Diagnosis and management in Primary Mental Health Care: a paradox and a dilemma

In this perspective paper we examine the issues associated with the diagnosis of mental health problems in primary care in relation to treatment and service provision, concluding that we are moving to formal acknowledgement that problems presenting in primary care are commonly mixed clinical pictures with associated social issues and that purpose designed refinements of current low-intensity treatments will be necessary.

Why do we classify and diagnose?

Diagnosis serves several purposes in all areas of clinical practice. Making a diagnosis requires classifying the clinical problem and gives the clinician a ‘short hand’ way of understanding the clinical problem, in particular what features the patient has in common with others with similar problems, what treatments are most likely to work, and what the prognosis is likely to be (Kendall 1975). Having a diagnosis enables health professionals to communicate with patients about the nature of the problem, and also with each other.

While clinicians have used diagnostic constructs for thousands of years, more recently diagnoses have also been used as part of sophisticated systems to determine what services people should have access to, and how services will be funded. The two main classifications in use, The World Health Organisation ICD system and the American Psychiatric Association Diagnostic and Statistical Manual (DSM), were both initially developed from systems which counted hospital statistics. They are now used not just in public health and research settings, but particularly in the case of the DSM, for health insurance and billing purposes.

Problems with classification and diagnosis

Although classification of psychological problems is important for research and service provision purposes and has become an important part of psychiatric practice, in clinical practice, it can be problematic for several reasons. Psychiatric diagnoses
may be unstable over time within an individual (Baca-Garcia E et al 2007; Ghazan-shahi et al 2009). The psychiatric diagnostic categories themselves are also unstable – for example, in the change from the DSM III (265 disorders in 1980) to DSM IV (279 disorders in 1994), 14 new disorders were introduced, with some new disorders being constructed and others disappearing. In ordinary psychiatric practice many of the treatments are not specific to existing diagnostic categories. Finally, having a psychiatric diagnosis is associated with the experience of stigma and discrimination, with some disorders being stigmatised more than others.

In the primary care setting, diagnosis is associated with these problems but additional issues add to the complexity. The diagnostic systems in common usage (i.e. the ICD and DSM systems) are largely derived from specialist psychiatric practice, and reflect the kinds of sign and symptom patterns that are seen in that setting. Over the years the diagnostic categories have been refined to better reflect the presenting problems and what is increasingly known about their aetiology and underlying pathophysiology. In this process the number of diagnostic categories has increased and the inclusion and exclusion criteria have become more precise. This process has also led to increasing use of the ‘not otherwise specified’ categories as even psychiatrists find the categories cannot accommodate the problems people present with. It led the classification system further away from what is commonly seen in primary care: for example until its current version the DSM system did not have a category for ‘mixed anxiety and depression’, the most common presentation in general practice settings. Furthermore, there has to date been a focus on categories rather than considering symptoms and functioning in various domains as dimensions of experience and observable phenomena. In relation to treatment, there have been increasing attempts to tailor treatments to the more specific diagnostic categories, although observation suggests that this is usually short-lived and that after a period the indications for new treatments tend to broaden out to include more diagnoses (i.e. the treatment becomes less specific).

Alongside all these issues, a fundamental problem for primary care practitioners is that the syndromes that reflect some aspects of problems presenting in psychiatric
practice quite well, do not suit primary care practice. This is because primary care patients usually do not present with such clear cut patterns of signs and symptoms. People often present to primary care with mixed clinical pictures, and syndromes evolve over time. Furthermore, in primary care settings, people commonly present with non-specific psychological distress, i.e. with syndromes that do not meet the diagnostic threshold. Just over one quarter of primary care patients are considered by GPs to have diagnostic sub-threshold problems. These ‘sub-threshold’ problems are common, and are associated with significant suffering and impaired functioning (Collings et al. 2006; Martin et al. 1996; Wagner 2000). For example, many patients in primary care with problem drinking would not reach the threshold for alcohol dependence, but nevertheless create significant problems for themselves, their families and society.

Medically unexplained symptoms (i.e. a combination of psychological and persistent physical problems with no detectable underlying pathology) often represent psychosocial distress and are common presentations in primary care. Many of these symptoms may come to be diagnosed as part of recognised medical conditions such as irritable bowel syndrome, but when the symptoms persist or become multiple in their nature it may be helpful to label them as a psychological problem. These can be challenging to manage as it is not clear which aspect to prioritise, and practitioners are fearful of ‘missing’ a treatable medical condition while also often experiencing frustration in the clinical relationship (Woivalin 2004).

Presentations of non-specific psychological distress associated with psychosocial complexity (e.g. welfare, housing or family/whanau issues such as violence) are common and do not lend themselves to simple diagnostic frameworks or responses (Dowell, Garrett, Collings et al. 2009).

