Implications of the World Health Organization study of mental illness in general health care for training primary care staff

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SUMMARY

A substantial international study of mental disorders seen in primary care settings has shown that there are marked differences in prevalence between centres. Detection of mental disorders is better in centres using a 'personal' style of clinical service, and where there has been close collaboration between psychiatrists and general practitioners. However, even in the better centres, substantial numbers of mental disorders are missed and treatment often appears to be given regardless of diagnosis. It is argued that changes need to be made to the way in which both undergraduates and vocational trainees are taught about mental disorders, so that teaching emphasizes the psychological syndromes that general practitioners are likely to meet in their everyday work. Training packages need to be developed for primary care staff in the detection and management of mental disorders.

Keywords: mental disorders; international study; training implications.

Introduction

THE World Health Organization has recently published a substantial study, carried out in 15 centres across the world, of mental disorders seen in primary care settings.[1] Seven of these centres were in Europe (Manchester, Groningen, Paris, Berlin, Mainz, Verona and Athens), but there were also three American centres (Seattle, Rio de Janeiro and Santiago de Chile), two in developing countries (Bangalore and Ibadan) as well as three in the Far East (Ankara, Shanghai and Nagasaki). Centres were chosen where there was an established track record of research of this type, and it is not claimed that centres are representative of their country. All centres used identical methodology and used three measures of mental disorder: self-report of psychological symptoms on a screening questionnaire; assessments by primary care physicians seeing the patients; and assessments based upon a standardized research interview administered soon after the consultation and capable of producing standardized assessments according to both the International Classification of Disease (ICD-10) and the Diagnostic and Statistical Manual of the American Psychiatric Association criteria (DSM-IV).

In both size and scope, the study was unusual. No fewer than 25 916 people were screened with the 12-item General Health Questionnaire (GHQ-12),[2] and 5438 received second-stage interviews using the primary care (PC) version of the Composite International Diagnostic Interview (CIDI)[3] and a disability scale, after being selected by the two-stage stratified random sampling methodology. Doctors seeing the patients selected for the second stage completed a detailed physician encounter form. It was possible to follow up a large sample of these patients at both 3 and 12 months after their initial consultation, so the response of various mental disorders to differing management strategies will eventually be available. The results of the follow-up assessments are not yet available. All results reported here have been weighted back to the original sample of consecutive attenders.

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Importance of the topic

The study confirmed what previous studies had indicated: across the world, the prevalence of mental disorders among consecutive attenders, diagnosed according to ICD-10 criteria is 24% [standard error (SE) 0.6; 95% confidence limits (CLs) 22.8–25.2], with a further 9% (SE 0.4; CLs 6.2–9.8) having disorders that just fall short of diagnostic criteria. The study represents an advance over previous studies in that it has shown that, using identical methodologies, there are very large differences in prevalence between centres: the figure of 24% is obtained by averaging across centres, which range from a high of 53.5% (SE 3.0; CLs 47.6–59.4) in Santiago de Chile to a low of 9.7% (SE 1.2; CLs 7.3–12.1) in Shanghai. Manchester came more or less where one would have expected from previously published work, its prevalence of 26.2% being in the middle of the range. Rates for the two centres in developing countries were not especially high (Bangalore 23.9%; Ibadan 10.4%). However, across all centres, educational advantage was associated with better psychological health [odds ratio (OR) 0.83], and physical ill-health assessed by the doctor with worse psychological health (OR 1.43).

The study showed that these disorders are of public health importance because they are associated with a greatly increased disability: for all centres combined, patients with either none or a single psychological symptom had on average 1.8 (SE 0.1; CLs 1.6–2.0) disability days in the previous month; those with several symptoms had 2.8 (SE 0.1; CLs 2.5–3.1); those with subthreshold disorders had 4.7 (SE 0.4; CLs 4.0– 5.4); and those with current ICD-10 disorders had 6.2 (SE 0.2; CLs 5.7–6.6) disability days. It is possible to compare disability caused by psychological symptoms with that caused by physical disease: this shows that both are related to disability, but that occupational disability is more sensitive to mental than to physical disorder.

