Mental health as an integrant of primary medical care

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IN 1975 I visited the National Institute of Mental Health as a Consultant for the World Health Organization to assess and report on the status of mental health care in the United States of America with special reference to primary care. At the time I recommended the close involvement of the Division of Biometry and Epidemiology and much has already been achieved under the leadership first of Dr Morton Kramer and then of Dr Darrel Regier. From the beginning this was based on the primary care physicians or general practitioners who occupy a central position in the health service organization, which differs radically from that prevailing in the other two models encountered in developed countries (Figure 1; Fry, 1969).

In the British National Health Service the general practitioner is the physician of first contact, the professional figure who is the gatekeeper to all medical facilities. As he keeps records of all consultations it is reasonable to try and assess the amount and nature of the mental disorders with which he is concerned. Accordingly, we started a series of studies on this issue. The most striking result was that a large section of morbidity, amounting to about one seventh of all consultations, was attributable or closely related to mental and ill health (Shepherd *et al.*, 1966).

Many workers have since confirmed our findings, but at the time most of the few people who appreciated their significance appeared to be individual general practitioners with an interest in emotional conditions.

It is not profitable to dwell on fine diagnostic categorization: it is more important to underline, first, the relative proportions of acute and chronic illness and of major and minor disease, and secondly, the dominance of mood disorders which are the general practitioner's particular concern, as is strikingly shown in Figure 2.

Policies

If the broad findings are accepted, then several educational and administrative policies follow in the interests of rational planning.

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It is easy for policy makers and official bodies to go seriously astray if they do not base their recommendations on the psychiatric facts of life. For example, Blacker's (1946) plan devised in the United Kingdom during the Second World War for the Ministry of Health included a detailed model for mental health services for a population of a million. Much of that report is eminently sensible, but Blacker saw the problems of the general practitioner service from the viewpoint of a specialist, not a general practitioner.

"The so-called psychosomatic disability," he wrote, "has been much discussed of late, here and in America; it has even been suggested that as much as a third of all sickness has psychiatric features, the term psychiatric being used to include psychosomatic illness. We can picture to ourselves the effects on clinical attendances if practitioners as a whole came to believe that a third of their patients could be benefited by the attention of psychiatrists. The community contains, as it has always contained, a reservoir of psychosomatic and psychopathic cases; their descent in vast multitudes upon the psychiatric clinics of this country might be caused by nothing more than an alteration of standpoint among general practitioners."

This curious comment reflects an attitude which appears again in his vision of the future relationships between the lofty, seignorial psychiatric specialist and the lowly general practitioner:

"It is therefore suggested that when the general level of psychiatric knowledge is raised throughout the medical profession by improved teaching methods—or even before this happy time is reached—it should be the aim of the clinic to send the patient back to his doctor, reporting improvement, at the earliest date reasonable, at the same time furnishing the practitioner with guidance as to how to handle the patient in future."

I am particularly fond of the phrase "reporting improvement," but the passage as a whole embodies a view of the general practitioner as the doctor who, in the opinion of the late Lord Moran (1960), had fallen off the specialist ladder. That view is still echoed today.

For example, in stating his views on the organization of psychiatric services, a prominent British social psy-

