Improving mental health through primary care

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SUMMARY. The government white paper Health of the nation *has highlighted mental health as a key issue for the next decade. Primary care is being encouraged to take a leading role in developing effective services for people with mental health problems. This paper reviews current research on key aspects of mental health in adults: the prevalence of mental health problems, improving detection and management of mental health problems, the role of counselling, and communication between primary and secondary care. Recommendations are made for initiatives in both research and service development.*

Keywords: mental health care; GP role; GP psychiatrist relationship.

Introduction

INCREASING attention is being paid at both political and professional levels to the role of primary care in looking after people with mental health problems.[1-3] For primary health care teams to be successful in their role, they must know the extent of the problems and be willing to adopt new initiatives which will support people with mental health problems in the community.

The aim of this paper is to provide general practitioners and their colleagues with an overview of recent research in this area and with ideas for the development of their mental health services. It is intended as a stimulus for discussion and research and not as a definitive set of guidelines.

The extent of mental health problems

At any given moment, approximately 30% of people in the United Kingdom are experiencing symptoms of anxiety or depression.[4] Up to 40% of patients attending their general practitioner for any reason have a probable psychiatric disorder.[5-7] In a study of Camberwell residents at least 10% of people aged between 18 and 64 years had symptoms severe enough to be diagnosed as 'cases' (having a defined psychiatric problem) by psychiatrists.[8] About half of these people were still symptomatic a year later.[9] Goldberg and Huxley, reviewing the literature on the incidence of depression and anxiety, estimated that psychological morbidity of all types affects between 26% and 32% of the population per year.[6] Skuse and Dunn, in an analysis of John Fry's patients, found that over a 20 year period three quarters of all women and a half of all men had seen their general practitioners about a mental health problem, usually depression.[2]

Some groups are at particular risk: 16% of elderly people have pervasive symptoms of depression;[10]; up to 22% of women develop depression postnatally.[11] People who are socially disadvantaged, such as those who are unemployed[12] or living in overcrowded or poor housing,[13,14] and ethnic minorities[15] are more likely to suffer mentally. Sexual abuse in childhood leads to psychological problems in later life.[16] Approximately 1% of all deaths are by suicide. Rates of suicide are increasing, particularly in young men aged between 15 and 24 years (Markowe H, conference presentation, Royal College of Physicians, November 1991).[17]

Self reports of alcohol consumption reveal that about half of all men aged between 18 and 59 years are moderate to heavy drinkers, averaging 28 units a week or more.[18] In a general practice of 10 000 patients there are likely to be about 125 people (almost all men) with a chronic alcohol problem.[19]

Psychotic illnesses, including schizophrenia and manic episodes of bipolar affective disorders, have a prevalence of about 1% in adults.[8] People suffering from schizophrenia tend to 'drift' into areas of urban deprivation, so rates will vary in different parts of the country.[20,21]

Three or four people in every 1000 have severe learning difficulties, with an intelligence quotient below 50; between 2% and 3% have an intelligence quotient of below 70.[22]

About 7% of people over the age of 65 years suffer from senile dementia, of whom about 5% have a problem significant enough to require the intervention of professional health services. This condition is still relatively rare in 'younger' elderly people, the prevalence increasing with age.[10,23,24]

Improving mental health services in primary care

Detection of mental health problems

Up to one half of cases of severe depression and other mental disorders presented in primary care are not recognized as such by general practitioners.[7,25] This is more likely to occur if physical illness is also present, or if patients present with predominantly somatic complaints.[25-29] Failures in diagnosis are also more likely if doctors have shorter consulting times,[30,31] and are lacking in communication skills.[32] For every person with a chronic alcohol problem known to a general practitioner, there are five unknown cases.[9] At least 70% of elderly people with dementia are not recognized as suffering from the condition by their general practitioner.[10,33]

