Unrecognized Mental Illness in Primary Care

Another Day and Another Duty in the Life of a Primary Care Physician

THE OVERWHELMING conclusion about the recognition of mental illness in patients in primary care settings is that such conditions and problems are not recognized. Therefore, they go untreated by primary care physicians. In this issue of the ARCHIVES, on the basis of a very extensive review of the literature, Higgins[1] concludes that (1) there is a high prevalence of unrecognized mental illness in primary care; (2) controlled studies show improvement in the recognition and treatment of mental illness by primary care physicians; and (3) there is no apparent effect of improved physician recognition of mental illness on the patient's clinical course.

Higgins[1] does a very admirable job of organizing, presenting, and discussing the implications of an issue that has been debated in the literature for over 25 years. However, one needs to examine his work and interpret his findings with caution. First, little is said about how the author actually obtained his sample of studies for review. In the abstract, Higgins reports using MEDLINE, a manual search of bibliographies, and the *Science Citation Index Compact Disk Edition* (1990-1992) to locate relevant articles. He also searched abstracts of papers from the Fifth, Sixth, and Seventh National Institute of Mental Health conferences on mental health problems in the general medical sector. These methods raise concern for the nonsystematic nature and lack of replicability of the review. In addition, although it is useful and likely necessary to somehow limit the scope of the review to a very specific definition of mental illness according to *Diagnostic and Statistical Manual of Mental Disorders, Third Edition*[2] or *Diagnostic and Statistical Manual of Mental Disorders, Revised Third Edition*[3] criteria, one wonders about the potential implications of this limitation in scope. It seems somewhat ironic that the standard for recognition and treatment of mental illness in general primary care settings is being established on the basis of definitions and criteria from a very specialized sector. Even limiting the focus to mental illness within the specialized criteria results in a large array of disorders, not to mention severity of these disorders. The situation is further confounded by the necessity of combining studies that focus on different mental illnesses, focus on adults vs children, are conducted in the United States vs other countries, and appear in the psychiatric, more specialized literature vs the general medical and primary care literature. The potential for bias and the possible lack of comparability in these instances are simply not known. Further, many of the studies cited and populations serving as the basis for conclusions by Higgins and others may not be representative of practice settings in the real world.

Despite these possible limitations, the work by Higgins[1] is important for his consolidation of an enormous database and secondary analysis of the topic of mental health issues in primary care settings. His first conclusion is that, on average, the rate of nonrecognition of mental illness by primary care physicians is about 50%. Interestingly, in an article also appearing in this issue of the ARCHIVES, Badger et al[4] examined 47 community-based practitioners' levels of psychosocial orientation, methods of medical interviewing, and correspondent recognition of depression in patients. They found that 48% of interviews with standardized patients resulted in a correct diagnosis of depression.

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Explanations for nonrecognition and underrecognition of mental and psychological problems must be considered: the presence of more immediate, acute needs to be addressed than the mental status of the patient during an office visit; insurability or confidentiality problems or the potential for stigma attached to the diagnosis of a recognized mental illness[5]; or the inability or the unreadiness of the patient or a family member to accept and manage a diagnosis such as depression or dementia. Organizational or practice variables in conjunction with physician factors may influence the documentation of mental illness in the primary care setting. Mental illness may be recognized but, for a variety of reasons, not always formally reported. Even so, with greater reliance placed on the primary care setting as the point of first contact, primary care physicians may need more education in recognizing and treating mental health problems.[6]

Can physicians be trained to better recognize mental problems in patients? The answer would seem to be a qualified yes. Not surprisingly, according to Higgins,[1] the most effective types of training that result in an improvement in the recognition of mental problems are educational interventions that teach the physician skills in

the diagnosis and treatment of mental illness. The issue of replicability again needs to be raised. To what extent are findings regarding improved performance in the recognition of mental illness, based on studies conducted for the most part in major academic settings and university-based residency programs, applicable to the clinical setting? Are academic, multidisciplinary, educationally based interventions compatible with the nature of day-to-day health care provision?