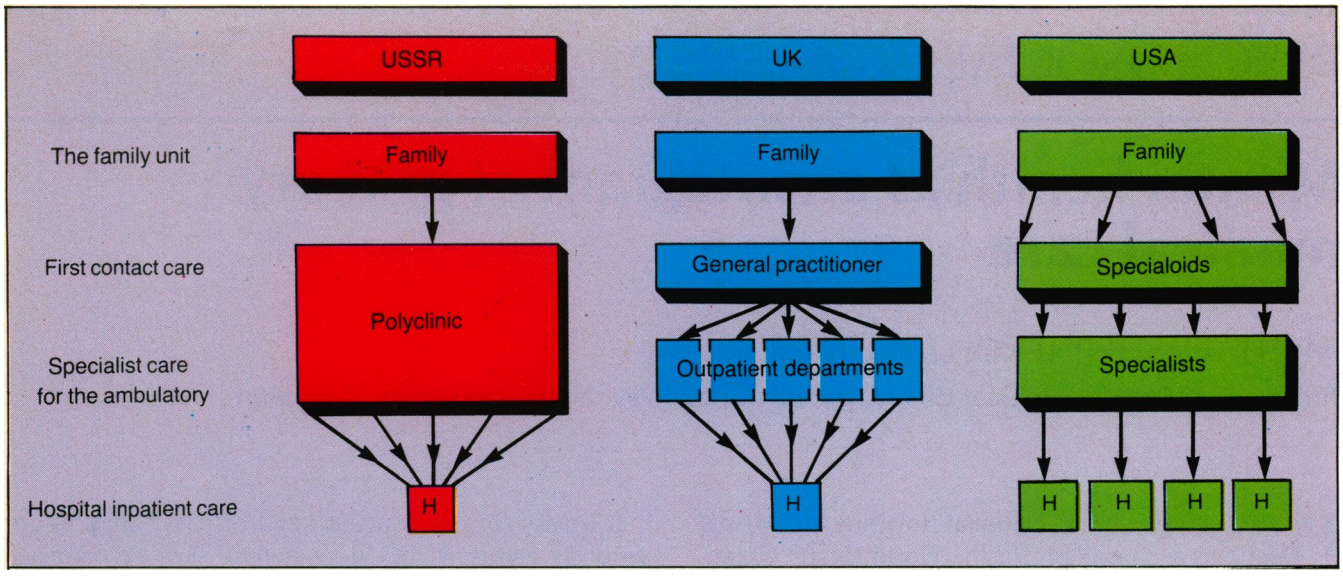
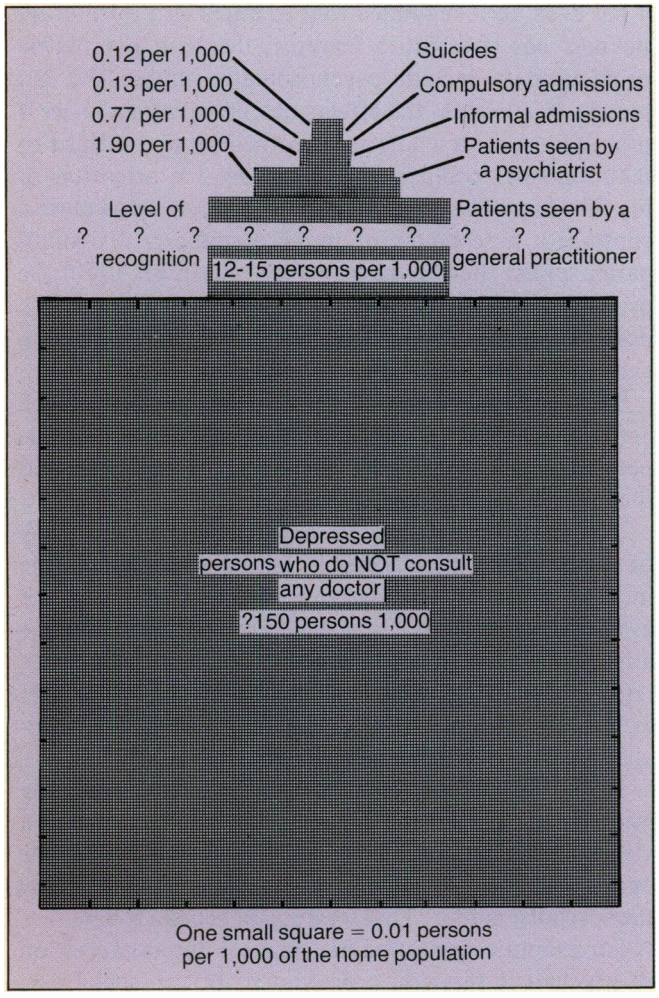


Figure 1. *A comparison of the flow of medical care in the USSR, UK and USA. (Source: Fry, J. (1969). Medicine in Three Societies. Aylesbury: Medicine and Technical Publications.)*

Figure 2. *Number of patients with depression and their involvement with medical services inside and outside hospital. (Source: Watts, C. A. H. (1966). Depressive Disorders in the Community. Bristol: John Wright).*



chiatrist (Bennett, 1973) not long ago estimated that three psychiatrists were needed for a population of 60,000 people, in order to care for about 1,000 patients during the course of one year. He then went on to say: "There will also be about 24 family doctors in the area. These doctors, however, cannot give psychiatrists much help, for in our Health Service family doctors are already seeing the bulk of the patients with socio-economic problems."

