symptoms.

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Further reading

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