These issues mean that both the diagnosis and treatment options for patients presenting in primary care are less clear-cut than in secondary care. From a classification perspective primary care does not fit well with the existing diagnostic systems. From a prognosis perspective, there is less evidence about the course of
these mild-moderate mixed picture syndromes, but it we do know that a high proportion are eventually self-limiting (Jackson 2007).

**Mental health problem identification in primary care**

Most management of mental health problems takes place in primary care settings (Hornblow et al. 1990). Despite the problems with the utility of psychiatric diagnosis, primary care practitioners manage mental health problems frequently as part of their day-to-day work: over one third of adults attending primary care are likely to have met the criteria for a DSM disorder over the previous 12 months (MaGPIe Research Group 2003). How are the complexities outlined above resolved in practice?

We suggest that GPs are more interested in *detecting* psychosocial problems than *diagnosing* them. Although it has been suggested that GPs fail to *diagnose* mental health problems, we suggest that this claim is an oversimplification. GPs are effective at *detecting* mental health problems. The MaGPIe study showed that GPs identified psychological issues in the past 12 months in 70% of people who had already presented within the 12 month period and who had a diagnosable mental disorder during that time, but in only 33% of those who had not been seen in the previous 12 months. That study also showed that higher frequency of consultation was associated with problem detection (MaGPIe Research Group, 2005; Bushnell and MaGPIe Research Group, 2004). This suggests that continuity of care is an important element of problem detection. The same study showed that GPs consider functioning as well as symptoms when detecting psychological problems (Collings and MaGPIe Research Group 2003), suggesting that GPs do not use the same diagnostic frameworks as used in secondary care.

The clinical practice context is an important determinant of whether a primary care practitioner will decide that a psychological problem is present, and whether a decision to actively manage it is appropriate at any given time. For example, having detected a psychological problem, the practitioner may choose to address other more pressing problems in that consultation if the patient has minimal functional
impairment (Klinkman et al. 1997). Furthermore there are almost always other constraints such as time and resource issues (Klinkman 1997).

**Links between problem identification, diagnosis, clinical management and service provision**

Because health resources (both money and skilled staff) are finite, there is a need to systematically determine what problems ‘qualify’ for treatment and what treatment options will be made available. The use of clinical diagnoses to determine access to treatment and other services is widespread in health services internationally, and ranges from tightly prescribed options such as those common in Managed Care settings in the USA, to clinician determined options which are common in secondary and tertiary mental health services in New Zealand.

Funding and service delivery in New Zealand primary mental health care (PMHC) is currently predicated on being able to define clinical problems using the general diagnostic fields offered in the DSM and ICD systems, and on being able to distinguish ‘mild-moderate’ from ‘severe’ problems. However, even outside mental health, GPs are known to use widely varying practices in relation to diagnostic coding (Brown et al. 2003). Add to this what is known about the specific frailties of psychiatric diagnosis, and the uncritical use of a purely diagnostic approach in day-to-day primary care clinical practice must be open to question.

Although the DSM and ICD diagnostic systems themselves are probably rarely used in PMHC in New Zealand (Dew et al. 2005), the screening instruments that have come into common usage as part of the process of determining eligibility for primary mental health services (e.g. the PHQ-9 and the K-10) are strongly linked to these diagnostic frameworks (Kessler et al. 2003; Kroenkek 2002). The choice to use these instruments was a consequence of the thinking that simple and brief tools were needed to determine eligibility for treatment.

We contend that this was easy to adopt in the PMHC setting because PMHC development in New Zealand was already being driven in part by secondary mental health service thinking and philosophies. Two simple examples support this
assertion. The first relates to the default and even articulated age limits on most of the PMHC programmes running in New Zealand at present. Very few cater for children or people over the usual working age, replicating the age-based service divisions seen in secondary mental health services but not primary care. The second example is that most PMHC services essentially replicate the secondary care model, where people with certain kinds of problem, in this case mental health problems, are referred out of the practice to be treated or managed by a person with ‘specialist’ skills such as a counsellor or psychologist. Associated with this are potential barriers to treatment and good clinical management, including waiting times, possibly having referrals declined, having to locate and attend an unfamiliar treatment setting, poor communication between treating and referring clinician and administrative problems (Mathieson, Collings & Dowell 2009).

We know that in New Zealand GPs take a very pragmatic approach to problem classification and management (Dowell, Garrett, Collings et al. 2009). Diagnosis is not always (or maybe even often) seen as a necessary step in arriving at a clinical management plan. Many GPs have been reluctant to ‘pigeon hole’ their patients with psychiatric labels, particularly if there are, for example, insurance company implications (Dew et al. 2005). Primary care practitioners will more often use generic labels such as anxiety/depression. They tend to be ‘lumpers’ when it comes to classification rather than ‘splitters’ who create multiple sub-categories. Practitioners are aware of the impact of psychosocial issues and are prepared to classify accordingly. In some parts of the country service provision is dependent on a psychiatric or DSM diagnosis, and where this is the case then GPs will tailor a diagnostic category to ensure access to treatment. In other cases, the practitioner only has to provide a ‘diagnosis’ of ‘mild/ moderate mental health problem, to obtain services for a patient.

