СТРУКТУРИРОВАННОЕ ДИАГНОСТИЧЕСКОЕ ИНТЕРВЬЮ ДЛЯ ВЫЯВЛЕНИЯ ПСИХИЧЕСКИХ РАССТРОЙСТВ ВРАЧАМИ ОБЩЕЙ ПРАКТИКИ

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STRUCTURED DIAGNOSTIC INTERVIEW FOR MENTAL DISORDERS FOR GENERAL PRACTITIONERS

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Mental disorders are leading causes of morbidity worldwide and widespread in industrialized countries, ranging from 4,3 to 26,4 % annually in the general population (WHO, 2004; Mathers and Loncar, 2006). Prevalence estimates of these disorders in primary care range between 10 % and 20 %. In Western countries, mental disorders are mainly treated in primary care, with general practitioners (GPs) providing the initial clinical contact. During their lifetime, about 80 % of the population in industrialized countries consults a GP, of which roughly between 30 and 40 % have significant psychological symptoms (Fleury et al, 2012). Given the high prevalence of mental disorders, GPs are increasingly called upon to provide appropriate treatment. Psychiatric services alone can neither meet the demand for care nor provide it cost effectively. It is reported that more than 75 % of patients with depression will relapse or experience recurrence (Lloyd et al, 1996). Accordingly, primary care is the cornerstone of current efforts to improve the performance and results of healthcare systems.

The GPs play the central role in most European countries, including Norway, both as gate-keepers and treating professionals concerning patients with mental health problems. This is especially the case in rural areas where there is a shortage of both specialist mental

health services and primary care clinicians. The majority of people with anxiety and depression who engage in treatment do so with GPs in the first instance. As such, GPs play a main role in the identification and management of such patients (Regier et al, 1993; Hodgins et al, 2007). In Norway, GP's efforts should be complemented by increasing of number of locally based specialized psychiatric services (district psychiatric centers – DPS) in the last 10-15 years. The DPS's have to be consultative and cooperation partners for GPs in the mental health issues. However, this cooperation has not been as successful as expected, among others because of lack of common professional language, mutual knowledge and often misunderstanding (Fredheim et al, 2011).

GPs' ability to detect, diagnose and adequately treat patients with mental disorders is often considered unsatisfactory. Comparison of research interview results with GPs' detection of mental disorders reveals that 30-70 % of GPs' patients with mental disorders remain undetected (Walters et al, 2008). There are some barriers which hinder GPs to discover mental health problems in routine practice. These include both individual and systemic issues: personal and professional beliefs and the degree to which priority is given to mental disorders, adequate training and experience, high work load for GPs not allowing for a consultation time necessary for the formation of an adequate treatment alliance and understanding of the situation and condition of the patient and stigmatization issues preventing the patients to disclose their mental health problems.

GPs are responsible for managing the majority of mental health problems in the health services and most of them attempt to fulfill this role with no more training than they received during undergraduate medical education. There is evidence that both recognition and management of mental disorders could be improved (Kerwick et al, 1997). The traditional postgraduate educational system has been criticized for not being effective or relevant for GP's needs for psychiatric education.

A structured diagnostic interview for mental disorders for GPs might be the most effective method to detect mental disorders in primary care. According to several comparative studies, the structured interviews have been considered as more effective and precise

than unstructured ones in clinical settings, especially concerning the common psychiatric disorders (Miller, 2001; Jensen et al, 2002; Thienemann, 2004). One example of such diagnostic tools is "Structured Psychiatric Interview for General Practice" (SPIFA) which was developed and validated in Norway in 1995-2003 (mostly in Nord-Trøndelag County). After only a brief training program for GPs', SPIFA provides structured and systematic assessment and reliable diagnoses of the most common mental health disorders (Dahl et al, 2009). The GPs who participated in the study were mostly satisfied with the SPIFA which showed to be an effective diagnostic instrument with simple structure and short time requirement. The Norwegian version of the SPIFA has been modified and tested in Sweden and Finland. Several hundred GPs have accepted the tool for their everyday using in clinical practice (Dahl et al, 2002, 2009).

