

Is there a place for mental health research in general practice?

Professor Irwin Nazareth
*Director of General Practice Research
Framework & Professor of Primary
Care & Population Sciences*

It might seem unreasonable to ask whether there is a place for mental health research in general practice, but this indeed was the very question asked of me several years ago during a telephone conversation with a person from a UK Department of Health. I was then asked whether I could offer evidence to support the assumption that research in general practice did lead to health improvements. This conversation arose from discussions on the possibility of allocating quality outcome framework points to general practitioners for their active involvement in practice based research. Several NHS managers at that time and possibly even now were sceptical about making such payments to general practitioners. They questioned the relevance of general practitioners' engagement in research and were unwilling to part with any of the NHS budget for such activity. Needless to say, general practice participation in research has not yet become a part of the quality outcomes framework remunerations and in the current economic climate it is unlikely to be given further consideration.

Over the last 13 years I have had the chance to reflect on some of the key issues in mental health that require further research exploration. These reflections have arisen from my dual experience of conducting research whilst also pursuing clinical general practice. Hence, although much of what I have to say relates to mental health, I believe that some of the broad concepts explored in the paper have wider application to other areas of general practice as well.

Correspondence to
Professor Irwin Nazareth
Director of General Practice
Research Framework &
Professor of Primary Care &
Population Sciences
MRC General Practice Research
Framework & UCL Department
of Primary Care & Population
Health
Stephenson House,
158-160 North Gower Street,
London,
NW1 2ND

One of many challenges in a general practice is the ability of practitioners to make efficient use of the very brief consultation time. This is only possible when the clinician is clearly able to understand or clarify the context of the clinical presentation. Primary care professionals are often able to judge the context of common presenting symptoms and this skill develops and improves with clinical experience. Hence, when a primary care practitioner is confronted with a presentation of headache or dizziness, the person is managed differently from someone seen in hospital. The person would not be subjected to a thorough medical drill that most doctors have learned as medical students. On the other hand, the general practitioner will skilfully combine their personal knowledge of the person, their past medical, family and social circumstances and will use this to focus their clinical investigations during their short consultation time. What makes such an approach to diagnosis reliable is still unknown. Knowledge of primary care epidemiology can inform general practice management. For example, few presentations of headache or dizziness are likely to be related to serious neurological disorders^{1,2,3}. In fact most are manifestation of psychological distress and most general practitioners get to learn about this through their training and experience in primary care rather than their knowledge of published epidemiology. Hence, diagnosis in primary care has often been referred to as an art rather than a science. But this view is held only because the science of clinical decision making in primary care remains poorly explored. There is

little research on how GPs make decisions through clinical uncertainty. Research that attempts to explore the active components of decision making by GPs will provide an insight into an important part of primary care medicine.

I have often been asked by relatives of people presenting to general practice with ill-defined paranoid symptoms about the likelihood of the person developing schizophrenia. Often these predictions may need to be made with knowledge of the person's family history (such as having a sister with schizophrenia). Most primary care practitioners are aware of clinical prediction rules for cardiovascular diseases such as the Framingham, Dundee and European Risk Scores that are now widely applied to general practice consultations⁴. These scores have over the last 10 years enhanced our ability to detect coronary heart diseases (CHD) and stroke before its inception and have advanced the field of preventive medicine. Is it possible that we can develop something similar for people with mental illnesses such as depression, anxiety disorders, psychoses and addiction disorders? Recent cohort studies conducted in primary care across Europe have created prediction rules for depression prior to the onset of an episode of illness⁵. This is the first step towards developing further prediction rules for mental illnesses and it can alter our clinical approach to the prevention of mental illness in the future.

There is still considerable clinical uncertainty on the management of mental illnesses. Following the advent of the Quality Outcomes Framework, most clinicians in primary care are able to make a diagnosis of depression through standardised screening of all new cases of suspected depression and existing people with CHD and diabetes. But the evidence on how best to manage these cases once identified still remains poor. Commonly used antidepressant therapy for the treatment of depression is based entirely on evidence from drug trials conducted in secondary care. The effectiveness of these drugs in mild depression still remains uncertain. Further evidence on these treatments are essential^{6,7}. The use of psychological therapies for the treatment of depression in primary care on the other hand has been more extensively evaluated over the last 10 years. One of the surprising findings was the

efficacy of usual GP care when directly evaluated against counselling interventions⁸. But as yet, we remain unaware of the exact active ingredients of general practice that are as effective as counselling. Only scientific research can answer this question.

