Common Mental Disorders

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ABSTRACT

Common mental disorders are a group of distress states manifesting with anxiety, depressive and unexplained somatic symptoms typically encountered in community and primary care settings. Risk factors for these disorders are mainly lower socio-economic status, psychological illnesses, poor reproductive health, gender disadvantage and physical ill-health. WHO has recommended that treatment of all these disorders should be based in primary care to be more effective and accessible to all the community people. The structure of mental health care in primary care is generally understood in terms of the "pathways to care" model and it plays a major role in countries like ours where community-based mental health services do not exist. Both the psychological and pharmacological therapies are found to be equally effective for treating these disorders. Integration of mental health into primary care can be considered as the stepping stone in the way forward to tackle the barriers and problems in effective management of common mental disorders in the community. The acute shortage of mental health professionals and the relatively low levels of awareness about mental disorders make it mandatory that primary health care should remain the single largest sector for mental health care in low and middle income countries like ours**.**

KEY WORDS

anxiety, depression, mental disorders

INTRODUCTION

Common mental disorders are a group of distress states manifesting with anxiety, depressive and unexplained somatic symptoms and are the contemporary equivalent of neurotic disorders typically encountered in community and primary care settings.[1] They are the leading mental health cause of disability in the global burden of disease.[2] Cross-sectional population-based studies consistently show that the poor and marginalized are at greater risk of having these disorders.[3]

These disorders present either alone or in addition to one or more physical disorders. There are no consistent differences in prevalence between developed and developing countries. GBD (Global Burden of Diseases) 2000 analysis showed that unipolar depressive disorders place an enormous burden on society and are ranked as the fourth leading cause of burden among all diseases, accounting for 4.4% of the total DALYs (Disability adjusted life years) and11.9% of total YLDs (Years lived with disabilities).[4] By the year 2020, if current trends for demographic and epidemiological transition continue, the burden of depression will increase to 5.7% of the total burden of disease, becoming the second leading cause of DALYs lost.[2] Worldwide it will be second only to ischemic heart disease for DALYs lost for both sexes. In the developed regions, depression will then be the highest ranking cause of burden of disease.[2,4]

WHO (World Health Organization) in 1960s-70s brought forward the concept of Severe Mental Illness (SMIs) comprising mainly of Schizophrenia, Manic depressive psychosis (MDP) and Epilepsy. Later around 1990s, Depression, Anxiety and Unexplained somatic illnesses (nowadays called as somatoform disorders) started being regarded as Minor mental disorders. But the studies and researches consistently showed those so called minor mental disorders were more common and had significant impact being the burden of health care delivery systems. Thus, corrections were made and these three groups of disorders were called collectively as common mental disorders.[5]

A multicenter, cross-national collaborative study conducted by WHO concluded that, in major cultures around the world, psychiatric disorder in primary care is common and associated with substantial levels of disability which was most strongly related to major depression, panic disorder, generalized anxiety, and neurasthenia, which remain within the domain of common mental disorders.[6]

Hence, the common mental disorders can be considered to be under the remit of primary care and can be described using standard diagnostic classification systems like ICD-10 and DSM-IV. ICD-10 primary care version meant for the use by primary health center (PHC) practitioners can be most appropriately used in primary care for the diagnosis of common mental disorders.[7-10] This concept will no doubt

provide appropriate and patient sensitive care.[11] The acceptability and applicability of this concept has been tested in different field trials.[12]

RISK FACTORS

Various factors were seen to be associated with common mental disorders in different studies, like lower socio-economic status, psychological illnesses, poor reproductive health, gender disadvantage and physical ill-health.[13,14] Socio-economic deprivation has been directly related to poor reproductive health, substance use disorders (especially tobacco), chronic medical illnesses which ultimately lead to common mental disorders.[15] Poverty has been linked with mental and behavioral diseases in many researches which in turn lead to economic hardship forming a vicious cycle.[13,15] Similarly higher psychological symptom scores at baseline, Sub threshold psychiatric morbidity, Tobacco and alcohol use were found interconnected to each other and with the life events and depressive illnesses.[13,16] Women reporting abnormal vaginal discharge were seen to have more chance of getting these disorders but no association was seen with sexually transmitted disorders or any other hormonal or biological mechanisms.[17-19] Females were found to have two to three times more risk than in males and presenting predominantly with somatic complaints and having mixed anxiety depression as the commonest diagnosis.[18] Higher risk was seen among divorced or widowed female or those who were exposed to intimate-partner violence.[14,18] A depressed female can be seen to be influenced by different vulnerability factors like low autonomy, low family support, low social integration and higher degree of domestic and sexual violence leading to increase in the severity of depression.

