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Mental Health Problems in Primary Health Care as Seen by Doctors

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Mental health problems in primary health care are much more common than can be concluded by routine registration of diagnoses. This has been shown in a previous study by the authors in 1979. In order to test the consistency of these results (Study I) and the reliability of our method a replication was carried out in 1983 at the same health centre but with mainly other doctors (Study II). All visits to the health centre were studied during a period of four weeks. During the study period all doctors recorded mental health problems of importance for the visit in addition to the routine registration of diagnoses. The results of both studies showed a high degree of consistency. Mental health problems were observed in about 17 % of the patients in both studies. Sex differences were similar: 20–21 % of female patients and 14 % of male patients had mental health problems. Psychiatric diagnoses were only registered in six per cent of patients in Study I and five per cent in Study II. Mental problems were especially common in connection with abdominal and chest disorders. The replication thus confirmed our previous findings that mental health problems are common in primary health care. Such problems should therefore be given more attention in the training of doctors in general practice.

Key words: mental health problems, primary health care.

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In a previous study all visits to a primary health care centre in Sweden were studied during four weeks in 1979 in order to estimate the frequency of psychiatric symptoms or psychosocial problems noted by the doctors. Such problems were observed in 553 out of 3205 visits made during the investigation period, corresponding to 17.3% (Study I) (1). This finding corresponded fairly well to figures cited in similar studies elsewhere and has recently been further corroborated (2). The frequency of routinely registered psychiatric diagnoses was much lower, however. Considerable variation in reporting problems was found between individual physicians.

In order to test the consistency of our results and the reliability of this method of measuring the frequency of mental health problems, a replication was carried out four years later (Study II).

MATERIAL AND METHOD

All doctors at the Tierp Health Centre were given oral and written instructions to register every psychiatric symptom and psychosocial problem which they observed and judged as a factor contributing to the illness or the visit. The observations were recorded on a special form including eight symptom categories (psychotic symptoms; depressive mood; anxiety; obsessive-compulsive and phobic states; autonomic/psychosomatic symptoms; nervousness; unspecified psychological disturbances; sleep disturbances) and four problem categories (acute crisis reaction; interpersonal problems; social problems; substance abuse). Each symptom or problem observed was also rated as to degree of severity. The doctors were asked to suggest one of the following three alternatives for action: no treatment at all,

Table I. *Percentage proportion of visits with psychiatric symptoms/psychosocial problems and psychiatric diagnosis by type of doctor in Studies I and II*

Type of doctor	No. of visits	With psychiatric symptoms/ psychosocial problems	With psychiatric diagnosis	
			As main diagnosis	Including secondary diagnoses
Study I				
Qualified general practitioners	738	20.9	6.0	7.9
Doctors in training	1 574	18.0	4.4	5.9
Emergency room doctors	342	16.1	4.1	4.1
Specialists	551	10.9	5.8	6.5
Total	3 205	17.3	5.0	6.3
Study II				
Qualified general practitioners	535	25.2	5.2	6.2
Doctors in training	1 466	19.6	4.8	5.5
Emergency room doctors	297	7.7	1.4	1.7
Specialists	426	8.7	1.6	1.9
Total	2 724	17.7	4.0	4.6

treatment at the health centre, or treatment by a specialist.

In the processing of the data, the diagnosis entered by the doctor on the patient's case record at the time of the visit was added to the information collected on the special form. As in Study I the investigation period covered four weeks. In Study II 2724 visits were made as compared to 3205 in Study I. The sex and age distributions of the patients were comparable. A more detailed description of methods and study area is available in the publication of results from Study I (1).

RESULTS

Psychiatric symptoms or psychosocial problems were registered in 482 of the 2724 visits (17.7%) in Study II, compared to 17.3% in Study I. In both studies mental health problems were more frequently noted at visits by female patients (20% in Study I and 21% in Study II) than by males (14% in both studies). The pattern with regard to age differences was also similar in both studies: Lowest frequency of mental health problems at visits by young patients and highest frequency in the 45–64 age group. The stability of the results is further supported by a recent study at two other health centres in the county of Uppsala (Bålsta and Gottsunda), in which the same procedure was utilized but for two-week time periods. Out of 1488 visits, 249 (16.7%) were noted as involving psychiatric symptoms or psychosocial problems (3).

In Study I, a psychiatric diagnosis appeared as the principal diagnosis in 5.0% of all visits and in 6.3% if secondary diagnoses were included. During the preceding years only two to three per cent of all visits involved a psychiatric diagnosis.

In Study II there was a clear tendency towards a lower frequency of psychiatric diagnoses for all ages and for all types of doctors. Out of principal diagnoses 4.0% were psychiatric diagnoses and 4.6% when secondary diagnoses were included (Table I). This means that the frequency of symptoms and problems noted was three to four times greater than the frequency of registered psychiatric diagnoses.

In Study I we found great doctor to doctor variation in reporting psychiatric symptoms and psychosocial problems, ranging from 5 to 33%. A similar range of 2 to 31% was obtained in Study II.