Strategies are available to improve general practitioners' ability to detect mental health problems. The obligations to screen new patients and those over the age of 75 years already provide opportunities.[34] These can be supplemented by screening questionnaires: the general health questionnaire or the hospital anxiety and depression scale, the Edinburgh postnatal depression scale,[35] the CAGE[36] and MAST[37] questions for alcoholism, and the mini-mental state examination for dementia.[38] Longer consultation times are likely to lead to greater detection rates.[31] Changes in undergraduate education,[39] and training for both general practice trainees and established principals[40,41] have been shown to lead to improvements in detection rates, particularly for depression and anxiety.[42]

It appears that detection of mental illness results in a better prognosis for the patient.[25,43,44] But it is not clear if this difference is the result of detection, or if illnesses with a better prognosis are also more likely to be detected.[45] Many problems may be transient and resolve spontaneously. Recognition of mental illness by a doctor may be less of a determinant of recovery than improvement in physical illness, resolution of a life problem or increased job satisfaction.[46]

Treating mental health problems

Should anxiety and depression be managed by drug therapy or psychological treatment? There has been a considerable decrease in benzodiazepine prescription over the past decade, and there

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have been several successful controlled trials of psychological strategies for managing anxiety.[47-50] Drug therapy can be successful in the treatment of depression,[51] but there is also now good evidence of the beneficial effects of psychological treatments.[52-54] There are often problems with compliance with antidepressant medication, owing partly to general practitioners' failure adequately to explain the side effects and duration of action of antidepressant medication.[55] There is disagreement about the place and benefits of the newer generations of antidepressant medication.[56,57] All antidepressants appear to have similar efficacy in the relief of depressive symptoms, but they differ in respect of side effects and cost. Some experts claim improved side effect profiles of the 5-hydroxytryptamine specific drugs while others doubt whether such benefits are worth the price differential. The cost implications of rational antidepressant prescribing have yet to be calculated, but it is likely to prove expensive.

With regard to helping people with learning difficulties, general practitioners should see themselves as part of a network of community resources.[58,59] People with learning difficulties often have their health needs neglected and may benefit from proactive screening programmes.[60]

Community care for schizophrenic patients is often inadequate: many continue to be disturbed by psychotic experiences, have poor or no accommodation, receive little social support and have no prospect of employment.[61-65] Those living with their families can cause enormous emotional strain.[66] General practitioners may be wary of becoming involved with these patients, preferring to adopt a minimalist role and deal only with crises.[67] Improvements in care are, however, possible.[68] The Worcester development project was set up by the Department of Health and Social Security in 1975 as a model for the closure of an old psychiatric hospital and its replacement by a comprehensive and flexible set of community mental health facilities. It has shown how, given adequate resources and time, community care can work.[69-72] General practitioners may become involved in case management as a result of the government paper *Caring for people.*[73] A training programme for general practitioners in the management of patients with longterm mental illness is underway (Kendrick T, Burns T, Freeling P, Sibbald B. General practice registers of the longterm mentally ill. Presentation to annual conference of the Association of University Teachers of General Practice, Manchester, July 1992). The Department of Health has set up a care programme involving four multidisciplinary psychiatric teams and an evaluation team, in inner London.[74] Early results are encouraging in terms of symptom improvement and reduced hospital inpatient time.

It is difficult to determine exactly what level of services people with mental health problems need. There is no direct correlation between a diagnosis of, for example depression and a need for input from health services. Measuring the prevalence of disorder is not the same as establishing need for treatment;[75] the level of disability consequent on a specific disorder needs to be estimated. This work, of crucial importance to health care purchasers, must be an urgent priority for researchers.

Counselling in general practice

Counselling involves the 'skilled and principled use of relationships to help the client develop self-knowledge, emotional acceptance and growth, and personal resources'.[76] Given the extent of psychological distress which is presented in primary care, there is an apparent need for such a service; there is also a growing demand. Counselling makes up one quarter of the health promotion clinics within Oxfordshire family health services authority (Griffiths J, conference presentation, Royal College of Physicians, November 1991).

