

Mental health research in general practice: from head counts to outcomes

MENTAL health research in general practice began in the 1950s. It gave impetus to psychiatric epidemiological and service research throughout the world and has led to the recognition of general practice as the cornerstone of community mental health services.¹

General practitioners (GPs) themselves were the first to identify the importance of recognition and treatment of mental disorders in their field.²⁻⁴ The psychiatrist Michael Balint, who wrote extensively about the doctor-patient relationship,⁵ influenced many GPs of his generation. The Royal College of General Practitioners, soon after its foundation in 1953, joined the then General Register Officer to produce the first National Morbidity Survey.⁶ These surveys have provided data ever since on the range of pathology in general practice, including mental disorders.

The late Michael Shepherd became the first psychiatric epidemiologist to take an active lead in primary care mental health research. Over 30 years ago, he and his colleagues undertook a study in London in order to establish the prevalence and characteristics of mental disorders in people registered with GPs.⁷ Doctors monitored a one-in-eight sample of their patients for a year. They recorded patient details, the nature of the consultation, the diagnoses made, and treatment undertaken — this effort seems unimaginable in the modern world of contracts and primary care consortia. The study revealed the links between mental and physical disorders, the variation in psychiatric morbidity between general practices, and the role of the doctor in management. There arose the concept of 'minor psychiatric disorder', which encompasses states of depression or mixed anxiety and depression. The term was unfortunate, as these conditions may be severe, chronic, and disabling. Neither is the concept 'common mental disorder', which has replaced it, particularly illuminating, except as a catch-all term for the most common states of emotional distress seen in general practice.⁸

An explosion of epidemiological work followed after Shepherd *et al's* study, in which structured questionnaires and interviews were developed.^{9,10} This work continues today. A screening questionnaire is used to detect possible cases of emotional disorder that should subsequently undergo a more comprehensive diagnostic interview. A selection of people who do not score abnormally at the screening stage are also interviewed for the purposes of comparison, or to confirm the sensitivity of the screening questionnaire. A body of such research has confirmed Shepherd's estimate of the prevalence of common mental disorders.¹¹ It has been extended to the study of substance abuse¹²⁻¹³ and behavioural disorders.¹⁴ Similar research has taken place in other countries around the world.^{15,16}

Early in the 1970s, there was increasing interest in how GPs recognized patients with mental health problems and how they decided to refer to the mental health services. The General Health Questionnaire (GHQ)¹⁰ or a standardized psychiatric interview⁹ were the gold standards against which GPs were judged. Despite criticism that such standards were not appropriate in general practice, it appeared that doctors detected two-thirds of patients with depression.¹⁷ The depression that went unrecognized by general practitioners was usually chronic, less obvious, and associated with physical illness.¹⁸ Whether recognition by the doctor leads to better outcomes is debatable, with results in favour^{19,20} and others against.^{21,22} While milder cases of

depression appear to benefit from recognition alone,²⁰ severe cases require specific treatment following recognition.²³

This work culminated in an understanding of how people take a variety of pathways to psychiatric care. In order to obtain care, they negotiated a number of 'filters' of varying permeability, such as their decision to visit the GP, or the doctor's ability to recognize their distress. Epidemiological research established the proportions of patients with mental disorders who reached each level of care on this trajectory from the community, through consultation with the GP to an inpatient stay on a psychiatric ward. Only 5% of those recognized as emotionally distressed are referred to mental health services, and this figure has changed little over the years.⁸ Predictors of referral are patients' socio-demographic characteristics, the nature of the diagnosis, the doctor's skill and interest in psychiatry, and the availability of services.