SPIFA consists of a screening and manual part, each of them in short and longer versions (Dahl et al, 2009). Final revised edition was made in 2003 and contain criteria for 18 mental disorders: ten most common psychiatric disorders and conditions in general medical practice in the short part of the interview (depression, bipolar disorder, panic disorder, agoraphobia, social phobia, generalized anxiety disorder, obsessive-compulsive disorder, somatoform disorders, alcohol abuse and dependence and cognitive impairment) and eight less typical for GP in the longer part (adjustment disorder, posttraumatic stress disorder, eating disorders, suicidality, substance abuse, psychosis, mental disorders related to somatic condition, personality disorders). The manual part contains criteria which could be used to define and confirm diagnosis in the case of positive screening.

The SPIFA is partly based on the well known instruments:

1) the criteria for depression condition are chosen from the Montgomery-Åsberg Depression Ration Scale (MADRS) (Montgomery and Åsberg, 1979);

2) the criteria for cognitive dysfunction based on the Mini-Mental Status 12 items version (Folstein et al, 1975);

3) suicidality criteria from the manual recommended by the National Health Services.

The SPIFA contains also the split version of the Global Assessment of Functioning Scale (Pedersen et al, 2007).

The Russian primary health care is under comprehensive reform. In 1987 a gradual transition from an entirely specialized outpatient health care to establishing of general practice (family doctors clinics) was initiated. According to new professional standards, the family doctors should actively participate in diagnostic evaluation and treatment of patients with psychiatric problems. The competence requirements for these tasks were defined in the National education standard for specialists in family medicine from 2005. According to this document, the family doctors should be able to communicate with psychiatric patients so that they could discover suicidality and use simple diagnostic methods to uncover depression and alcohol/ drug abuse. The family doctors should have basic theoretical knowledge about main psychopathological psychiatric conditions, indications for admission to psychiatric hospital and principles of acute psychiatric assistance.

Today's mental health system in Russian Federation, both hospital and outpatient-based, still mostly consists of specialized psychiatric services working after the territorial principle (Rezvy et al, 2007). The outpatient mental health services are represented by local psychiatric specialists working at the district policlinics and districts / countries psychiatric dispensary or centers.

The collaboration between primary care and specialized mental health services is still weakly developed and most of the family doctors are reluctant to take responsibility for psychiatric patients. The use of a structured psychiatric interview in primary care may significantly contribute to remedy these limitations.

For the time being, no structured diagnostic instrument for mental health problems is available for Russian primary care settings. We are now preparing a study in which the SPIFA will be adapted to Russian language and culture and tested in a Russian primary care setting in Archangelsk County.

References

1. *Dahl A.A.*, *Krüger M.B.*, *Dahl N.H.*, *Karlsson H.*, *Knorring L.V.*, *Stordal E.*, *Mykletun A*. Angst, depresjon og psykiatrisk epidemiologisk forskning I Nord-Trøndelag. // Norsk Epidemiologi. 2002. Vol. 12 (3). S. 347-353.

2. *Dahl A.A.*, *Dahl N.H., Krüger M.B.* Strukturert Psykiatrisk Intervju for Allmennpraksis – SPIFA, Revidert kort- og utvidet versjon. iDANT, GlaxoSmithKline, 2003.

3. *Dahl A.A.*, *Krüger M.B., Dahl N.H., Karlsson H., Knorring L.V., Stordal E.* SPIFA – a presentation of the structured psychiatric interview for general practice. // Nord. J. Psychiatry. 2009. Vol. 63 (6). P. 443-453.

4. *Fleury M.J.*, *Imboua A., Aube D., Farand L., Lambert Y.* General practitioners' management of mental disorders: a rewarding practice with considerable obstacles. BMC Family Practice. Vol. 13. P. 19.