Despite the strong justifications for mental health research in general practice, several counter views have questioned the conceptual frameworks used to conduct this type of research in general practice. The use of the randomised trial methodology to evaluate new treatment has been seriously questioned^{9,10}. This methodology was originally developed for the evaluation of drug therapies and has now been widely applied to the evaluation of complex care packages delivered in general practice such as social and/or psychological interventions. Mounting concerns about the use of this methodology and the collective wealth of research experience gained by those who have tried to apply this framework to primary care and mental health evaluations has informed the recent revision of the original framework developed by the Medical Research Council (MRC)¹¹.

Major depression remains a leading cause of morbidity and social disability world-wide and will rank second to cardiovascular disease as a global cause of disability by 2020¹². Despite these worrying trends leading academics have questioned current concepts of depression¹³. It has been suggested that depression is merely an altered interpretation of normal human experiences. If this were true is there any value in using antidepressant therapy? On the other hand should we merely help the person suffering with this condition to gain a new sense of the meaning of life? More moderate statements from the Royal College of General Practitioners (RCGP) suggest that:

“Mental health is a positive state of being in its own right and is much more than the absence of a diagnosis of mental illness; low-level symptoms and unhappiness, not reaching diagnostic criteria, are associated with poorer quality of life”^{14,15}.

While the discussions around depression as a diagnosis remain the subject of further debate, we need better scientific evidence on the biology of depression to counter these views.

In conclusion, mental health problems are still very common in primary care and make up at least 10% of all general practice consultations¹⁶ but yet there remain several unanswered questions on the diagnosis, prevention and treatment of primary care mental health. Scientific strides in the field can only be made through further research investigation that attempts to address these questions.

REFERENCES

- 1 Smith T. Epidemiology and impact of headache: an overview. *Prim Care* 2004 Jun;31(2):237-41.
- 2 Yardley L, Owens N, Nazareth I, Luxon L. Prevalence and presentation of dizziness in a general practice community sample of working age. *Br J Gen Pract* 1998;48:1131-5.
- 3 Yardley L, Burgneay J, Nazareth I, Luxon L. Neuro-otological and psychiatric abnormalities in a community sample of people with dizziness: a blind controlled investigation. *J Neurol Neurosurg Psychiatry* 1998;65:679-84.
- 4 van Steenkiste B, Grol R, van der Weijden T. Systematic review of implementation strategies for risk tables in the prevention of cardiovascular diseases. *Vasc Health Risk Manag* 2008 June; 4(3): 535–45.
- 5 King M, Walker C, Levy G, Bottomley C, Royston P, Weich S, et al. Development and validation of an international risk prediction algorithm for episodes of major depression in general practice attendees: the PREDICT study. *Arch Gen Psychiatry* 2008;65(12):1368-76.
- 6 Peveler R, George C, Kinmonth A-L, Campbell M, Thompson C. Effect of antidepressant drug counselling and information leaflets on adherence to drug treatment in primary care: randomised controlled trial. *BMJ* 1999; 319: 612-15.
- 7 Anon. Mild depression in general practice: time for a rethink? *Drug-Ther-Bull.* 2003 Aug; 41(8): 60-4
- 8 Friedli K, King MB, Lloyd M, Horder J. Randomised controlled assessment of non-directive psychotherapy versus routine general-practitioner care. *Lancet* 1997; 350: 1662–5.
- 9 Stronks K, Mackenbach J. Evaluating the effect of policies and interventions to address inequalities in health: lessons from a Dutch programme. *Eur J Public Health* 2006;16 (4):346-53. (doi:10.1093/eurpub/cki157).
- 10 Hawe P, Shiell A, Riley T. Complex interventions: how "out of control" can a randomised controlled trial be? *BMJ* 2004;328:1561-63. (doi:10.1136/bmj.328.7455.1561).
- 11 Craig P, Dieppe P, Macintyre S, Michie S, Nazareth I, Petticrew M. Developing and evaluating complex interventions: the new Medical Research Council guidance. *BMJ* 2008;337:a1655. (doi: 10.1136/bmj.a1655).
- 12 Murray CJ, Lopez AD. Alternative projections of mortality and disability by cause 1990-2020. *Lancet* 1997;349: 498-504.
- 13 Dowrick C. *Beyond Depression: A New Approach to Understanding and Management.* Oxford: Oxford University Press; 2004.
- 14 Royal College of General Practitioners Position Statement. *Mental Health and Primary Care.* RCGP; 2005.
- 15 Thomas P, Evans S, Gately C, Stordey J, Huxley P, Rogers A et al. State–event relations among indicators of susceptibility to mental distress in Wythenshawe. *Soc Sci Med* 2002; 55: 921-35.
- 16 Goldberg DP, Huxley P. *Common Mental Disorders: A Bio-Social Model.* London, England: Tavistock/Routledge; 1992.

