PRIMARY CARE PSYCHIATRY: A CONTRADICTION IN TERMS?

David Harris
University of Liverpool

ABSTRACT

Changes in the nature of psychiatric care have necessitated a move towards primary mental health care. Mental health represents a significant burden in terms of psychological and social wellbeing, and has serious implications for a person’s medical health. Further to these personal costs, mental health also represents a sizeable financial cost to the country. This review aims to assess whether the notion of primary care psychiatry is, in fact, a contradiction in terms. The evidence suggests that a substantial number of people with mental disorders go unrecognised, and that issues including compliance make for suboptimal treatment. Obstacles including knowledge base, skills, and time constraints placed upon General Practitioners (GPs) stand between us and improved standards of care. The evidence indicates that primary care psychiatry is doing poorly at present, but for mental illness primary care probably represents the best point of contact for care. We should be inspired to raise standards by ensuring the adoption of a patient-centred model, with the delivery of evidence-based treatments – indicating the need for continued research in this area – that is readily accessible for those in need, but which develops a focus on prevention. With the implementation of the Health and Social Care Bill, the UK healthcare system finds itself at a crossroads. It is surely not hopeless optimism to say that these identified obstacles are not insurmountable.
PRIMARY CARE PSYCHIATRY: A CONTRADICTION IN TERMS?

David Harris
University of Liverpool

INTRODUCTION: A STATE OF NEGLECT

As the psychiatric institutions of a bygone era have made way for a community-based model, primary care has become the point of contact for an entire spectrum of mental illness. Currently, over 85% of all care of patients with chronic health problems is undertaken in primary care (1). Striving towards improving health standards in the 21st century, it is only natural that we consider where the main burden of care for mental health is going to lie. One in four will experience mental illness in their lifetime, whilst one in six will experience mental illness at any one time (2). Mental health represents, therefore, a hugely significant burden. In 2004, 22.8% of the total burden of disease in the UK was attributable to mental disorder (3). This shows few signs of abating: mental health has been identified as one of the most important health problems we will face in the 21st century (1). This raises the question: is mental health being neglected?

The effects of mental illness carry implications for a person’s physical health, psychological and socioeconomic wellbeing; with far-reaching consequences in terms of prevalence, persistence and breadth of impact (4). Disappointingly, whilst the poor physical health of those with mental illness has been known for some 80 years (5), recent data has done little to dispel the notion that improvements have been made (6). With health inequalities very much in the public eye and, as such, forming a significant contemporary political battleground, the promotion of good mental health remains paramount. With an estimated cost in England of £105 billion (7), establishing good mental health care is both prudent and pragmatic. As if further proof were needed, in 2011 the now-former Secretary of State for Health, Andrew
Lansley, commissioned a policy paper outlining “our ambitious aim to mainstream mental health in England” (8).

There are important questions to consider for this significant group. We are asking general practitioners (GPs) to bear the main burden of psychiatric illness. Are cases of mental illness correctly identified and treated in primary care? Is there sufficient knowledge, skill and experience to successfully achieve these aims, and is this reflected by outcomes? What factors impede progress to this end? This review aims to address and answer these questions, and in the process determine whether primary care psychiatry is a contradiction in terms.
DIAGNOSIS: DO GPs DO A BAD JOB?

It is only through correct and appropriate identifications that efficacious, evidence-based treatments may be offered to patients. Under-diagnosis means undertreatment, and this risks progression of symptoms, with intrinsic effects for the individual, but also much greater implications in a public health sense. Over-diagnosis risks trivialising mental illness and exposing people to harm through the prescribing of medications with a variety of potential side effects. Just as important though, is that the correct diagnoses are reached. If patients are initially incorrectly labelled, patients may be given treatments that do not work, and through this exposed to unnecessary risks.

A recent meta-analysis (9) investigated the diagnosing of depression in primary care. They pooled data from 41 studies which amounted to more than 50,000 patients. From this, they conclude that of 100 presentations (with a rate of 20% depression), a GP would correctly diagnose 10/20 cases, and correctly reassure 65/80 non-cases. Thus, 10 depressed patients would be missed (false negatives), and 15 non-depressed patients would be incorrectly diagnosed with depression (false positives). Depression was correctly identified in a total of 47.3% of cases. Coyne et al (10) found, in a study of US “family physicians”, that they detected only 27.9% of cases of depression.

A study looking at under-detection of bipolar disorder (11) found that between 3.3-21.6% of primary care patients diagnosed with depression may have unidentified bipolar disorder. This large range is reflected by what the authors describe as different levels of conservative estimation. There was quite a poor response rate: only 18.5% of those invited to participate volunteered. Volunteers and non-volunteers were demographically similar but there were differences between these two groups; such as in prescribing rates of antidepressants, suggesting differences in the mental illness profiles. However, these results suggest an element of
misdiagnosis which may cause inappropriate treatment and exposure to harmful side effects.

A recent meta-analysis has shown that GPs do no worse than other medical physicians in diagnosing depression (12). Yet there is clearly a significant number who go unrecognised and, therefore, untreated. This may well be true of other mental disorders, but there is a genuine paucity of data in these other areas. Further research is required to establish the extent to which this is the case. What data we do have point to worrying trends, which suggest that depression is frequently missed in primary care.