A similar perspective has been adopted all too often by clinical psychiatrists, although they peep at the matter through the practitioner's key-hole rather than through the planner's. Thus, for example, if Figure 2 is correct and we summate the first four categories, the proportion of depressed patients who come to the attention of a psychiatrist is no more than 2.92 per 1,000 of the general population and no more than 1.8 per cent of all depressed people.

Consequently, psychiatrists are familiar with only a very small band of the depressive spectrum and one, furthermore, which differs in respect of presenting features and in severity from the larger part. Nevertheless, at a recent international conference on depression a well known European psychiatrist made the following comment: ". . . In possibly as many as 40 per cent to 50 per cent of all patients consulting a general practitioner for any reason whatsoever, no organic causes for their symptoms can be found . . . This raises the question as to whether all these patients should be regarded as psychiatric cases and therefore treated by a psychiatrist. The answer is probably 'No' " (Nijdam, 1973).

It is worth pondering on the two principal reasons for this seemingly wilful disregard of the evidence by mental

health professionals as demonstrated by the views I have cited. The first of these reasons, I suggest, has to do with an understandable reluctance to relinquish what may be termed the psychocentric perspective, whether this is identified with psychotherapy, psychiatric education, administration or clinical skills. As such, it exemplifies an outlook which is common enough in science as well as other forms of less rational human activity. In all essentials this was described, and even named, as early as 1440 by Nicholas of Cusa who, 20 years before Copernicus' observations, attacked the assumptions of medieval scholarship for the egocentricity of its outlook on the physical universe in a famous tract which he entitled *Learned Ignorance*. Although the present example is rather less momentous, there has been a medieval flavour to the pronouncements of many psychiatrists, not only in their unwillingness to modify their own perspective but also—and this is the second of my two reasons—in their attempt to impose their own conceptual apparatus on the material under study, regardless of its goodness of fit.

The consequences of this variety of learned ignorance reveal themselves clearly through systems of classification which, on the whole, reflect no more than the underlying systems of thought. When we started to work with general practitioners our first inclination was to adopt the standard *International Classification of Diseases*. Very soon, in the light of clinical problems encountered, however, it became clear that neither the *ICD*, then in its 7th edition, nor any available alternatives, did justice to reality.

Accordingly, we were compelled to construct more relevant systems of our own, designed to meet the needs of general practitioners by distinguishing between 'formal' psychiatric illness and what we called 'psychiatric-associated' disorders, thereby anticipating the multiaxial systems which have since been widely canvassed to do justice to the health/mental health interface (Table 1).

Using this scheme, with all its manifest imperfections, we found that about one third of recorded psychiatric morbidity had to be classified in this way (Table 2). Attempting to identify in more detail the content of this heterogeneous category, we found that the 'associated' factors included a wide range of physical disorders on the one hand and of social pathology on the other (Figure 3).

Our framework was devised to reflect our findings rather than any theoretical preconceptions. We found that emotional disorder was associated with a high demand for medical care, the patients attended more frequently, exhibiting higher rates for general morbidity and more categories of illness, especially chronic illness. Of course, these findings could be manifestations of a high demand for medical care attributable to the patients' attitudes to health, and patients may have been labelled as neurotic largely because of the frequency of their attendances and the multiplicity of their ailments. Independent data were therefore sought by estimating physical disease among groups scoring high and low on a screening questionnaire, a procedure which yielded similar findings.

We then sought to find out whether individuals with psychiatric illness did or did not suffer from more physical illness than mentally healthy people. From a population undergoing a health screening programme, those between the ages of 40 and 64 were randomly chosen and assessed in four stages: 1) by the completion of a self-administered questionnaire; 2) by a standard-

Table 1. Classification of psychiatric conditions.

