Primary Care Mental Health

Dr Henk Parmentier
General Practitioner
London, United Kingdom
Mental Health Workshop EFPC

15:15 welcome and opening: Primary Care Mental Health: Henk Parmentier

15:30 introduction workshop: Jan De Lepeleire

slot 1 (max 45 mins): the organization of mental health care in your country. Many reforms are ongoing in different countries contributions by Lisa Hill: The UK perspective and Christos Lionis: The Greek perspective

slot 2 (max 15 mins): the urgent need for research and action on the somatic health and quality of life of all those living with mental illness (Hermann, 2014). What are barriers and solutions for this crucial element in the organization of mental health in Europe?

slot 3 (max 15 mins): Pharmaceutical care. We see an overwhelming use of psychofarmaca

slot 4 (max 15 mins): the DSM-V is published. Is this a workable tool in primary care?
Primary care

- Primary care covers the holistic care of people from conception till death

“From conception to death: a mental health primary care pathway”

WPA International Conference, Istanbul, July 2006
Primary care: Mental health

- Mental disorders are found in all countries, in women and men, at all stages of life, among the rich and poor, and in both rural and urban settings\(^1\)

- Up to 60% of people attending primary care clinics have a diagnosable mental disorder\(^1\)

- 90% of all mental health problems are looked after in primary care\(^2\)

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Affective disorders

mania
Hypo-mania
anxiety
depression
Major depression
Overlap between anxiety disorders and depression can make diagnosis difficult.

Major depressive disorder

Anxiety disorders

Unexplained medical symptoms & misdiagnosis of GAD… a vicious cycle\textsuperscript{1,2}

Unexplained medical symptoms & misdiagnosis of GAD... a vicious cycle

- Unexplained medical symptoms
- Misdiagnosed, untreated persistent GAD
- Medical consequences: HPA, cytokines
- Investigations: -ve findings
- Exacerbation of Existing chronic illness
- Development of new illnesses

Unexplained medical symptoms & misdiagnosis of GAD… a vicious cycle

- Unexplained medical symptoms
- Misdiagnosed, untreated persistent GAD
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Investigations -ve findings

Bodily stress disorder

Presentation of somatic distress in primary care

Meaning of symptoms

Cultural norms and expectations

Illness beliefs

Need for social support

Family roles and expectations

Anxiety or depression

Increased perception of noxious stimuli

Previous illness experience

Functional disorder (e.g. irritable bowel)

Abuse or trauma

Chronic illness

Access to health care
ICD-10/DSM-IV: Depressive Episode

- “The fundamental disturbance is a change in mood or affect”
- “Most other symptoms are either secondary to, or easily understood in the context of, such changes”
  - ICD-10

- “Disturbance in mood is the predominant feature”
- “Some individuals emphasise somatic complaints (e.g. bodily aches and pains) rather than reporting feelings of sadness”
  - DSM IV

DSM IV = Diagnostic and Statistical Manual of Mental Disorders.
Physical Symptoms are Often the Chief Complaint of Patients with Depression

- In an international study of 1,146 patients with major depression, 69% reported only physical symptoms as the reason for their physician visit\(^1\)

Mind – Body

“The only way to separate the mind from the body is with an axe.”
Affective disorders

- anxiety
- Physical comorbidity
- Psychiatric comorbidity
- biological
Affective disorders

- social
- housing
- Financial problems
- anxiety
Affective disorders

- Mania
- Hypomania
- Social
- Anxiety
- Depression
- Financial problems
- Housing
- Major depression
- Biological
- Physical comorbidity
- Psychiatric comorbidity
The three-dimensional matrix of primary care diagnosis
SCIENCE TO SERVICE GAP: BRINGING IT ALL TOGETHER

COMMUNITY
- Social determinants of health
- Self management
- Families
- Leisure activities
- Education & employment
- Housing
- Social networks
- Social inclusion
- Safety & security

GP Assessment

GP Decision

Secondary Care
- Evidence Based Practice & Outcomes

Intermediate Care
- Evidence Based Practice & Outcomes

General & Enhanced GP Interventions
- Evidence Based Practice & Outcomes

Data & information sharing including investigations & test results; IT systems; Physical health care; Promoting wider determinants of health; Role of family & carers; Skill mix; Training; Audit; EBP

COMPANION TO PRIMARY CARE MENTAL HEALTH
Chair's Message RCGP e-news:
Dr Clare Gerada:  25/11/2011

• “The highlight for me was yesterday’s launch of the excellent report into the National Audit of Cancer Diagnosis in Primary Care, which has revealed that nearly three quarters of patients with symptoms of cancer in England are assessed, investigated and referred within a month of presenting to their GP.”
Low registration rates at GP surgeries

Patients with schizophrenia arouse concerns in general practitioners that are not simply due to those patients suffering from a psychiatric or chronic illness. Our results suggest that some patients with schizophrenia may find it difficult to register with a general practitioner and receive the integrated community-based health care service they require.