Interest also developed in the natural history of minor psychiatric morbidity: British general practice is particularly suited to natural history studies. As patients change GPs their medical records are forwarded to the new doctor and therefore the records provide life-long dossiers for epidemiological scientists. The patients with minor psychiatric disorders identified in the study by Shepherd *et al* were followed-up over three years.²⁴ Thirty per cent recovered. Another longitudinal study at that time also showed that a large proportion of people with emotional problems ran a chronic or relapsing course, and that this tendency was most marked in women.²⁵ Subsequent work has not always confirmed these dismal findings,²⁶ but recovery is often partial.²⁷ Physical illness, older age, social adversity, poor housing, and poverty predict poor outcome.^{26,28} There have also been natural history studies of specific disorders, such as eating disorders.²⁹

Except for one or two pioneering studies,^{3,4} the role of general practice in the care of the severely mentally ill has been neglected.³⁰ With the advent of community care, more patients with schizophrenia have begun living in the community and seeking general practice care. A number of studies appeared in the 1990s concerned with the epidemiology and health service needs of these patients.^{31,32} Case-control work revealed that patients with schizophrenia presented a workload for GPs that was similar to patients with other chronic physical disorders,³³ but that the GP's approach was much less consistent.

As the field developed, interest turned to intervention studies. Patients seen in mental health services are usually those who fail treatment in primary care. Paradoxically, most outcome work continues to be conducted in specialist settings. Antidepressant drugs are most often prescribed in general practice, despite all the major randomized trials concerning these drugs having been carried out in specialist care. Research in general practice often reveals much more about appropriate treatments for psychiatric disorder than that conducted in specialist practice. In one of the first, well-conducted treatment outcome studies in British general practice, Corney³⁴ evaluated the ability of practice-based social workers to manage depressed women. There were no differences in outcome between those women managed by the social workers and those receiving routine care. A post hoc analysis, however, demonstrated that women with acute-on-chronic depression showed a better response to a social work intervention. Many randomized trials in general practice followed. The effectiveness of counsellors,³⁵ nurse behaviour therapists,³⁶ com-

munity psychiatric nurses providing counselling,³⁷ and GPs as therapists were evaluated.³⁸ Either patient recruitment was so selective as to have little external validity³⁶ or outcomes were as disappointing as Corney's original research with social workers.³⁵ All such trials were hampered by difficulties in recruitment, randomization, measurement of outcome, and follow-up.^{39,40} The expansion of psychotherapy services in general practice, however, has continued to fuel a demand for better assessment of effectiveness.

Intervention studies for patients with major mental illness also began to be published. Earlier work on care of patients with psychoses led the way to randomized trials of the use of checklists and health clinics. Checklists to guide the GP do not lead to better care of patients.⁴¹ However, regular health clinics in which trained primary care staff monitor the psychological and physical well-being of patients with schizophrenia show some promise.⁴²

Mental health research in primary care is entering a new era. Computers are now the norm in general practices: their accuracy in mental health research is now being established.³³ Computers have the potential to provide vast quantities of data for epidemiological and health service research allowing rare disorders to be readily researched. Case-control studies will be easier to conduct using computers to select controls, and networks of general practices, modelled on the well-known Medical Research Council's Research Framework are springing up around the country. Networks such as these will provide an extensive base for large multicentre projects.

Qualitative methods are also increasing in popularity, although direct observational studies that were popular years ago⁴³ have not been revived. Although useful for examining the detail of the work of GPs in mental health, it is doubtful whether qualitative studies will provide the data needed on a large scale to measure effectiveness of treatments. A new paradigm is urgently required in which to assess the effectiveness of treatments as psychological interventions do not lend themselves easily to randomized designs. Partial randomization, in which patients with strong views can express their preferences for treatment groups and thus have a role in the process of randomization,⁴⁴ may provide part of the answer. Such trials remain vulnerable, however, to the criticism that effectiveness cannot be established for patients who are not randomized to treatment groups. Randomized trials in which only minimum data are collected for large numbers of patients may be the next step. Large quantities of data collected in randomized trials are useful, at best, in post hoc analyses and do not address the central question of effectiveness. The central player in all of this is the GP. It is vital that administrative and clinical burdens do not reduce the inclination of doctors and their staff to participate in mental health research.

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Palliative terminal care

Palliative care can be defined as the 'active total care of patients whose disease is not responsive to curative treatment'.¹ General practitioners (GPs) have a pivotal role in the delivery of palliative care. Most patients with any advanced disease are under their GP's care during most of their illness. More deaths from advanced cancer occur under the care of GPs (home, community hospitals, nursing homes (51-73%)) than in hospices and acute hospitals.² GPs treat many diseases, other than advanced cancer, that benefit from palliative care.