Formal psychiatric illnesses	
1. Psychosis	Schizophrenia, manic depressive psychosis, organic psychosis
2. Mental deficiency	Marked subnormal intelligence
3. Dementia	Deterioration of mental powers in excess of normal ageing process
4. Neurosis	Anxiety state; depressive, hysterical, phobic or asthenic reactions; others
5. Personality disorder	
Physical illnesses, or physical symptoms with psychological component	
6. Physical illnesses	Where psychological mechanisms
7. Physical symptoms	have, in your opinion, been important in the development of the condition
8. Physical illnesses	Which have, in your opinion, been
9. Physical symptoms	elaborated or prolonged for psychological reasons
Other psychological or social problems	
X Psychological or social problems	Please describe in full

Table 2. Patient consulting rates per 1,000 at risk for psychiatric morbidity, by sex and diagnostic group.

Diagnostic group	Male	Female	Both sexes
Psychoses	2.7	8.6	5.9
Mental subnormality	1.6	2.9	2.3
Dementia	1.2	1.6	1.4
Neuroses	55.7	116.6	88.5
Personality disorder	7.2	4.0	5.5
Formal psychiatric illness*	67.2	131.9	102.1
Psychosomatic conditions	24.5	34.5	29.9
Organic illness with psychiatric overlay	13.1	16.6	15.0
Psychosocial problems	4.6	10.0	7.5
Psychiatric-associated conditions*	38.6	57.2	48.6
Total psychiatric morbidity*	97.9	175.0	139.4
Number of patients at risk	6,783	7,914	14,697

*These totals cannot be obtained by adding the rates for the relevant diagnostic groups because, while a patient may be included in more than one diagnostic group, he will be included only once in the total.

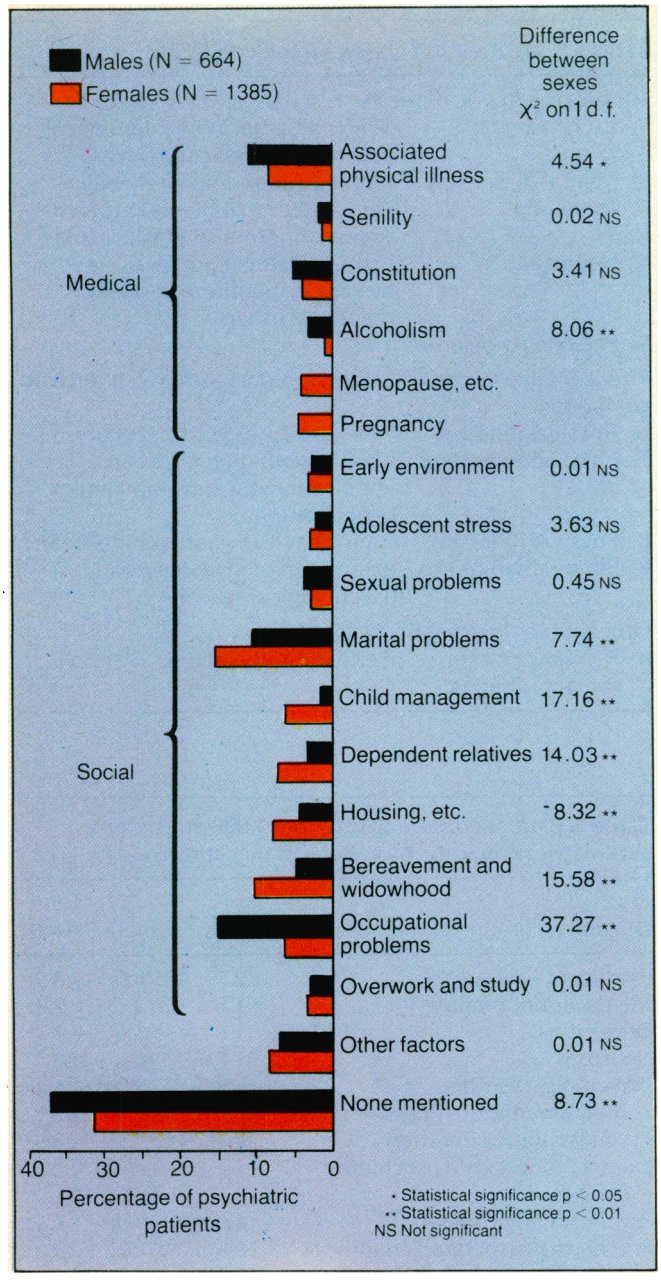


Figure 3. *Classification of problems in psychiatric patients by medical and social factors and by differences between the sexes.*

ized psychiatric interview; 3) by physical screening tests carried out by trained ancillary staff; and 4) by a physical examination by an independent physician. Patients with psychiatric disorders were compared with a control group from the same population matched for age, sex, marital status, and social class. The results showed strong presumptive evidence of an association between physical and mental illness in the population, the links being most marked with patients suffering from cardiovascular and respiratory disease.