Poor mental health outcomes

The proportion of patients with schizophrenia who lose contact with the secondary services is between 25% and 40%. The general practitioner remains the health care professional most likely to be in contact with such patients.

Mental health in primary care

- Most patients with severe mental illness view primary care as the cornerstone of health care, and preferred to consult their own GP, who listened and was willing to learn, rather than be referred to a different GP with specific mental health knowledge.

A reminder of what is expected

(Zero Draft WHO 27/08/2012)

Global Mental Health Action Plan

Vision

A world in which mental health is valued, mental disorders are effectively prevented and in which persons affected by these disorders are able to access evidence-based health and social care and exercise the full range of human rights to attain the highest possible level of health and functioning free from stigma and discrimination.

Cross-cutting Principles

<table>
<thead>
<tr>
<th>Universal access and equity</th>
<th>Human rights</th>
<th>Evidence-based practice</th>
<th>Life course approach</th>
<th>Multisectoral approach</th>
<th>Empowerment of persons with mental disorders</th>
</tr>
</thead>
<tbody>
<tr>
<td>All persons with mental disorders should have equitable access to health care and opportunities to achieve or recover the highest attainable standard of health, regardless of age, gender, or social position.</td>
<td>Mental health strategies, actions, and interventions for treatment, prevention and promotion must be compliant with international human rights conventions and agreements.</td>
<td>Mental health strategies and interventions for treatment, prevention and promotion need to be based on scientific evidence and good practice.</td>
<td>Mental health policies, plans and services need to take account of health and social needs at all stages of the life course, including infants, children, adolescents, adults, and older adults.</td>
<td>A comprehensive and coordinated response of multiple sectors such as health, education, employment, housing, social and other relevant sectors should be utilized to achieve objectives for mental health.</td>
<td>Persons with mental disorders should be empowered and involved in mental health policy, planning, legislation, service provision, and evaluation.</td>
</tr>
</tbody>
</table>

Goal

To promote mental well-being, prevent mental disorders, and reduce the mortality and disability for persons with mental disorders

Objectives and Targets

1. To strengthen effective leadership and governance for mental health
   - T 1.1: 80% of countries will have updated their mental health policies and laws (within the last 10 years) by year 2016.
   - T 1.2: 80% of countries will be allocating at least 5% of government health expenditure to mental health by year 2020.

2. To provide comprehensive, integrated and responsive mental health and social care services in community-based settings
   - T 2.1: The number of beds used for long-term stays in mental hospitals will decrease by 20% by year 2020, with a corresponding increase in the availability of places for community-based residential care and supported housing.
   - T 2.2: The treatment gap for severe mental disorders will be reduced by 50% by year 2020.

3. To implement strategies for mental health promotion and protection including actions to prevent mental disorders and suicides
   - T 3.1: 80% of countries will have at least two national, multisectoral mental health promotion and protection programmes functioning by year 2016 (one universal, one targeted to vulnerable groups).
   - T 3.2: Rates of suicide in countries will be reduced by year 2020.

4. To strengthen information systems, evidence and research for mental health
   - T 4.1: A global observatory for monitoring the mental health situation in the world will be established by year 2014.
   - T 4.2: 80% of countries will be collecting and reporting at least a core set of mental health indicators annually by year 2020.
Doing nothing is not an option

Changes in rankings for 15 leading causes of DALYs, 2002 and 2030 (baseline scenario)

