The Journal of Mental Health Policy and Economics
J. Mental Health Policy Econ. **2**, 85–86 (1999)

Commentary

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Comments upon 'Improving Research on Primary Care Patients with Mental Health Problems'

by K. Rost

This paper is written as though primary care is everywhere similar to services in the USA, and that depression is the protypical example of a mental disorder occurring in this setting. In fact, general practitioners in other countries are often prepared to deal with the psychological and social aspects of their patients' illnesses; and somatized presentations of psychological distress, alcohol misuse and anxiety related disorders are also equally important forms of disorder.

Doctors everywhere are concerned to cut down on unnecessary investigations, to use the most efficacious treatments and to make the best use of scarce resources. However, it is too often assumed that everyone is using the same models for distress, and this is often not the case. Thus, those identified by doctors as 'depressed' may see themselves in other, more complex ways—hence the use of multiple remedies in the study quoted by Dr. Rost. Indeed, those patients presenting to their doctors with somatic complaints are often more concerned to have their doctor exclude a serious physical disorder causing their symptom than have a detailed enquiry made into possible psychological causes of their symptoms. If these patients are to be spared a series of physical investigations which only end if the symptoms themselves remit, both doctor and patient may need to amend their explanatory models.

The framework proposed by Dr. Rost of pre-contemplators, contemplators and action groups is useful, as it draws attention to the differing needs of both doctors and patients at the various stages of her model. Where patients are concerned, Jacob showed that rather than train doctors in manifestations of depression in ethnic minorities, better results were obtained by using an information leaflet explaining the manifestations of depression to the patients themselves. Better outcomes were obtained in terms of reductions in GHQ scores, even though medical behaviours did not change.[1]

Similarly, when helping primary care physicians acquire new skills it is necessary to take them though three stages: first, a presentation of evidence that the new skills are more cost-effective than those that they replace; second, demonstration of the skills by modelling them using videotaped recordings of established GPs carrying out the skills, and third, actual practice of the skills using role play.[2]

Dr. Rost wishes different research teams to tackle different scientific questions, but there is in fact no disadvantage in the same problem being tackled in somewhat different ways. The treatment trials undertaken by a particular research team seldom provide unequivocal results for a particular intervention: if the question is important, replication is essential. Nor should research always be on topics that 'people get passionate about': there is a great deal to be said for a dispassionate approach to these problems.

The main problems facing the field are how to persuade existing staff to adopt therapeutic behaviours which have been shown to be effective; how to train them in new skills and how to incorporate new technologies in these settings. The use of non-medical staff in treatment; the use of computerized treatments; the encouragement of self-help groups and voluntary organizations—all represent a challenge that has yet to be taken up in most places. The problem is that medical schools often do not teach doctors the skills they will need to tackle mental health problems effectively, and that those responsible for training para-medical staff may often be stuck with yesterday's solutions to problems. Unless funding organizations can be persuaded that the evaluation of training procedures and the encouragement of new roles for existing staff are good research topics, we are often stuck in predicaments from which extrication is difficult.

The demonstration by Morriss and others[3,4] that a new skill for primary care physicians in dealing with somatized presentations of distress can actually save money spent on investigations is likely to interest practitioners who are concerned to cut down on unnecessary costs without sacrificing medical outcomes: in this case, psychological and social outcomes were better, at reduced cost. Perhaps sometimes the science needs to come first, so the passion can follow later?

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CCC 1091–4358/99/020085–02$17.50

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