On the other side of the same coin, several workers, including ourselves, have shown that many discrete clinical conditions are associated significantly with mental ill health and at least one large-scale American study has shown that psychosocial factors must also be considered in this context. Shaffer and colleagues (1972) investigated a population for disability benefits under the US Social Security Administration's disability programme. They made psychiatric assessments of such patients suffering from physical disorders and assessed the mental health of more than 1,000 individuals matched with 14,000 patients attending a medical clinic. The results showed a marked difference between the two groups, giving an estimate of up to 44 per cent of individuals with moderate or severe psychoneurosis or personality disorders among the applicants for disability benefit.

Such findings lead naturally from the physical to the environmental associations of psychiatric morbidity. However, the necessary spadework in classifying terms like 'social malaise' and 'subjective social indicators' had not been carried out and we were compelled to construct instruments for the purpose. Our findings showed that at the level of primary care social factors entered so closely into the matrix of what physicians call psychiatric disorders as to justify study both in their own right and in their role as potential pathways for intervention. Figure 4, for example, illustrates the findings on the health status of 300 consecutive patients referred by eight general practitioners to their attached social workers in the course of their routine clinical practice. The ratings were made by a medical member of the research team and demonstrate that the health of the population was generally poor; only seven per cent of referrals were without a somatic or a psychiatric diagnosis and more than a quarter were suffering from both mental and physical ill health.

Implications for the future

What are the implications for the future provision of primary medical care? In Britain, the socio-medical approach to health has been officially recognized by the National Health Service Reorganization Act 1973, which was followed by a Working Party Report entitled, significantly, *Social Work Support for the Health Service* (DHSS, 1974). In their report the Working Party paid particular attention to the development of social work in the context of general practice and entered a strong plea for experimentation in this field. Our own research, which long antedated the report, has been conducted very much in its spirit.

One prospective study designed to evaluate the therapeutic role of a social worker attached to a metropolitan general practice in the management of chronic neurotic illness has already been reported (Cooper *et al.*, 1975). The psychiatric and social status of two matched groups of patients, one attending the practice with a social worker attachment and the other attending neighbouring practices without this facility, were ascertained independently at the beginning and end of a 12-month period, using standardized interviewing techniques. A