**TREATMENT: DOES IT ALL BOIL DOWN TO COMPLIANCE?**

Another important question surrounds the management of mental health in primary care. Do correctly identified patients receive appropriate treatment?

An American study published in 1992 (13) found that less than half of all patients evaluated as needing antidepressant therapy received it, and those that did failed to take an adequate course for duration or dosage or both. These are concerning results, though differences in the respective natures of UK and US healthcare could mean that the same would not be applicable here. Poor compliance seemed to have been in part influenced by failure to warn of potential side effects and the delay in therapeutic response.

Compliance is a significant issue in treatment of a variety of diseases and conditions, and good compliance is imperative. A 2007 study showed that over the 6 month study period, only 19% of the 149 participants persisted with prescribed antidepressants in accordance with guideline recommendations (14). Looking at
discontinuation rates, Olfson et al demonstrated that 42% of 829 patients had stopped taking prescribed antidepressants at 4 weeks (15). A longitudinal study of primary care antidepressant prescribing in the UK (16) showed only 32.9% of 6150 patients prescribed a selective serotonin reuptake inhibitor (SSRI) received adequate dose and duration of treatment. There is no doubt however, that the factors surrounding treatment compliance are complex and multi-faceted, so it is difficult to draw firm conclusions around the suitability of primary care psychiatry from these data. Katon et al’s (13) findings point to potential failure to initiate drug therapy when indicated. Appropriate treatment is also dependent upon appropriate diagnosis, as prior discussed, so failure to identify mental illness will mean failure to treat.

OUTCOMES: WORSE IN PRIMARY CARE?

With diagnosis and compliance posing serious problems for primary mental health care, does this also mean worse outcomes? Rost et al prospectively assessed outcomes in major depression over a 1-year period (17). In this study, conducted in the USA, of 98 patients identified with major depression through screening, 32% went undetected over the year. 46% of this group reported serious suicidal ideation during the study period, however fewer than a third of this group presented during their worst month for symptoms. Of the initial cohort of 153, 36% did not attend a primary care physician during the first 6 months. So clearly a significant number are never assessed, but equally a significant number of those who are assessed remain unidentified, which is especially troubling given the suicidal ideation reported by some.

Of course, as the oft-quoted adage goes, prevention is better than cure. Data from a randomised controlled trial carried out in Holland (18), looking at intervening to prevent depression, indicate that it is probably superior in terms of cost-effectiveness, too. Smit and colleagues report a reduction of incidence of one-third in the intervention group, and a 70% probability of better cost-effectiveness. The
authors themselves point out that their results may not be applicable for other countries. There are few studies which have looked at outcomes; further research is necessary so firm conclusions may be reached.

**MEDIA PERCEPTIONS: ARE GPs PRESCRIPTION-HAPPY?**

Prescribing rates are a commonly cited source of mental health debate in the UK. From respected journal (19, 20) to tabloid newspaper (21), the reveal of new data inevitably stimulates fresh discussion surrounding these common themes of diagnosis and treatment. Prescriptions for antidepressants increased by 9.1% in 2011, compared with 2010 (22). This, amid a backdrop of increasing patterns of antidepressant prescribing that has been occurring since the 1970s (23). Some feel that this is the result of overdiagnosis and overtreatment, through the medicalisation of the “normal” human condition, and the ease of the supposed quick-fix of pills. A large study however, looking over the period 1993-2005, found that increased prescribing patterns were reflected by small changes in the proportion of patients receiving long-term treatment (24), as opposed to the hypothesised exponential increase in numbers of people being prescribed antidepressants.

**BARRIERS: WHY DOES IT GO WRONG?**

**MEDICAL BARRIERS**

Research discussed thus far, taken collectively, suggest that there are failings in diagnosis and treatment, and highlight the potential for poor outcomes. A systematic review of GPs (among studies including, but not limited to, the UK) (25) found that the commonest approaches to diagnosing depression were based on knowledge of the long-term history, use of the patient-doctor relationship, and a rule-out algorithm of alternative diagnoses; in contrast to the use of formal diagnostic criteria.
Consultations with depressed patients are viewed, in the main, as time-consuming and draining. Lack of available time was identified one of the foremost barriers.

Time represents arguably the single greatest limiting factor in primary care. The average GP has a 10 minute appointment slot to see a single patient. That’s 10 minutes to greet, seat and treat. To elicit the main factors causing presentation through open, then closed questioning to guide diagnosis. To measure relevant observations and perform appropriate clinical examinations. Combine this information and then devise a plan for investigation and management; and to discuss these so that the plan is shared and agreed upon. The 10 minute consultation time has been and remains a bone of contention (26) in general practice. Many agree that it scarcely provides sufficient time for what is required of GPs. In the case of mental health, a thorough assessment should include severity at the time of presentation, consideration of differential diagnoses, a risk assessment, exclusion of underlying medical causes, and consideration of other coexisting issues. And what of the patient’s social wellbeing; work, home, family, relationships? Can a truly comprehensive, holistic approach be expected under such constraints?