Chronic physical illnesses can lead to common mental disorders by different mechanisms, i.e., through direct effect on the brain due to infection, cerebrovascular accidents, trauma, degeneration etc or through the effect of illness burden or comorbidity effecting the treatment and outcome as well as the help seeking behavior and compliance to treatment. Similarly, common mental disorders can lead to physical illnesses as they are associated with risk factors to physical health, e.g., smoking, poor diet, reduced activity and may cause biological changes effecting serotonin metabolism, causing endocrinal effects via cortisol and leading to the immunological changes.[20]

PRIMARY CARE IN MENTAL HEALTH

Above illustrations point to the fact that mental health problems in general and common mental disorders in particular are an important source of burden worldwide. WHO has recommended that treatment of all these disorders should be based in primary care to be more effective and accessible to all the community people.[2] Mental health care in primary care has been defined as the provision of basic preventive and curative mental health care at the first point of contact of entry into the health care system.[5] The structure of mental health care in primary care is generally understood in terms of the "pathways to care" model.[21] Accessing mental health care involves passing through five levels and three filters between the community and specialist care (Figure 1). The model highlights the decreasing proportion of the total population who access higher levels and the important role of the primary care clinician, whose ability to detect disorder in presenting patients (filter 2) and propensity to refer (filter 3), represent key barriers to care. Hence a wide range of mental health problems present in primary care. A distinction has to be made between "severe and long term mental health disorders" (type 1) and "common mental health disorders" (types 2-4) as illustrated in the Table 1. Although primary care has an important role to play in the management of more severe disorders, common disorders are generally viewed as the main remit of primary care.
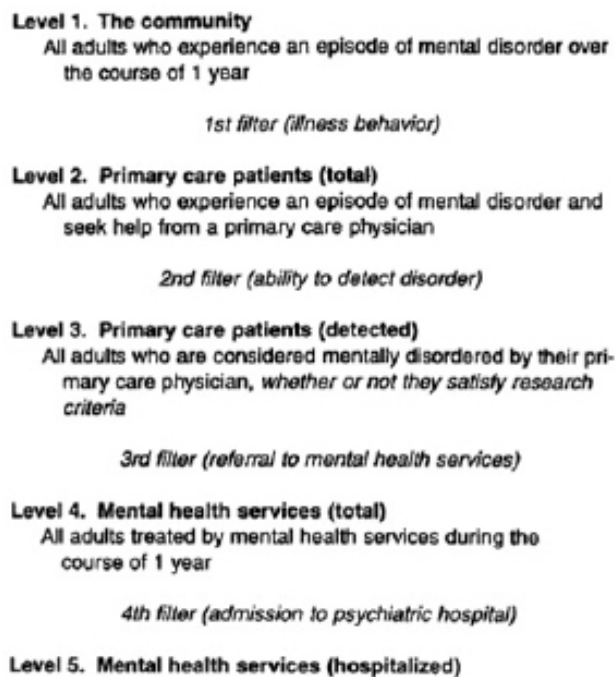

Level 1. The community
All adults who experience an episode of mental disorder over the course of 1 year

1st filter (illness behavior)

Level 2. Primary care patients (total)
All adults who experience an episode of mental disorder and seek help from a primary care physician

2nd filter (ability to detect disorder)

Level 3. Primary care patients (detected)
All adults who are considered mentally disordered by their primary care physician, *whether or not they satisfy research criteria*

3rd filter (referral to mental health services)

Level 4. Mental health services (total)
All adults treated by mental health services during the course of 1 year

4th filter (admission to psychiatric hospital)

Level 5. Mental health services (hospitalized)

Figure 1. The pathway to psychiatric care: five levels and four filters[1]

Primary care in mental health is guided by the following objectives[11]

a) Effectiveness—Services should improve health and wellbeing.

b) Efficiency—Limited resources should be distributed to maximize health gains to society.

c) Access—Service provision should meet the need for services in the community.

d) Equity—Resources should be distributed according to need.