<table>
<thead>
<tr>
<th>Category</th>
<th>Disease or Injury</th>
<th>2002 Rank</th>
<th>2030 Rank</th>
<th>Change in Rank</th>
</tr>
</thead>
<tbody>
<tr>
<td>Within top 15</td>
<td>Perinatal conditions</td>
<td>1</td>
<td>5</td>
<td>-4</td>
</tr>
<tr>
<td></td>
<td>Lower respiratory infections</td>
<td>2</td>
<td>8</td>
<td>-6</td>
</tr>
<tr>
<td></td>
<td>HIV/AIDS</td>
<td>3</td>
<td>1</td>
<td>+2</td>
</tr>
<tr>
<td></td>
<td>Unipolar depressive disorder</td>
<td>4</td>
<td>2</td>
<td>+2</td>
</tr>
<tr>
<td></td>
<td>Diarrhoeal diseases</td>
<td>5</td>
<td>12</td>
<td>-7</td>
</tr>
<tr>
<td></td>
<td>Ischaemic heart disease</td>
<td>6</td>
<td>3</td>
<td>+3</td>
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<tr>
<td></td>
<td>Cerebrovascular diseases</td>
<td>7</td>
<td>6</td>
<td>+1</td>
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<td></td>
<td>Road traffic accidents</td>
<td>8</td>
<td>4</td>
<td>+4</td>
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<tr>
<td></td>
<td>Malaria</td>
<td>9</td>
<td>15</td>
<td>-6</td>
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<td></td>
<td>Tuberculosis</td>
<td>10</td>
<td>25</td>
<td>-15</td>
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<td></td>
<td>COPD</td>
<td>11</td>
<td>7</td>
<td>+4</td>
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<tr>
<td></td>
<td>Congenital anomalies</td>
<td>12</td>
<td>20</td>
<td>+4</td>
</tr>
<tr>
<td></td>
<td>Hearing loss, adult onset</td>
<td>13</td>
<td>9</td>
<td>+4</td>
</tr>
<tr>
<td></td>
<td>Cataracts</td>
<td>14</td>
<td>10</td>
<td>+4</td>
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<tr>
<td></td>
<td>Violence</td>
<td>15</td>
<td>13</td>
<td>+2</td>
</tr>
<tr>
<td>Outside top 15</td>
<td>Self-inflicted injuries</td>
<td>17</td>
<td>14</td>
<td>+3</td>
</tr>
<tr>
<td></td>
<td>Diabetes mellitus</td>
<td>20</td>
<td>11</td>
<td>+9</td>
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Disability Adjusted Life Year
Measure of overall disease burden, number of years lost due to ill health, disability or early death
Primary care is very important

Integrating mental health into primary care
A global perspective

Integração da saúde mental nos cuidados de saúde primários
Uma perspectiva global
**SOME FACTS**

More than **450 million** people suffer from mental disorder globally.

The lifetime risk for schizophrenia is **0.8% - 1.44%**.

**25%** of all individuals develop one or more mental disorders during their life course.

Globally, nearly **50%** of people who have schizophrenia receive **NO mental health interventions**.

**CANNABIS** is the most widely used illicit drug and **3.8%** of the global population older than **15** years use this drug.

**Suicide** is a serious public health problem and accounts for more than **10% of deaths** in industrialised countries.

**LIFETIME** estimate of prevalence for depression and dysthymia is **4.2% - 17%**.

**4.4%** of the worldwide burden of disease is attributable to alcohol consumption.

Disorders due to use of illicit drugs are associated with an increased risk of other infectious diseases such as hepatitis B and C and HIV infections.

Treatment is often **INADEQUATE** in those people who have received treatment for schizophrenia and **2.8%** of total years lived with disability are due to schizophrenia.
Population Mental Health (PMH)

- Promoting positive mental health is an important goal for achieving healthy populations
- Mental and behavioural interventions are important strategies to improve physical health
- Promoting Primary Prevention of some Mental Disorders is cost-effective
- Promoting Secondary Prevention, Treatment and Rehabilitation of all Mental Disorders is cost-effective
FIVE ARGUMENTS FOR PMH

- Mental disorders: high prevalence and burden.
- Mental and physical health are inextricably linked.
- Mental health promotion and prevention of disorders are not implemented.
- Mental health systems development have the potential to positively and substantially change the lives of people with mental disorders.
- There is a global human rights gap in mental health.
The GBD study offers significant surprises:

- The burdens of mental illnesses, such as depression, alcohol dependence and schizophrenia, have been seriously underestimated by traditional approaches that take account only of deaths and not disability.

- While psychiatric conditions are responsible for little more than one per cent of deaths, they account for 12 per cent of disease burden worldwide and for 24% in the Americas.
Disease Burden (DALYs)

- Maternal conditions
- Perinatal conditions
- Nutritional deficiencies
- Other NCDs
- Malignant neoplasms
- Diabetes
- Cardiovascular diseases
- Sense organ disorders
- Respiratory diseases
- Digestive diseases
- Diseases of the genitourinary system
- Respiratory infections
- Malaria
- Childhood diseases
- Diarrhoeal diseases
- HIV/AIDS
- Tuberculosis
- Other CD causes
- Injuries
- Congenital abnormalities
- Musculoskeletal diseases
- Neuropsychiatric disorders

Source: WHR 2002
The Global Burden of Mental Disorders and Non-communicable diseases

(GBD - DALYs 2005)