The replication allows a more detailed analysis of some characteristics and possible causes of this variation. In both studies qualified general practitioners had the highest and doctors in training the second highest frequency. These two categories also accounted for the greatest number of visits and showed a smaller variation in the frequency of reported mental health problems. On the other hand

Table II. *Distribution of treatment alternatives according to problem in Studies I and II*

	Treatment							
	None		Health centre		Specialist		Total[a]	
Problem type	*N*	%	*N*	%	*N*	%	*N*	%
Study I								
Psychiatric symptoms	14	14.1	47	47.5	29	29.3	99	100
Psychosomatic/unspecified symptoms	118	28.9	235	57.6	26	6.4	408	100
Psychosocial problems	20	18.0	29	26.1	48	43.2	111	100
Total	152	24.6	311	50.3	103	16.7	618	100
Study II								
Psychiatric symptoms	9	12.0	46	61.3	15	20.0	75	100
Psychosomatic/unspecified symptoms	65	15.9	340	82.9	21	5.1	410	100
Psychosocial problems	10	20.8	21	43.8	11	22.9	48	100
Total	84	15.8	342	64.3	47	8.3	533	100

[a] Includes 52 visits in 1979 and 60 visits in 1983 without information on treatment.

specialists and doctors working temporarily in the emergency room tended to have fewer patients during the study period and on average fewer reported psychiatric disturbances but greater variation in the frequency. These tendencies were even more pronounced in Study II.

In Table I it can be noted that there is a close correspondence between the two studies in relative frequency of psychiatric diagnoses and frequency of problems reported by qualified general practitioners and doctors in training, while there was a significant drop in both respects for specialists and emergency room doctors.

Altogether 47 doctors participated in the two studies; 12 of which participated in both studies. Seven of the 12—mainly GP's—reported roughly the same high frequency of problems in both studies. The five remaining doctors had lower proportions in Study II; they were either specialists or emergency room doctors. Patients with certain somatic diagnoses tended to have higher proportions of visits with mental health problems in both studies. Thus, higher frequencies were found for diseases and symptoms from the digestive and cardiovascular systems, especially gastritis. There were no marked differences between the two studies in this respect.

The distribution of different groups of problems reported had slightly changed. Of all reported problems *psychiatric* symptoms were registered in about the same proportions in both studies (16 and 14% respectively). The predominance of *psychosomatic* and unspecified disturbances was even more pronounced in Study II (from 66 to 77%), while the relative amount of *psychosocial* problems had diminished. These tendencies were generally the same in all age groups. The different pattern between males and females noted in Study I remained in Study II. Thus, alcohol abuse was more common among men and interpersonal problems more often reported among women.

For each problem noted the doctor was asked to suggest one of three alternative measures: No treatment, treatment at the health centre, or treatment by a specialist. The distributions of treatment alternatives suggested are shown in Table II according to symptom and problem type. The proportion of problems assessed as needing specialist referral decreased from 17% in Study I to 8% in Study II as well as the amount of problems where no action was considered necessary (from 24 to 16%). On the other hand, there was an increase in the proportion of problems considered suitable for treatment at the health centre—from one half to two thirds.

The smaller number of cases judged to be in need of specialist care in Study II were more often actually referred to a specialist: 59% as compared to 28% in Study I. To a great extent, however, these referrals were to somatic specialists (13% in Study I and 34% in Study II).

DISCUSSION

The replication, which was carried out four years later and with mostly different doctors participating, showed a similar frequency of mental health problems among patients in primary health care. The same level of mental health problems has also been found in other primary care studies within the same region. The reliability of the method thus appears good, with similar results obtained at different points of time, with different doctors participating, and at different health centres. Thus, the frequency of reported mental health problems for visits in Swedish primary care seems to be 15–20% in this type of population. Studies from large cities in our country are lacking, however, and frequency may be different in such populations.

It is important to remember that this type of study does not reflect the actual prevalence of mental health problems in the population. We have only studied primary health care patients and our method only measures psychiatric disturbances or psychosocial problems which have been observed by doctors. There is a tendency among the doctors to register a psychiatric diagnosis in the patient record only in some of the cases in which mental health problems have been noted. In Study II the frequency of registered psychiatric diagnoses was even slightly lower than in Study I. Many physicians probably feel reluctant to write down a psychiatric diagnosis because they think that the patient might be embarrassed to be looked upon as a psychiatric patient. This explanation for the low frequency of psychiatric diagnoses must not be overemphasized, however. A similar discrepancy would probably be found if one studied differences between observed and registered diagnoses concerning many somatic diseases such as spondylosis, osteo-arthritis, obesity, and common skin disorders. The doctor usually registers only the main problem at the visit, the principle diagnosis. Secondary diagnoses are not commonly used even if the doctor observes other problems. (In Tierp the average number of registered diagnoses per visit is 1.4.) Nowadays, it is also generally accepted that psychosocial problems are of great importance for certain "somatic" diagnoses, such as gastritis, and have to be considered without registering a separate psychiatric diagnosis.

In both studies there was great doctor to doctor variation in reporting mental health problems. This variation probably has several explanations. Besides different individual criteria regarding what should be reported, the doctor's patients were differently selected. Somatic specialists had a lower frequency of mental health problems than most other doctors, probably because many of their patients were referred to them from general practitioners with a specific somatic question.

The qualified general practitioners had the highest frequency in both studies, which could also be explained by a selection process. Because of their permanent position they are able to provide higher continuity of care than the doctors in training, and patients with mental health problems have a greater need to be looked after by the same doctor. The emergency room doctors reported fewer mental health problems in Study II than in Study I for which there is no obvious explanation. The total number of patients seen by these doctors was small, however, which means that random variation can have greater influence on results.

Physicians were prepared to take care of mental health problems themselves to a greater extent in Study II than in Study I. Only half as many were considered to need specialist referral. Of course, our study does not show the actual need for referral or the extent to which the care given by primary care doctors was adequate from a psychiatric point of view.

In conclusion, this study confirms our previous findings that doctors in primary care observe mental health problems to a considerably greater extent than they register psychiatric diagnoses. Most of the problems are taken care of by the primary care doctors themselves. It is important to be aware of the fact that mental health problems are common in primary health care and that this has to be considered in the training of doctors in general practice.

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