5. *Folstein M.F.*, *Folstein S.E., McHugh P.R.* "Mini-mental state": a practical method for grading the cognitive state of patients for the clinician. // J. Psychiatr. Res. 1975. Vol. 12 (3). P. 189-198.

6. *Fredheim T.*, *Danbolt L.J., Haavet O.R., Kjønsberg K., Lien L.* Collaboration between general practitioners and mental health care professionals: a qualitative study. // Int. J. Ment. Heath. Syst. 2011. Vol. 23, N 5 (1). P. 13.

7. *Hodgins G.*, *Judd F., Davis J., Fahey A.* An integrated approach to general practice mental health training: the importance of context. // Australasian Psychiatry. 2007. Vol. 15 (1). P. 52-57.

8. *Jensen A.L.*, *Weisz J.* Assessing match and mismatch between practitioner-generated and standardized interview-generated diagnoses for clinic-referred children and adolescents. // J. Consult. Clin. Psychol. 2002. Vol. 70. P. 158-168.

9. *Kerwick S., Jones R., Mann A., Goldberg D.* Mental health care training priorities in general practice. // Brit. J. Gen. Pract. 1997. N 47 (417). P. 225-227.

10. *Lloyd K.R.*, *Jenkins R., Marin A.* Long-term outcome of patients with neurotic illness in general practice. // BMJ. 1996. Vol. 313 (7048). P. 26-28.

11. *Mathers C., Loncar D.* Projections of global mortality and burden of disease from 2002 to 2030. // PLoS Medicine. 2006. Vol. 3 (11). P. 442.

12. *Miller P.* Inpatient diagnostic assessments. Part 2. Interrater reliability and outcomes of structured vs. unstructured interviews. // Psychiatry Res. 2001. Vol. 105. P. 265-271.

13. *Montgomery S.*, *Åsberg M.* A new depression scale designed to be sensitive to change. // Br. J. Psychiatry. 1979. Vol. 134. P. 382-389.

14. *Pedersen G.*, *Hagtvedt K.A., Karterud S.* Generalizability studies of the Global Assessment of Functioning – split version. // Comprehen. Psychiatr. 2007. Vol. 48. P. 88-94.

15. *Regier D.A.*, *Narrow W.E., Rae D.S., Manderscheid R.W., Locke B.Z., Goodwin F.K.* The de facto US mental and addictive disorders service system. Epidemiologic catchment area prospective 1-year prevalence rates of disorders and services. // Arch. Gen. Psychiatry. 1993. Vol. 50. P. 85-94.

16. *Rezvy G.*, *Øiesvold T., Parniakov A., Ponomarev O., Lazurko O., Olstad R.* The Barents project in psychiatry: a systematic comparative mental health services study between Northern Norway and Archangelsk County. // Soc. Psychiatry Psychiatr. Epidemiol. 2007. Vol. 42. P. 131-139.

17. *Sørlie T.*, *Rezvy G., Høifødt T.S., Jashkovich V., Proselkova E.* Collaboration in psychiatry between Archangelsk and Northern Norway. // Tidsskr. Nor. Laegeforen. 2011. Vol. 23, N. 131(16). S. 1568-1570.

18. *Thienemann M*. Introducing a structured interview into a clinical setting. // J. Am. Acad. Child Adolesc. Psychiatry. 2004. Vol. 43. P. 1057-1060.

19. *Walters P.*, *Tylee A., Goldberg D., Murray R.M., Kendler K.S., McGuffin P., Wessely S., Castle D.J.* Psychiatry in Primary Care. Essential Psychiatry. 4th edition. Cambridge: Univ. Press, 2008. P. 479-497.

20. WHO: World Mental Health Survey Consortium. Prevalence, severity, and unmet need for treatment of mental disorders in the World Health Organisation Mental Health Surveys. // JAMA. 2004. Vol. 291 (21). P. 2581-2590.