Counselling is appropriate for people going through difficult life events (transitions) such as bereavement or relationship problems and who are becoming anxious or depressed as a result. While it is less likely to benefit people with personality disorders or severe mental illness, it may be helpful for people withdrawing from drugs or alcohol.[76] Some general practitioners see counselling as a useful therapy to refer their 'heartsink' patients to.[77] While a fresh approach may be helpful for such patients, this is generally unlikely to be an efficient use of counsellors' time.

General practitioners are in a prime position to counsel those patients with psychosocial problems. However, few doctors have received training in counselling, and the difference between the use of counselling skills and the process of counselling — the former needed in every consultation, the latter only in consultations where psychological problems are the focus — is not always understood.[78] Other professional groups may have skills to offer. Community psychiatric nurses are developing an interest in this field[79] and social workers are becoming adept at identifying psychosocial needs.[80] Indeed, the Edinburgh depression study has shown social workers to provide a better short-term outcome for depression than general practitioners, clinical psychologists or psychiatrists.[81] Clinical psychologists are equipped with a variety of counselling techniques, but they are scarce and may be most efficiently employed in a consultative capacity.[82] The clergy represent an important, often neglected resource.[83] Counsellors may have a wide variety of backgrounds and training, and care must be taken to ensure their expertise is both adequate and relevant to primary care. The British Association for Counselling and Royal College of General Practitioners have produced guidelines.[76,84,85] It should not be forgotten that family and informal support networks and self care programmes may be as effective as formal counselling.[86] Nor should the mental health of general practitioners themselves be ignored or the fact that they too may need counselling.[87]

Analyses of psychotherapy and counselling indicate that on average, a client in therapy has a better outcome than three quarters of individuals not receiving therapy.[88-90] Corney's review of studies of counselling in primary care found benefit for patients in two thirds of the studies reviewed.[91] Proponents of behavioural and cognitive therapies argue that they are more effective than psychodynamic approaches, but there is lively debate on this question.[92] It seems likely that short term focused group work is more cost effective than long term open ended individual work. Jacobson and Truax have proposed guidelines on 'clinically significant improvement' which should prove useful in evaluation.[93] Counselling may also have indirect benefits, in reducing costs of prescribing, hospital investigations and treatments.[49,94,95] This merits further investigation.

There are thus several questions which need to be addressed when considering the role of counselling within primary care. How much counselling will general practitioners do themselves, and will they need further training? What is the role of the counsellor — to counsel patients, to offer consultancy for general practitioners, or indeed to counsel general practitioners?[96] What are the referral criteria from doctor to counsellor? What types of counselling are offered — behavioural, cognitive, problem solving or psychodynamic? Are counselling contracts short or long term, are they for individual or groupwork, or for family therapy?[97] What is the level and quality of supervision offered to those who are counselling? How is the counselling evaluated — consumer satisfaction, effect on primary care workload, effect on prescribing and hospital costs, or effect on patients' mental health? How is counselling funded? This last question is of increasing importance as family health services authorities grow anxious at the amount of health promotion money going in this

direction. Primary care teams will need to demonstrate either that they are providing tangible benefits to patients or that counselling is reducing the costs of other services.

Primary and secondary care

The closure of mental hospitals and the increasing emphasis on community care means that the old distinctions between primary and secondary care are rapidly becoming obsolete. Psychiatrists are increasingly working outside hospitals in community mental health teams.[98,99] This trend is broadly welcomed by general practitioners,[79,100] but there is a need to clarify the roles and boundaries of the new relationship.