Presentations of mental disorders

The study confirmed previous studies[4] by demonstrating that mental disorders usually present to primary care physicians with physical symptoms. In Manchester, 76.4% presented in this way; across the world, 69% did so. Across all centres, the most common main complaint of patients with mental disorders was pain (29.3%), fatigue or poor sleep (6.9%), and other somatic complaints (32.8%); only 5.3% presented with psychological symptoms. Some of these illnesses (47% in Manchester) are accompanying physical illnesses known to their doctors, but others are presenting with unexplained somatic symptoms. Thus, the old 'either/or' dichotomy, whereby patients were to be thought of as

having either a physical illness or a mental one, is inappropriate — and this was true in all centres.

Detection of mental disorders

Just as the prevalence of mental disorders (according to ICD-10) was widely variable, so was agreement between the primary care physicians and the research interview. Across the world, primary care physicians agreed that 48.9% of the patients with research interview diagnoses were psychological 'cases'; the physicians in Manchester detected 62.9% of these illnesses. Agreement between doctor and research interview was better when illnesses were severe or when illness was accompanied by disability. Where medical services used a 'personal' style of service, detection was better than in other places (54% versus 27%). A 'personal' style of service meant that patients usually saw the same doctor, had an appointment and that records of the visit were kept and the doctor felt responsible for follow-up or referral of the patient. It was of interest that, in four centres where psychiatrists have worked closely with primary care physicians (Manchester, Groningen, Seattle and Verona), the doctors detected most of the illnesses, and the Kappa coefficients — a measure of agreement between doctor and research interview that takes into account the ability of a doctor to assess a non-case on the research interview as a non-case — also tended to be high. The explanation of this finding is perhaps that doctors are more likely to use a 'patient-centred' style of interviewing, and this has been shown to be related to the ability to make accurate ratings of psychological disorders.[5] Disorders are often missed when patients have unexplained somatic symptoms or have current physical disorders, as these serve to distract the doctor.[6]

Diagnosis and treatment

Across the world, the study has shown that the treatment provided is little different from one diagnosis to another and that benzodiazepines are extensively used (except in Manchester and Seattle) irrespective of diagnosis. Some centres (e.g. Ibadan and Shanghai) do not use antidepressants at all, whereas others (Athens and Rio de Janeiro) use them for fewer than 10% of cases of recognized depression. This situation is unacceptable, as the National Advisory Council on Mental Health has shown in the USA that the efficacy of pharmacological treatments for mental disorders is at least as good as that for physical treatments, such as angioplasty and atherectomy.[7] As a diagnosis is necessary for specific treatments, doctors need to be better able to make diagnostic assessments. Specific pharmacological treatments are available for depression, panic disorder and psychotic illness, and specific psychotherapies are available for agoraphobia, obsessive–compulsive disorder and generalized anxiety disorder. Thus, doctors need to know how to make these diagnoses if their patients are to receive appropriate treatment, just as they need to understand details of effective treatments.

Where non-drug treatments were concerned, findings were generally good about the availability of counselling by the doctor, which was said to be available for over 50% of recognized cases of mental disorder; referral to a mental health professional occurred in only 10.2% of cases; and no treatment was prescribed for 18.3% of recognized cases.

Discussion

The study has succeeded in bringing similar measuring instruments to bear in very different cultural settings and including a measure of the patient's distress (GHQ), the doctor's assessment and the presence of mental disorder based upon a modern research interview. Its shortcomings are that the centres are not necessarily representative of their countries, that 'culture-specific' ways of expressing distress may not be detected by the CIDI-PC and that it was not possible to devise a measure of social deprivation that could be applied across such contrasting cultural settings.

The findings about disagreement between the doctors and the research instrument must be treated with caution. On the one hand, the doctor often makes a psychological assessment at a later interview with the patient, whereas on the other, the patients are often not aware that they have satisfied diagnostic criteria for a mental disorder and usually agree with their doctor's view that they are psychologically well. Some of the disorders detected will remit spontaneously, while others do not respond to any treatment. Doctors are generally detecting disorders that are more severe and are associated with greater disability.