Table 1. Mental health disorders in primary care[11]

Type	Description	Examples of Disorders	Current care
1	Severe mental disorders, unlikely to remit spontaneously, associated with major disability.	Schizophrenia, Organic disorders, Bipolar disorder.	Involves both primary and secondary care.
2	Well defined disorders, associated with disabilities for which there are effective pharmacological and psychological treatments. Disorders may remit, but relapse is common.	Anxious depression, Pure depression, Generalized anxiety, Panic disorder, Obsessive-compulsive disorder.	Can usually be managed entirely within primary care.
3	Disorders in which drugs have a more limited role, but for which psychological therapies are available.	Phobias, Somatized presentation of distress, Eating disorder, Chronic fatigue	Rarely treated within primary care, only a small proportion of cases are treated by specialist services.
4	Disorders that tend to resolve spontaneously.	Bereavement, Adjustment disorder	Supportive help, rather than a specific mental health skill is needed.

Different models have been advocated in order to improve the quality of primary mental health care.

1) Training primary care staff[5,11] — This is the key model which involves the provision of knowledge and skills concerning mental health care to primary care clinicians, mainly directed towards improving prescribing or providing skills in psychological therapy. Training can involve widespread dissemination of information and guidelines or more intensive practice based education seminars. "Defeat depression campaign" as practiced in UK, China and Kashmir region of India use this model of management.

2) Consultation-liaison[22] — This is a variant of the training model which involves mental health specialists entering into an ongoing educational relationship with primary care clinicians, to support them in caring for individual patients.

3) Collaborative care[23,24] — Collaborative care can involve aspects of both training and consultation-liaison but also includes the addition of case managers who work with patients and liaise with primary care clinicians and specialists in order to improve quality of care. This model may also involve screening, education of patients, changes in practice routines, and developments in information technology.

4) Replacement/referral[11] — In this model, the primary responsibility for the management of the presenting problem is passed to the specialist for the duration of treatment. This model is most often associated with psychological therapy.

The primary care clinician has the greatest involvement in the training model, and that involvement decreases in the consultation-liaison, collaborative care, and replacement/referral models. The degree of involvement of the primary care clinician provides a link between quality improvement models, the pathways to care model, and goals such as access and equity. Assuming equivalent effectiveness, models that put greater focus on increasing the abilities of primary care clinicians have the greatest potential impact on access and equity. This is because these models can most readily influence filter 2 and treatment at level 3, which can potentially influence the largest numbers of patients, i.e., all the patients with common mental disorders presenting

in primary care.[11]

As reported by WHO, experiences in some African, Asian and Latin American countries showed that adequate training of primary health care workers in the early recognition and management of mental disorders can reduce institutionalization and improve clients' mental health.[2] The quality and quantity of specialist mental health services needed depend upon the services that are provided at the primary health care level. Hence the provision of services needs to be balanced between community care and hospital care. Patients discharged from psychiatric wards (in either general or specialized hospitals) can be effectively followed up by primary health care doctors. It is clear that primary health care plays a major role in countries like ours where community-based mental health services do not exist.[25]