Some GPs feel that serious mental illness is too specialised for primary care, and some believe that they lack the skills and knowledge to provide good care (27). A survey of doctors conducted in Norway identified treating common mental disorders as a significant learning need, though (strangely) also reported high-self efficacy in this (28). Perhaps the largest and most contemporary study we have to identify current primary care skills in mental health (9), indicates that whilst identification of depressed and non-depressed patients is generally good, there is certainly room for improvement in terms of false positives and negatives. On the whole, whilst a specialist-level of skill cannot be expected in GPs, the reported data is certainly disappointing.
Undoubtedly, the workload for primary care has increased over time. It is not only psychiatry that has been preferentially shifted into the community, with care of the elderly and chronic diseases among them. These were previously treated within hospitals but a variety of reasons including better outcomes, and fewer complications and reduced costs, have necessitated the move out to primary care, in much the same way as for psychiatry and without hugely different motives.

**The Spectre of Stigma**

Attitudes may affect any number of factors already considered, and there are two distinct groups to consider: patients and doctors (or other healthcare professionals). It has been reported that most healthcare professionals view mental illness as a lifelong, chronic disease (29). This can have a disheartening impact on patients, who at their lowest ebb may feel utterly hopeless. Patients may fear presenting to the GP with mental health problems; they worry that they will be wasting the GP’s time or that the GP does not have time to listen, or that they will not understand their problems (29). There may also be discrepancies between the expectations of the patient and the management by the doctor. Concerns exist that the guidelines and protocols which exist to provide standards of care may lead to a medicine by-the-numbers approach, with printed prescriptions issued in exchange for what the patient may want (and need); to be listened to (30).

The spectre of stigma is still a problem for mental health in the public perception and this is no doubt a contributory factor to unidentified mental health disorder. A number of high profile campaigns such as “time to change” have been run, in the hope of eroding these antiquated views. Stigma is not, however, limited to the general public. It is perhaps little surprise that the neologism-generating paper “Five years of heartsink patients” (31) cited mental health issues in a significant number of this group. The brandishing of the heartsink moniker may, unfortunately, reflect a diminishing sense of understanding towards a patient, and may result in the delivery of suboptimal care.
GPs face increasing pressures, tight time constraints, self-perceived difficulties with mental illness, and mental health stigma is rife among doctors, patients, and the public at large. Arguably, identified factors such as these must be addressed from a public health point of view; they are substantial obstacles, but ones which surely must be eliminated for improvements in primary care psychiatry to improve.
CONCLUSION: A CONTRADICTION IN TERMS?

Psychiatry has changed beyond all recognition over the course of the last century. One of the biggest catalysts for and conductors of change has been deinstitutionalisation. Community-based care of mental illness has become the status quo, and awareness of mental health has never been greater in the public consciousness. Primary care itself has grown out of necessity, to attempt to meet the demands of a changing disease profile and ageing population. With these 21st century pressures, it is only right that the ability of primary care to deliver good quality psychiatric care for patients is questioned. The evidence currently available suggests that primary care is managing mental health poorly. Issues with missed diagnoses and poor compliance with treatment appear to be rife. Primary care is financially costly and GPs are facing a huge burden of care. It is certainly also disappointing that the physical health of these patients may still be neglected, in spite of this being a known, longstanding problem. There are a number of obstacles to good primary care of mental disorders, with GP consultations confined to 10 minutes, and some GPs feeling deficient in the knowledge and skills required for what may be complicated people with complex problems. These issues could be in-part resolved through changes currently discussed, such as increasing the GP training programme and increasing consultation length. But the results discussed should also stimulate discussion as to whether mental health should be moved, in its entirety, to secondary care.

The development of a robust primary mental health care system is surely the ideal scenario: where the approach is patient-centred, there is continuity of care and care is delivered in the community as much as possible. Treatment would be evidence-based and access to services available for all who require them. Continuity of care ought to be a positive factor in improving the physical health of those with mental health problems, and primary care probably offers the best opportunity to deliver continuity of care. There is a paucity of data across many of the areas investigated for the purpose of this review. As such, further research is required to determine any
contemporary issues with diagnosis, management and outcomes in patients, and to identify obstacles to good primary care delivery for this patient group. Change is afoot, however, and the mental and physical health of millions depends on the delivery of good mental health care.

A contradiction in terms, then? The evidence suggests this is the case and it seems reasonable, therefore, that a shift to secondary care is considered. The evidence is also, however, lacking in both quantity and quality. GPs are accessible and well-placed to develop good therapeutic relationships with their patients, and so good primary care psychiatry must surely be the ideal scenario for all. I feel confident that we are well placed to improve the status quo, and am hopeful that in doing so that we will address the health inequalities plaguing mental illness.
REFERENCES


12. Cepoiu M, McCusker J, Cole MG, Sewitch M, Belzile E, Ciampi A. Recognition of depression by non-psychiatric physicians--a systematic literature review and
1. O'Dowd A. GPs must have more consultation time with patients, college says. BMJ. 2010;340.