Implications for training and clinical practice

Because of their high prevalence, their relationship to disability, their susceptibility to treatment and the fact that most disorders will continue to be managed entirely within primary care, it is important that training about common mental disorders and their management is emphasized both within medical schools and in vocational training schemes for general practitioners. The great variability in agreement between doctors and research assessments shown in 15 centres across the world points to a near universal problem, as yet unsolved.

Undergraduate needs. Where medical school teaching is concerned, teaching needs to include individual feedback of interview performance in order to acquire communication skills, and students need to be taught on patients, either on the general medical wards or in general practice, by teachers who have mental health skills. Such teaching will involve collaboration between departments of psychiatry and physicians and general practitioners. Doctors who use directive rather than closed styles of interviewing, who know when to make supportive comments and who both possess and use psychological problem questions are more likely to make accurate ratings of psychological disorder.[5] A directive approach leaves the patient free to provide a range of information ('Tell me more about the pain'), whereas a closed question restricts the patient's replies ('Does the pain wake you at night?'). Teaching of communication skills was described by Sanson-Fisher *et al*[8] and shown to lead to persistent changes in medical behaviour.[9]

Regrettably, in practice, teaching tends to be confined to those disorders that can easily be found in the specialist service, such as dementia, schizophrenia and bipolar illness. It is an unusual training scheme that provides much instruction on the detection and management of those disorders which have been shown to be most common in general medical settings, notably states of mixed anxiety/depression, either accompanying known physical illness, or other somatic symptoms for which no organic cause can be found. Training on such conditions requires collaboration between departments of psychiatry and departments of medicine on the one hand, and general practice on the other. At present, such collaboration is the exception rather than the rule.

Mental health training for general practitioners. A review of mental health training for primary care residents in the USA[10] indicated that two major dimensions needed to be addressed: one relating to knowledge as well as social and cultural issues, the other relating to skills, including interview skills, counselling, detection of disorder and diagnosis leading to clinical management. Successful training leading to fewer hospitalizations and a reduction in the suicide rate was reported in the Swedish island

of Gotland, although the reduction in suicide rate was not maintained at follow-up.[11,12]

In this country the joint Royal Colleges have produced an agreed statement on the training needs of general practitioners,[13] but despite this, there is still no coordinated training for mental health skills in general practice. It has been shown that 39% of a large sample of general practitioners found that vocational training had been of little value in helping them meet the mental health needs of their patients.[14] The College has appointed a national mental health education fellow, who now relates to a national network of trainers and disseminates training methods and materials to them.[15] Gask *et al*[16,17] have shown that general practitioner trainers can be taught the methods used by psychiatrists in teaching communication skills.

Van Dulmen *et al*[18] studied 110 patients with functional abdominal complaints and showed that doctors who are good at assessing their patients' attributions produced a greater change in these attributions and found that results were better when patients saw the same doctor: they draw attention to the therapeutic value of the doctor–patient interaction. Training should include knowledge on how treatable disorders are diagnosed and vocational training schemes should provide doctors with the necessary therapeutic skills. If this cannot be done, it is difficult to see how appropriate treatment can ever be given. The primary care version of the ICD-10 section on mental disorders (ICD10-PHC) is designed with just this end in mind.[19] This consists of 24 conditions which are common in general medical settings, together with detailed advice on management of these disorders.

There is a need for training packages for all disorders for which an intervention exists of proven efficacy, so that these can be made available to doctors and staff in primary care settings. Assessments for possible mental disorder should be made early on, rather than being 'diagnoses by exclusion'. Overprescribing in general medical settings should be avoided, and doctors should be trained to give both counselling and health information to patients and to their families. As these disorders are often recurrent, doctors need to be helped to produce a treatment strategy for helping these patients over the long term. This will often include knowing the therapeutic help which happens to be available to them locally and availing themselves of such help.

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