

Primary Care Psychiatry in Pakistan - A Long Way Ahead

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Dealing with mental health is still a huge burden in Pakistan when it comes to its social, economic and management implications. The government's health policies and W.H.O. have strongly recommended/suggested the inclusion of psychiatric services at primary care level. With an alarming situation of less than 300 psychiatrists, growing social disruption and high prevalence of mental disorders augmented by brain drain of psychiatrists, the brunt falls on the general practitioners who are the back bone of health care system in the country. The question arises as how prepared are the general practitioners to share the burden of treating depression/anxiety and some allied neurotic disorders and are able to refer the other cases beyond the scope of their treatment domain.

About 20% of the patients seeing primary care physicians have a significant mental disorder¹, and only 23% of the patients with depression treated by primary care physicians receive an antidepressant in an insufficient dose.^{2,3} Family practitioners spend 50% of their time dealing with emotional problems but will refer less than 10% of these cases for psychiatric treatment because of uncertainty experienced by these physicians and difficulty of referring to specialized services.⁴ They consistently have been found to under recognize or misdiagnose depressive disorders; however, it is unclear whether it is due to lack of skills or attitude towards these disorders.⁵ A local study also revealed that the knowledge of family doctors about depression was quite low.⁶ Reasons for failure to detect such disorders include the diagnostic practices taught in medical schools, the inadequacy of psychiatric taxonomy of neurosis and most of the doctors have not been taught how to interview their patients.⁷ Primary care physicians fear loss of control, stigmatization from psychiatric labels and issues of time and money. These are reasons for limiting psychiatric intervention, this is an important factor which should be known to the psychiatrist who are in close liaison with the general practitioners.⁸ The GP variables include their mis-diagnosis by not considering personal and family history and presence of stressful factors whereas in some cases they are likely to over diagnose patients who suffer from the effects of physical illness. There are other factors, which can possibly influence the ability to detect depression. These include patients who describe physical symptoms only as they believe that their doctors only want to hear about physical symptoms. Some patients have a sense of guilt or stigma about feelings such as gloom and sadness while others view

such complaints as evidence of weakness. Such patients consult physicians with other symptoms and don't mention their actual psychological symptoms. This can also happen when the patients are not psychological minded, are of low intelligence or belonging to other cultures without appropriate vocabulary or concept of emotional hurt.⁹ Personal traits and qualities may remain a stronger determinant of general practitioners' reaction to patient problems than formal training and qualifications and general practitioner communication skills are also important to enhance depression-specific interventions in bringing about improvements in patient outcomes.¹⁰

Amid the ruins of mental care delivery system influenced by inadequate planning, financial support or public consensus, efforts to integrate mental health services with the health services of primary care physicians are considered the best hope to improve access to mental health care.¹¹ In order to change the scenario, it is vitally important to consider training the general doctors and family practitioners in the best possible way.

Psychiatric education is initiated early, before attitudes become fixed, to emphasize self-reliance and mental health problem solving skills, to make learning experience longitudinal and to integrate psychiatric training into the rest of the resident's curriculum. Seminars, clinical experience and liaison with mental health team are all utilized in the training program.¹² The pharmaceutical companies are making good efforts in arranging CME programs for the GPs but without the credit systems and points for maintenance of certification there would always remain a doubt about its efficacy. The McMaster's model is worth reviewing.⁴

Moreover, monitoring and evaluation of both knowledge and practice at work place are important. Evaluation through dummy patients and providing appropriate feedback to the GPs, ample use of videos, CD's and hands on training in the respective place of practice along with observation by a psychiatrist can improve the skills and knowledge of these practitioners who may in turn provide maximum benefit to the patients in the primary care settings.

A diploma/certification route may also be followed in the subject of mental health geared for primary care practitioners through a university or a postgraduate body by practitioners interested in gaining further knowledge and expertise.

There are challenges ahead but in order to improve the existing condition evident of high prevalence of mental disorders, mandatory inclusion of mental health component in the primary care system and continuous surveillance will go a long way in changing the current scenario.

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