MANAGEMENT OF COMMON MENTAL DISORDERS IN PRIMARY CARE

Management guidelines group of New Zealand has outlined some recommendations for the management of common mental disorders, especially depression.[26] It has been suggested that the assessment, support and treatment of such disorders should be culturally appropriate. Use of psychosocial assessment and screening tools prior to the diagnostic interviewing would be supportive for recognition of the disorders. Psychological and pharmacological therapies are found to be equally effective for treating these disorders.[27] A 'stepped care' approach has been advocated in mild to moderate depressive illnesses in younger population which principally involves choosing the least intrusive intervention required to achieve clinical change for an individual.[28] It says that it is often possible to 'do more with less', by starting with a low-intensity therapy, monitoring patient response and moving to more intensive treatments only if the problem persists. This model guides treatment using a combination of evidence-based principles and continuous clinical assessment and management involves combination of both the pharmacological and non-pharmacological measures that mostly includes psycho-education, group support and antidepressants.29 Progression through levels of care is determined on the basis of patient response. Support for self-care is additional

Figure 2. Barriers to effective intervention in primary mental health care.[2]

Stigma and discrimination			
Policy level		**Health systems level**	
• Extent of the problem dispro-portionate to the limited mental health budget. • Mental health policy inadequate or absent. • Mental health legislation inadequate or absent. • Health insurance which discriminates against persons with mental and behavioral disorders.	Large tertiary institutions • Stigmatization • Poor hospital conditions • Human rights violations • High costs • Inadequate treatment and care	Primary health care • Lack of awareness, skills, training and supervision for mental health • Poorly developed infrastructure	
	Community mental health services • Lack of services • Insufficient resources	Human resources • Lack of specialists and general health workers with the knowledge and skills to manage disorders across all levels of care	
	Psychotropic drugs • Inadequate supply and distribution of psychotropic drugs across all levels of care	Coordination of services • Poor coordination between services including non-health sectors	
War and conflicts Disaster	Urbanization	Poverty	

feature in this approach. Affordable antidepressants such as fluoxetine are considered the treatment of choice as they are associated with improved clinical and economic outcomes, especially in the short term.[30,31] The most effective management policy is an ongoing, interactive, contextually relevant continuing education which focuses not only on knowledge, but also on skills and attitudes of primary care physicians.[32]

CHALLENGES IN PRIMARY CARE MANAGEMENT

The primary care management of these disorders is not without any challenges and problems.[26] Patients may be reluctant to seek or comply with treatment, due to the stigma associated with mental disorders. The treatment may fail as a result of inadequate dosage and duration of antidepressant therapy or due to failure on the part of clinicians to educate patients about the nature of diagnosis and to support self-management. There may be limited access to psychiatrists and other mental health practitioners and lack of ongoing monitoring and maintenance treatment despite high rates of relapse and recurrence. For more intensive treatments, such as psychological therapies, there is a constant tension between need and treatment availability. WHO report 2012 identified different levels of barriers to implementation of effective intervention for mental disorders in community (Table 2).

THE WAY FORWARD

In an introductory message of the publication of "Integrating Mental Health into Primary Care: A Global Perspective" by the World Health Organization (WHO) and the World Organization of Family Doctors (WONCA) in September 2008 , WHO Director General Dr. Margaret Chan and WONCA President Professor Chris van Weel stated that, "Primary care starts with people. And, integrating mental health services into primary care is the most viable way of ensuring that people have access to the mental health care they need…..".[33] It was highlighted in the publication that mental health care delivered in primary care minimizes stigma and discrimination, and removes the risk of human rights violations that occur in psychiatric hospitals as well as it generates good health outcomes at reasonable costs. This avoids indirect costs associated with seeking specialist care in distant locations. Hence integration of mental health into primary care was considered as the stepping stone in the way forward to tackle the barriers and problems in effective management of common mental disorders in the community. Similar views were found in different publications on the issues of global mental health, more importantly prioritizing the needs of low and middle income countries like ours.[34,35] More recommendations can be seen in different world health reports.[2,5,25,33] They have emphasized that the care should shift away from large psychiatric hospitals to community services that are integrated into general health services. Making psychotropic drugs available, training the required health workers, utilizing mass media and starting public awareness campaigns, supporting non-governmental organizations and consumer groups are the other issues raised.

CONCLUSION

Common mental disorders are the commonest mental health problems that usually present in primary care. The acute shortage of mental health professionals and the relatively low levels of awareness about mental disorders make it mandatory that primary health care should remain the single largest sector for mental health care in low and middle income countries like ours.

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