Mental illness in general practice

Detecting and treating mental illness in general practice has always been challenging. Newer pharmacological agents like agomelatine, indicated for major depressive disorder, have a different and possibly superior side-effect profile than conventional antidepressants. Since side-effects of antidepressants is a major reason for non-compliance, it is hoped that this will improve treatment rates and compliance. Despite these newer treatments, the general practitioner is challenged to detect psychiatric disorders and treat and monitor recovery during a 10-minute consultation. This feature explores some of the factors that influence low detection rates, and introduces a unique DVD set that discusses 13 psychiatric disorders in a uniquely South African way.

Introduction[1]

Approximately one in five South Africans suffer from a mental disorder severe enough to affect their lives significantly. Ten to sixteen per cent of South Africans will suffer from a mood, anxiety or substance use disorder at some stage in their lives and, every year, approximately 20% of high school learners think about fatally harming themselves.

Mental disorders tend to be chronic, strongly impair quality of life, cause excess mortality, and substantially increase societal costs. Worldwide, major depression is the disorder with the second highest disease burden, after HIV/AIDS. Four of the ten most disabling medical conditions are mental disorders. The burden of disease is significantly greater if detection of the disease is delayed.

Low detection rates

Research has shown that the practitioner in general practice is not always adequately equipped to deal with the burden of mental health problems of his or her patients.[2,3] In particular, the short consultation time allowed in most practices may be a main reason for this; a full 50-minute psychiatric consultation is not possible. It has been shown that a psychiatric consultation and examination can be a lengthy undertaking, and a general practitioner (GP) may simply not have enough time to deal with psychiatric cases.

The reasons for low detection rates are, however, complex, and include factors originating from both the primary care physician and the patient. Some research has shown that, in half the patients presenting with a depressive disorder, this diagnosis has been missed on the first visit, and that 18% of these cases may still be undetected after three years.[4]

GP rates of diagnosis and treatment of anxiety disorders are probably even lower than those for depressive disorders, given the prevalence of these conditions.[5] Anxiety disorders are often more chronic than other mental disorders, presumably because anxiety is often left untreated and it is frequently co-morbid with depressive disorders or chronic physical health problems.[6,7] Lower detection rates of anxiety disorders may be due to patient and physician factors. Patients often dismiss symptoms of anxiety, worry, tension, irritability or tiredness, thinking that these are part of everyday life, and they may be unsure about presenting to their GPs. GPs, again, may also dismiss these symptoms as unimportant or attribute them to general malaise or a potentially physical condition requiring investigation, and they may not specifically consider or ask about anxiety.

Apart from depression and anxiety, there are, of course, a wide range of other psychiatric disorder with which the GP must be familiar. Especially, substance abuse has become an increasingly bigger problem in South Africa and this poses new and complex challenges for family practice, requiring specialised skills and a good referral network.

Patient satisfaction

Despite these low detection rates, patients seem to prefer to be treated by their family physicians, and up to 95% of mental illness cases are treated by their GPs.[8] Referral to a specialist seems to be uncommon, and it may be because of patient preference, with the patient wanting to avoid being labelled as having a mental illness. It may also just be because the patient has an established relationship with the GP and has easy access to the primary care facility, and that there are longer waiting times to access specialist care.

One study attempted to measure patient satisfaction rates with regard to detection of psychiatric morbidity in general practice.[9] Although patient satisfaction may be a desirable outcome measure for clinical practice, it remains difficult to determine if this objective has been achieved. Nevertheless, the only significant finding was that patients

in whom psychiatric illness was correctly identified reported that felt as if they had been "more helped" than those patients in whom psychiatric illness was not detected.

Consultations in which psychosocial problems are dealt with, rather than just noted, last longer, and patients are more satisfied with longer consultations. Sharing a psychosocial diagnosis is only the first step in management, although it may be all that is needed for transient mood disorders with high spontaneous remission rates.

TV Schedule for "*'n Lewe met*"

A series of 13 programmes will be broadcast and rebroadcast from 18 October 2011.

Tuesdays: 20h00
Wednesdays: 15h00
Thursdays: 13h00
Saturdays: 22h30

Education and screening questionnaires

A lot has been done to improve detection rates of mental illness in general practice. Educational interventions and practice questionnaires have been some of the most common methods utilised.

It is interesting to note, however, that many studies that investigated psychiatric educational programmes to determine knowledge gaps in primary care were performed by psychiatrists. There were significant differences in what specialists perceived to be important compared to GPs. GPs mostly wanted to increase their knowledge regarding somatisation, psychosexual problems, "difficult" patients and stress management. Psychiatrists, on the other hand, emphasised the diagnostic criteria of schizophrenia, bipolar disorder and depression. In terms of skills development, the GPs placed emphasis on crisis, family, individual and marriage counselling and strategies to prevent their own burn-out. Psychiatrists, again, were more concerned about the need to teach GPs sabout new pharmacological agents.[10-13]

Educational meetings may improve clinicians' knowledge and attitudes about depression, but had no impact on recognition or depression outcomes.[14, 15]

The routine administration of and feedback gained from simple questionnaires measuring depression or quality of life, mostly filled out in waiting rooms, seem to have had no significant impact on the recognition, management or outcome of depression in non-specialist settings.[16] Detection rates, however, increased when a practice nurse or administrative assistant scored and processed the questionnaires. However, there is no evidence that this actually influences clinical practice or clinical outcome.[17]

Two major studies[18,19] used a population-based approach to educational and organisational strategies. Intensified care, incorporating patient education, and the sharing of care between the primary care physician, psychiatrist and psychologist were associated with improved treatment adherence and patient recovery rates. A sustained improvement in the management of depressive disorder was, however, not seen beyond the period of advanced organisational care, suggesting that clinician education alone was not sufficient to maintain change.

Patient education

Patient education may play an essential role in the detection of mental disorders and despite, a host of information on the internet, GPs may need to direct patients to a reputable and authoritative source of mental health information.

In South Africa, GPs can now draw on a very helpful and comprehensive DVD series, developed by Medihelp Medical Scheme. The Medihelp "Living with" series covers 13 psychiatric topics, and is a must-have for every GP in South Africa. The series inspired a discussion programme entitled "'n Lewe met" on kykNET during 2010, and has done much to create awareness and inform patients about a wide range of psychiatric conditions. A new series of "'n Lewe met" is currently screened on kykNET and covers 13 new topics The "Living with" DVDs can be ordered online at www.medihelplivingwith.co.za or www.kalahari.com, and are also available at all Look and Listen and Exclusive Books stores.

The DVD series is unique, truly South African, and goes beyond being merely a reputable source of patient information and disease awareness. Each condition is introduced by a case study. Actual patients are the narrators of their own personal experiences of living with the condition. As in most psychiatric conditions, living with the condition before diagnosis usually has serious implications on social lives and professional careers. Occasionally, misdiagnosis and incorrect treatment were aggravating factors. The case studies are honest reflections of how psychiatric disorders can disrupt every aspect of life, and how families, partners and colleagues can be affected.

An in-depth professional interview then follows, facilitated by Dr Franco Colin, an eminent psychiatrist from Pretoria, and Ruda Landman, well-known journalist and television presenter. They examine each case from both a patient and a medical perspective, thereby shedding light on how common the disease is, why it is difficult to diagnose, how it is diagnosed, and which other conditions should be considered in the differential diagnosis.

A series of psychiatry articles will be featured in *SA Family Practice*, as from next month, to discuss all 13 topics.

References

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