In terms of patient or diagnostic categories, there are clear spheres of interest and expertise at each end of the spectrum: patients with transient social and psychological distress should remain in the domain of the primary care team while patients with acute psychotic episodes are best managed by psychiatrists. But there is a broad group in the middle, including patients with depression and chronic schizophrenia, where both primary and secondary services can have a useful role.[101] General practitioners and psychiatrists need to come together to work out how best to manage this large middle ground. Cooperation between community mental health teams and primary care teams is likely to be both more rational and cost effective than developments in isolation.[102]

Two main models are in operation. In the shifted outpatient model, the psychiatrist sees outpatients in a primary care setting instead of a hospital. Patients prefer this to attending hospital, and it enables better access to general practitioner notes and better communication with general practitioners.[103] In the liaison-attachment model, the psychiatrist visits the primary care team on a regular basis for liaison meetings and case discussions. The psychiatrist may also see a few patients either with the general practitioner or as formal referrals. This latter model appears to make more cost effective use of psychiatric expertise: more patients are seen by psychiatrists, but more continue to be managed by the general practitioner after one psychiatric consultation.[104]

Even where general practitioners and psychiatrists are continuing to communicate by means of the traditional doctor's letter, patient care can be improved by more effective use of the hospital discharge summary.[105]

Liaison with other professionals requires consideration. Social workers have much expertise in mental health work and, if the logistical and organizational problems of the interface between health and social services can be overcome,[6,73] they may make an important contribution to primary care mental health services. Community psychiatric nurses[79] and clinical psychologists[82] are of increasing importance, though their roles have yet to be fully defined. There is a large overlap with the clergy in terms both of pastoral skills and of clients.[83]

Improving primary mental health care

This review of the current literature on mental health services in primary care has identified a number of areas for service development and for further research.

Improving mental health services in primary care teams

- Increase collaboration within primary health care teams and between teams and secondary care. It may also be helpful to designate a member of the primary health care team to take particular interest in mental health issues.
- Audit aspects of care including: known versus expected prevalence of mental health problems; use of drug therapies — how many benzodiazepines and which antidepressants; use of psychological therapies; use of counselling services — staff involved, referrals, types of counselling, evaluations; contact with psychiatrists — random or systematic.
- Develop care in areas of: detection — training programmes for primary health care team members, use of screening questionnaires, longer consultation times for general practitioners; management — rational prescribing policies, use of psychological therapies, protocols for use of counselling services; liaison with psychiatric teams — effective written communication, development of consultation–liaison models, protocols for shared care of patients with chronic mental illness; liaison with other agencies; mental health of the primary team members themselves.

Predicted outcomes of improving mental health services

It is hoped that through improvement in mental health services, certain outcomes may become apparent; these predicted outcomes are amenable to audit and research. Regarding mortality and morbidity there may be fewer suicides. However, a decrease is unlikely to be detectable within a general practice but could be detectable at the family health services or district health authority level.[106] More people with mental health problems may be detected and adequately treated, perhaps leading to shorter illness episodes, less severe illnesses, less chronic depression and alcoholism, less time off work or school, a decrease in marital breakdown, a greater sense of well being and a greater satisfaction with primary care.

Improved mental health services may have financial consequences. As general practitioners become more able at diagnosing depression, so prescription costs for antidepressants may increase. However, prescribing costs for anxiolytics may decrease as alternatives to drug treatment are used. This may result in a possible exponential increase in costs of psychological treatment and counselling services, depending on protocols, extent of use of self help strategies and family health services authority cash limits.

Effects on secondary care may include an increase in referrals to psychiatrists but a decrease in referrals to specialists other than psychiatrists. There may be a decrease in the costs of physical investigations and treatments. It is hoped that careful monitoring and follow up of patients with mental health problems may result in a decrease in emergency psychiatric admissions and a decrease in length of stay in psychiatric beds.

Conclusion

Mental health services are ripe for change. An important consensus has emerged between central government and the professional medical bodies concerned with mental health, that primary care has a crucial role to play in the development of new and effective means of managing mental health problems in the community. General practice has the potential to improve the detection of mental disorder, whether it be depression in the context of physical illness or early signs of a relapse of schizophrenia; to deliver better treatments, whether through rational prescribing policies or focused counselling strategies; and to take a pivotal role in hospital and community services. We should take this opportunity to translate potential into action.

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