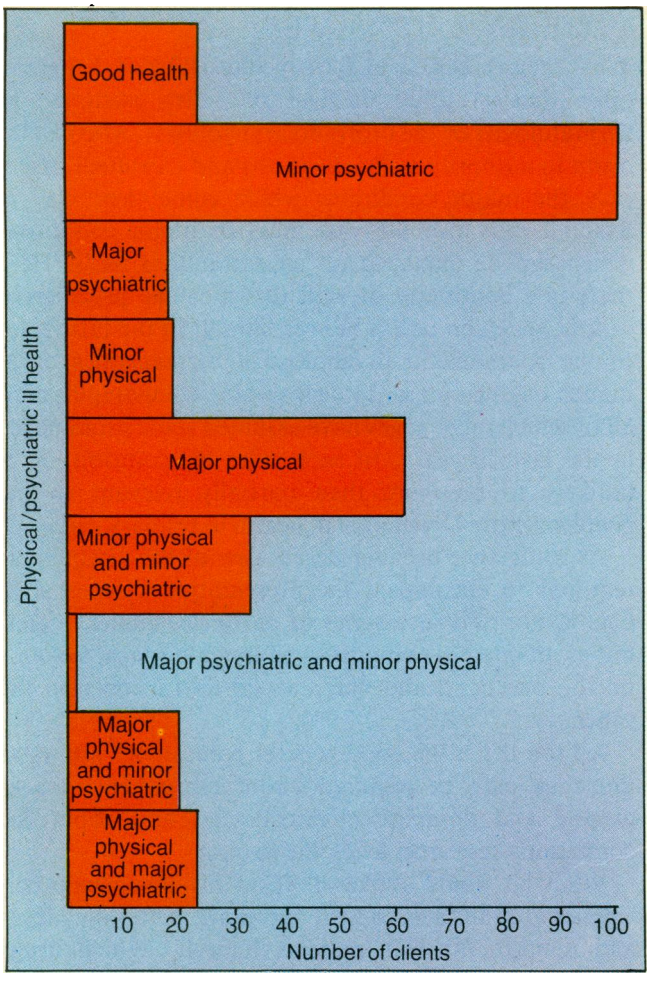


Figure 4. *The health status of 300 consecutive patients referred by eight general practitioners to their attached social workers during the course of their routine clinical practice. (Source: Corney, R. & Briscoe, M. (1977). Investigation into two different types of attachment schemes.* Social Work Today, **9**, No. 15.)

comparison between the outcome of the groups indicated some benefit to those patients who had received the experimental service.

Continuing medical care and supervision were deemed necessary for 59.8 per cent of the experimental patients, compared with 77.3 per cent of the controls. Similarly, the experimental patients were found to have improved in all main areas of social functioning, whereas the controls showed very little change in this respect at the end of 12 months. Changes in psychiatric and social adjustment scores for the two groups were positively correlated. These findings suggest that social worker intervention has some therapeutic effect on chronic neurotic illness, at least in some cases, and hence that it is realistic to speak of 'social treatment'.

Social treatment

However, social treatment is a term which is associated with conflict— ". . . . . the conflict between casework and the young radical school of community action. This refers to the knowledge mainly used by caseworkers and that mainly used by community activists. To the latter the unpardonable sin is that casework method is largely based on psychoanalytic theory which causes the caseworker, so they allege, to be primarily concerned with a professional relationship, with the client's unconscious motivation, and with use of the transference in an essentially unequal situation, when what he really needs is help in getting means tested benefits to which he is entitled, or better housing or education or more pay. Conversely, community work draws largely on knowledge from sociology and political theory, both of which seem to be active, related to the real world and concerned with how to bring about social change. This is in sharp contrast to dynamic psychology which seems to them anything but dynamic in its social context because it implies that basically human nature is unchanging" (Younghusband, 1974).

The 'casework' concept has tended to dominate the theory and practice of social work in the United States, especially with the large corps of social workers in private practice. It has also been influential in Britain despite the many differences in organizational structure. Yet while its relevance to the needs of the general population have been challenged on theoretical grounds by the advocates of social change, neither group has provided empirical evidence to confirm its own claims. As part of our study of chronic neurotic illness it was possible to undertake a detailed analysis of the social worker's activities and to relate these to the client response (Shepherd *et al.*, 1979).

In nearly two thirds of this sample the social worker's contribution was restricted to helping the patient and his or her family in dealing with practical problems and difficulties, a function for which social workers are specially trained and in which their skills do not overlap to any large extent with those of the psychiatrist. In the remaining one third she exercised what may be regarded as a quasi-psychotherapeutic function, although here also practical help and support were given in a proportion of cases. The prominence of what has also been called 'social brokerage' (Baker, 1976), rather than traditional 'casework', has been detected in other studies which have analysed social worker activities in general practice (Collins, 1965; Forman and Fairbairn, 1968; Ratoff and Pearson, 1970; Cooper, 1971; Goldberg and Neill, 1972).

The specificity of such intervention, however, remains questionable. On the available evidence the most probable explanation of any benefits conferred by the social worker appears to reside in the way in which her personal activities supplement the resources which she mobilizes and which facilitate a more positive approach by the general practitioner towards an awareness of the social orbit of morbidity. Stimson (1977) has pointed out that the global notion of the social element in general practice embraces several themes: the social

relationships between doctors and their patients; the awareness of social factors in disease and in illness behaviour; the social causes of disease; the social consequences of disease; social welfare problems; and the socio-psychotherapeutic role of the doctor. The presence of a social worker as part of a primary care team may be expected to catalyze all these activities and so diffuse his or her influence at various points of professional contact.