The apparent paradox of PMHC is that while most mental health care is provided in primary care settings and this is usually done without a formal psychiatric diagnosis, treatment can be very effective at reducing symptoms and improving functioning (Dowell, Garrett, Collings et al. 2009). This brings with it a significant dilemma for
those working in policy, planning and funding, for whom the accurate estimation and forecasting of clinical activity and associated budgets is critical. While funders may recognize the reality of primary care practice, they find it hard to commit funding to programmes that appear loose in their prescription.

Figure 1 on the next page illustrates the elements of the primary care practitioner’s process for detecting and characterising mental health problems. This is adapted from our previously published work (Dew et al. 2005) to highlight the introduction of screening for the determination of eligibility to receive services. During the course of a consultation, the clinician weighs up the options around focussing on one problem, or one aspect of a problem, over others. Note that the determination of eligibility to receive primary mental health services outside the routine consultation can occur at any time and is not contingent on a formal diagnosis being made. In some cases the practitioner will have decided early on that additional help for the psychological or psychosocial issue is warranted and will construct the diagnostic or other eligibility criteria to ensure the person receives help.
Figure 1: The primary mental health assessment process, which is reiterated over multiple consultations: mindful prioritising between multiple competing issues.
An interesting aspect of PMHC development in New Zealand is that there is an upper threshold for eligibility. The original Primary Mental Health Initiatives were required to be designed so that those with ‘severe’ disorders were not seen but were referred on to secondary care. This created some interesting scenarios where it was known by GPs that the local secondary services would not accept the referral. as although screening scores (e.g. K10 scores) were at the severe end, the person was neither psychotic nor at risk of suicide. These people were commonly kept in the PMHC service and often managed effectively.

The dilemma around treatment provision in primary care is compounded by inconsistent links between the type of clinical problem and treatment. In primary care there appears to be a lack of a tight linkage between problem type (or diagnosis) and clinical management. At the high level of the Primary Mental Health Initiatives Evaluation, it appeared that brief non-specific treatment approaches made a clinically important difference for most people (Dowell et al. 2009). Even at a more specific level, treatments for mild-moderate depression are effective for patients with mild-moderate anxiety. There was no real difference in the proportional benefit between patients with anxiety or depression and those in whom social factors were prominent in their assessment. Regardless of the combination of problem and treatment, up to 80% of patients showed some overall improvement and 58.1% showed an improvement of at least 20 percentage points on their outcome following intervention (equivalent to a change of 8 points on the K10).

However, for problems which are mainly characterised by depressive symptoms of mild to moderate severity, both drug and psychological therapies are effective (NICE 2004; De Rubeis et al. 2005; de Mello et al. 2005). This makes the dilemma more acute for service planners and funders, as while psychological therapies may be better tolerated (NICE 2005) and may have a more sustained effect (Ma & Teasdale 2003; Teasdale et al. 2000), they may be less accessible due to cost and skill availability. The patient with moderate depression could be treated for six sessions of CBT or given a prescription for an SSRI with very similar treatment outcomes, and
significant difference in health care costs. This scenario needs to be tempered with the knowledge that there is some suggestive evidence that for mild-moderate disorders, talking therapies may be better than medication and that medication is definitely more effective with more severe than with moderate disorders.

Towards a resolution

The fundamental purposes of diagnosis are to ensure the patient has the most appropriate effective treatment and can be given an account of how they can expect to be in the future, so they can actively participate in the management and prevention of future episodes where possible. It is therefore important that primary care practitioners portray an accurate picture of the way they themselves are framing the problem. For example, it is quite appropriate not to give, say, a simple diagnosis of depression, but tell a patient that a particular presentation is a common kind of psychological problem where depression and anxiety are mixed.

Both assessment and management should be pragmatically geared to the working environment of PMHC and the kinds of problems that present. At the international level the ICD and DSM classifications are currently being revised, and both will address general practice and primary care working practices. The outcome is likely to be a smaller number of broader groupings that cover the main problems seen in primary care.

For planners and funders at DHB and PHO level, funding and management needs likewise to be geared to broader groupings and not tied to specific diagnostic categories. Funding and services need to be inclusive of the wide range of problems seen in primary care and to fund the social components of management options.

Because of the large numbers of potential patients services need to be tailored to relative efficiency. This means that we may see a reduced range of specialised psychological therapies being offered within the PMHC frame, accompanied by the development of more available generic low intensity interventions specifically designed to be delivered in primary care for problems as they present in primary
care (Collings, Mathieson, Dowell et al. 2009). Such interventions will fit in between self-help and more specialised therapies in the treatment menu, and are likely to become one of the standard treatment options in New Zealand PMHC.

References