CVD 21%
Sense organ 10%
Respiratory 8%
Other 7%
Digestive 6%
Musculoskeletal 4%
Endocrine 4%
Neuropsychiatric 28%
Cancer 11%
Schizophrenia 2%
Unipolar affective disorder 10%
Bipolar affective disorder 2%
Dementia 2%
Substance and Alcohol use 4%
Other mental disorder 3%
Epilepsy 1%
Other neurological disorder 2%
Other neuropsychiatric disorder 3%
Neuropsychiatric disorders

- Account for 24% of the burden in high-income countries, 16.6% in middle-income countries and 8.8% in low-income countries.
- Unipolar depressive disorders are the third leading cause of burden of disease and is expected to become the top leading cause by 2030.
- Neuropsychiatric disorders account for 1.26 million deaths every year; suicide account for additional 844,000 deaths, 84% of which committed in low and middle-income countries.
- Comorbidity is also extremely high contributing to an even bigger complexity of the association of psychiatric disorders with the burden of disease.
### Leading Causes of Years of Life Lived with Disability (YLDs)

#### By income categories

<table>
<thead>
<tr>
<th>Low and middle income countries</th>
<th>High income countries</th>
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<tbody>
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<td><strong>1</strong></td>
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The Mental/Physical Argument

Mental Health is relevant to Public Health not only because mental disorders are common but also because body and mind are linked

and

course and outcome of physical illnesses are influenced by mental health status.
Comorbidity within mental health

Comorbidity of mental disorders with general physical disorders

Co-occurrence of mental disorders and social problems

Multi-morbidities
MAJOR DEPRESSION AND PHYSICAL ILLNESS

PREVALENCE

- Hypertension: up to 29%
- Myocardial Infarction: up to 22%
- Epilepsy: up to 30%
- Stroke: up to 31%
- Diabetes: up to 27%
- Cancer: up to 33%
- HIV/AIDS: up to 44%
- Tuberculosis: up to 46%
- General Population: up to 10%
Asthma & Depression in Waltham Forest: Regression Analysis

There is a direct correlation between asthma & depression and higher use of services in the Waltham Forest GP practice population.
Heart Failure & Depression: Regression Analysis

There is a direct correlation between heart failure & depression and higher use of services in the Waltham Forest GP practice population.

\[ y = 0.0904x + 0.325 \]

\[ R^2 = 0.9882 \]

CORRELATION: 0.98398617
Stroke & Depression: Regression Analysis

There is a direct correlation between stroke & depression and higher use of services in the Waltham Forest GP practice population.
There is a direct correlation between CHD & depression and higher use of services in the Waltham Forest GP practice population.
There is a direct correlation between cancer & depression and higher use of services in the Waltham Forest GP practice population.
There is a direct correlation between diabetes & depression and higher use of services in the Waltham Forest GP practice population.
There is a direct correlation between hypertension & depression and higher use of services in the Waltham Forest GP practice population.
The widening health gap
Death ratios by social class

England & Wales
Differences in Life Expectancy within a small area in London

Travelling east from Westminster, each tube stop represents nearly one year of life expectancy lost - Data revised to 2002-06

Male Life Expectancy
78.6 (CI 76.0-81.2)

Female Life Expectancy
84.6 (CI 82.5-86.7)

Male Life Expectancy
72.8 (CI 71.1-74.6)

Female Life Expectancy
81.4 (CI 79.3-83.6)

Source: Analysis by London Health Observatory using Office for National Statistics data revised for 2002-06. Diagram produced by Department of Health
Model of care: Integrated care

Integrated Case Management Overview

Identify Service User
- High Risk patients identified via Health Analytics and Clinical Expertise

The Integrated Care Team
- GP
- Community Matron
- Social Worker
- District Nurse
- Integrated Case Coordinator
- Mental Health professionals

Case Conference & Care Plan
- Fortnightly meetings at practice level
- High risk patients discussed and care plan implemented

Care Delivery
- Care delivery by Integrated Team as coordinated by Integrated Care Coordinator with the patient

Care Plan Review

Self Management

Onward Referral

Ongoing Care

Access

Directory of Service / 111

Community Planned Care (Health and Social Care)

IC is supported by unplanned community services

Rapid Response support to provide 24/7 unplanned care
Out of Hours medical cover working in partnership with Rapid Response
Thank you……

A diamond is just a piece of charcoal that handled stress exceptionally well.

Henk.parmentier@gmail.com
MENTAL HEALTH FOR ALL
CONNECTING PEOPLE AND SHARING EXPERIENCE

INTERNATIONAL MENTAL HEALTH CONGRESS

Preliminary Programme

28 TO 30 APRIL 2015
LILLE - FRANCE - EUROPE
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