Conclusion

On logistic grounds it is apparent that the mental health care of the community at large cannot be provided by psychiatric specialists. Our own alternative, advanced 15 years ago and based on epidemiological evidence, was that "the cardinal requirement for improvement of the mental health services . . . . . is not large expansion and proliferation of psychiatric agencies, but rather a strengthening of the family doctor in his therapeutic role" (Shepherd *et al.*, 1966). In practice, of course, this emphasis on the primary care system must pay regard to the national variations in the structure of medical organization, but the underlying principle has since been endorsed and extended by the conclusion of the World Health Organization report which stated that: "The primary medical care team is the cornerstone of community psychiatry" (WHO, 1973).

This statement is slowly finding favour with good general practitioners who see the core of their task in their own terms, as exemplified by Crombie who, as a prominent British representative of the Royal College of General Practitioners, commented in 1972: "The first thing a general practitioner has to decide is the relative importance of the emotional and physical factors in his patient's problems. Only the general practitioner approaches the matter quite in this way, and his ability to do so depends on his unique previous knowledge of the patient. Where this knowledge is denied to the doctor, assessment has to be made by the more devious and less certain method of evaluating the emotional component by exclusion of the organic. This method of evaluating the emotional component is clumsy. For the 10 to 20 per cent of selected problems which reach the hospital-based doctor, it is unsuitable and also wasteful of medical resources.

"The organic element is less definable in illness encountered by general practitioners than it is in the selected illness encountered in hospital practice. The emotional element, on the other hand, is relatively more important in general practice."

Today, I suspect this physician would substitute 'psychosocial' for 'emotional', and 'the primary care team' for 'the general practitioner'. He would not, however, modify his conclusions that the assessment of mental ill health in its broader sense is a central function of the primary care team, including non-medical members of the caring professions—the social worker, the health visitor, the midwife and the nurse.

Role of specialist psychiatrist

What then is the role of the psychiatrist? Not, I suggest, quite that of other medical specialists such as the dermatologist or the otorhinolaryngologist, who can lay claim to authority in the diagnosis and treatment of not only the major conditions which come their way in hospital, but also the vast mass of minor conditions which can be managed on an extramural basis. Here there is a continuity of skill to which the psychiatrist cannot lay claim unless he sees himself in the false roles of the specialist in psychological hermeneutics or in human engineering or in neurobiological manipulation, all of which self-images have assumed some prominence in the last 30 years. In such roles his contribution is unlikely to be more than partially relevant to the problems posed by mental ill health in primary care.

An altogether broader based view of the discipline is required to encompass the presentation of mental ill health, not only as a series of particular clinical states, but as an integral component of much physical sickness on the one hand and much social dysfunction on the other.

All too often the good general practitioner knows as much as may be required about his patient's background and domestic circumstances, and about the community resources available to him.

What he wants above all from his psychiatric colleagues are the facts to help him make better diagnoses and manage his own patients himself. Which drugs should be administered to which patient, in what dosage, and for how long? What are the diagnostic criteria he should employ? How effective are the available therapeutic measures, whether physical or psychosocial, for the population under his care?

Such basic questions and their numerous congeners cannot be answered satisfactorily in the present state of knowledge. They are, however, eminently susceptible to investigation and, in many instances, to clinical investigation, although in a rather different setting from that to which the psychiatrist based in hospital, clinic, or office is accustomed. Here, I suggest, is a logical point of entry for psychiatrists in search of a necessary, if not sufficient, role in primary care. Furthermore, as a participant on these terms the mental health professional may become a beneficiary as well as a donor, for the task would surely help restore the holistic concept of the discipline of psychiatry which, although it has receded in recent years, underlay Adolf Meyer's notions of psychobiology, which itself reached back to the earlier concept of psychological medicine and, still earlier, to the views of Andrew Wynter on psychiatry in relation to family medicine, expressed more than 100 years ago. "We are convinced," he wrote in 1875, "for the good of general medicine this particular study of psychological medicine, dealing as it does with so many complex problems, should be merged in the general routine of medical practice."

Such a process of integration, or rather of re-inte-

gration, would be good not only for general medicine and general practice but also for general psychiatry.

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