The modern hospice movement spread from the pioneering work of Dr Cicely Saunders at St Christopher's Hospice, London, which opened in 1967. In 1997, there were 223 inpatient units and 408 home-care teams in the United Kingdom and Ireland. Most GPs should therefore have easy access to specialist physicians and nurses. The philosophy of the hospice movement is highly relevant to palliative care in general practice. Key features are the use of drugs in symptom control (particularly pain), good communication, multiprofessional teamworking, the appropriate use of specialist palliative care services, and training of other professionals — particularly that of GPs and district nurses.

Studies from the 1970s exposed serious weaknesses in the GP management of patients with advanced cancer. Severe pain was unrelieved in up to half of patients.^{3,4} Carers reported difficulties in getting reliable out-of-hours advice. There is evidence that some improvement has occurred, for example, Jones *et al* in a study of carers' perceptions, from South-West England, published in 1993, reported that pain was better controlled, with only 4% having no relief.⁵ Many other symptoms, however, such as vomiting and constipation, were not so well managed. It was reported that up to 25% of the patients had no relief from these other symptoms. A minority of carers felt unsupported. In spite of these concerns, however, 94% of the carers rated the care received as 'excellent' or 'good'.

In this edition of the *Journal*, there are two papers, also from South-West England, which suggest that the quality of care continues to improve, but again highlight clear areas of concern. They compare, for the first time, admissions of patients with advanced cancer to community hospitals with admissions to a hospice. The first paper compares medical and nursing management in these two settings.⁶ Although patients who had been admitted to the hospice were more likely to need symptom control, and less likely to be admitted for terminal nursing, comparisons are still worth making. It is encouraging that the authors found that 'prescribing on admission and at death, and indications of active treatment of symptoms were broadly similar'. The poorer quality of community hospital note-keeping may be explained by the reduced level of medical and nursing resources, as compared with a hospice.

The second paper studied the views of the patients' closest

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carer.⁷ Again, there is reason to be encouraged. Of the carers interviewed, 90% felt that the 'total care' received by the patient, and themselves, was excellent or good in the community-hospital patients (100% in the hospice group). However, significantly more community-hospital patients' carers expressed concern about poor communication, poor nursing organization and standards, and poor bereavement follow-up. There was regret that some community hospitals did not have overnight accommodation for relatives, which may have prevented them from being at the bedside at the time of death.

Palliative care, as we approach the new millennium, presents GPs with many challenges and opportunities. We need to improve our communication skills. These are now taught and tested in vocational training, particularly using video-recording of real consultations. However, a recent survey found that over 20% of GP principals had received no formal training in communication.⁸ This situation could be improved by the use of books, videos, and courses, which are available on subjects such as breaking bad news.⁹

We need to genuinely embrace multiprofessional teamworking. This means working closely with our primary care colleagues as well as appropriately enlisting the skills and knowledge of specialist palliative physicians and home-care nurses.¹⁰ One novel approach in this direction was the 'Facilitator Project', a joint venture of the RCGP and the Cancer Relief Macmillan Fund. Five GPs with palliative care training were successfully used to raise standards in their localities. It was recommended that more appointments of this nature should be made.¹¹

The majority of terminally ill patients can be cared for by their GPs either at home, in community hospitals if available, or in nursing homes. As the demand for hospice inpatient beds generally exceed supply, GPs have a responsibility to admit to hospices only those with difficult physical symptoms or psychosocial problems, which need the expertise of the specialist services.

General practitioners are uniquely placed to apply palliative care to other patients, including those suffering from end-stage heart or lung diseases, dementia, and the elderly with multiple pathologies. Increasing numbers of such patients are being cared for by GPs at home, in community hospitals, and in nursing homes. Although some hospices offer their services to patients with diagnoses other than cancer, motor neurone disease, or AIDS, their capacity to treat more patients is limited.

The recent changes in provision of out-of-hours cover by GPs, including the growth of cooperatives, may adversely affect emergency care to patients with advanced cancer. This was raised as a concern in earlier studies.^{4,5} It is the GP's responsibility to organize effective cover for these patients, who are small in number but may need urgent and skilled intervention.

Some GPs give their home telephone number to the carer.