Perhaps the most significant topic that Higgins examines—regardless of the questions of prevalence and whether or not physicians can be trained—is the actual effect of improved recognition on patient outcomes. Does improved recognition help the patient? On this topic, the evidence is mixed at best. Part of the reason is the difficulty in systematically evaluating outcome. There is not a lot of information on the natural history of mental illness, making it difficult to demonstrate that interventions are truly effective. Treatments may work, but are all patients at the same level at the beginning of the treatment? What happens to the patient who is not treated? Does this patient also improve over time? In an era of cost-consciousness and health care system reform, do we want to pay for more training and more interventions when, in the long term, the patient's problem may be resolved without intervention?

There are at least two implications and three unrecognized observations that follow from the work by Higgins.[1] The first and most straightforward implication is that recognition and identification of mental illness do not necessarily equate with change and improved outcomes relating to the cost of care, number of office visits, etc. However, are we focusing on the most relevant outcome variables? At the level of mental illness in the primary care setting, having someone like the physician to talk with and confide in, although costly in the short term, may be important to the patient's long-term functioning. Follow-up in the studies cited may have been too short.

A second implication stated by Higgins is that research should focus on developing tools that will enable the primary care physician to recognize patients who can benefit from psychiatric interventions. This may require the development of a classification system more suitable for mental illness in primary care settings. Indeed, if both the quantity of and reliance on primary care physicians continues, along with presentation of increased numbers of patients with mental health problems, more user-friendly and office-based tools are needed for effective and efficient treatment. In another related article in a previous issue of the ARCHIVES, Kroenke et al[7] examined how the type and number of physical symptoms reported by primary care patients relate to psychiatric disorders and impairment. Their results were based on data collected using the Primary Care Evaluation of Mental Disorders, a 26-item, self-administered patient questionnaire and clinician evaluation guide with which the physician asked about patient responses to establish the presence or absence of psychiatric disorders. In terms of clinician friendliness, the average amount of time for the physician to administer the evaluation guide to patients scoring positively on the questionnaire was about 8.5 minutes. Ostensibly, at least, instruments are being developed to assist primary care physicians in more readily identifying the mental health problems of their patients.

One observation is that the distinction between mental and physical illness may be artificial in the primary care setting. Depression, anxiety, and other mental or psychological problems often go hand in hand with physical conditions and symptoms. Certainly, Kroenke et al[7] attested to this with the findings that the number of physical symptoms is highly predictive of psychiatric disorders, and multiple or unexplained symptoms may signify a potentially treatable mood or anxiety disorder. Patients presenting in primary care practice settings often cannot be pigeonholed into one distinct category of physical vs mental illness, in spite of billing and reimbursement policies.

The second observation is the blurring between medical and social problems. The role of the primary care physician or generalist is being debated both within medical and political arenas. If health care system reform continues in its anticipated direction, there will be even greater reliance on primary care physicians to meet the public's health care needs. Even without major changes in the health care provision system, increased reliance on the primary care sector continues, not only for the diagnosis and treatment of physical problems but also for help with such health-related problems or conditions as depression, alcohol abuse, domestic problems, memory disorders and dementia, living wills, nursing home admission, etc. Appropriately or otherwise, problems in living and biopsychosocial concerns are being defined within the professional domain of the primary care physician. The scope of primary care medicine must be wide enough to include these life issues as major contributing factors in the appearance and treatment of patients' problems.

A third observation—unrecognized and unstated, but perhaps telling—relates to the references cited by Higgins[1] and the fact that only six citations are specifically from primary care journals. There are a few more from general medical journals like the *Journal of the American Medical Association* and the *New England Journal of Medicine,* but most are from psychiatric and related journals and publications. The issue of mental health assessment in primary care is largely being discussed and debated in a forum outside the communication sector of the practicing primary care physician.

In our own final analysis, Higgins raises as many questions as he answers and opens new areas to explore. For this reason alone, his contribution is valuable. Perhaps, though, as we examine and debate this issue of mental illness in primary care, and as such a high percentage of problems go unrecognized and therefore untreated, other data collection strategies should be considered in the future. More work should be done in mental health classifications for primary care, and more of it needs to be done in primary care settings. Most importantly, however, the long-term outcomes of family physician intervention need much more emphasis and research.

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