Mental disorders, risks, and disability

Primary care needs a novel approach

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Canada and other countries have made extraordinary progress in recognizing mental and addiction disorders as important public health targets. However, there remain numerous general hospitals and emergency departments in Canada where people presenting with mental and addiction disorders are neither welcomed nor treated in a manner consistent with the morbidity and mortality these conditions cause on a population basis. The specialties of family medicine and psychiatry assess and manage most mental and addiction disorders in Canada and do so in a manner that is minimally coordinated, suggesting a limited appreciation of the effect of these conditions on population health. In no age group are the ravages of these conditions more apparent than among our youth. In those aged 15 to 24 years in Canada, the leading disease-related cause of death is suicide, and not by a small margin. In fact, suicide in this age group accounts for 3.7 times more deaths than the next leading cause of death, malignant neoplasms (**Figure 1**).[1]

We hope that some of our colleagues familiar with Table 102-0561 from Statistics Canada, the source of the data in **Figure 1**,[1] will have realized that the table does not group causes of death into a category labeled *disease-related causes of death*. Indeed, the category of suicide is labeled *intentional self-harm (suicide)* and is nestled between *accidents (unintentional injuries)* and *assault (homicide)*. It is notable that a federal database fails to reflect that suicide is almost exclusively a result of mental and addiction disorders and, as such, is the most common cause of death in patients with these conditions. To classify these deaths as *intentional* fails to reflect the influence of mental illness and addiction on human emotions, thoughts, and actions. We are aware that many readers will repeat the common argument that suicide is complicated at an individual level but this is an argument that is also easily made for heart disease–related deaths, as well as for deaths caused by other diseases. To further emphasize the point, Statistics Canada does not list neoplasms that are almost exclusively seen in smokers as *intentional self-harm (small cell lung cancer)*.

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Risk and disability

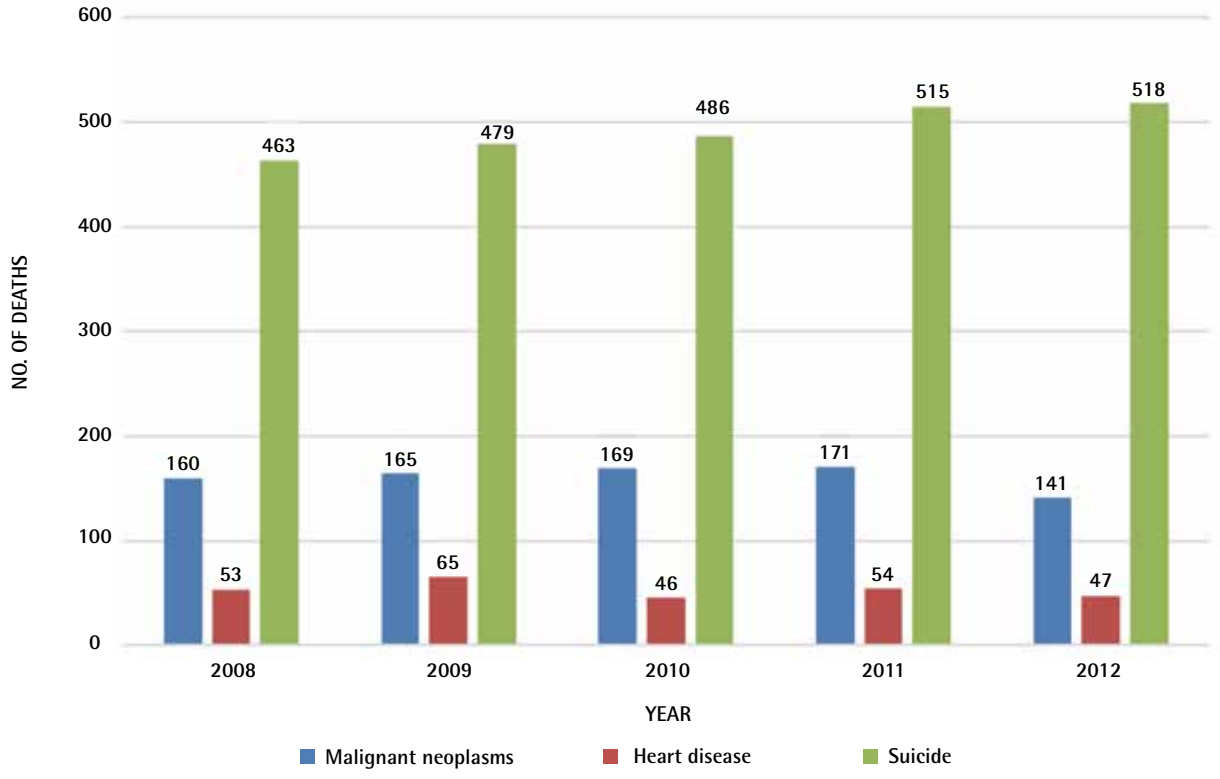
Mental and addiction disorders, while tragically affecting our youth most severely, are a massive contributor to burden of disease in Canada even when combining all age groups. **Figure 2** demonstrates the contribution of "mental and behavioral disorders" (a World Health Organization category that includes both addictions and common mental disorders) to both disability-adjusted life-years and years lived with disability.[2] When including mortality, as is done in disability-adjusted life-years, mental and behavioural disorders are second only to malignant neoplasms in their contribution to burden of disease and are the number one cause of years lived with disability. The latter is in part a function of the early age of onset for most mental disorders (15 to 24 years of age) and their persistent effect on activities of daily living when they are not optimally treated.

There is a concerning gap between the risk of death and disability associated with mental and addiction disorders and the focus of attention in the medical literature. The approach to assisting primary care practitioners with managing psychiatric conditions as reflected in the medical literature is focused on diagnostically defined case identification.[3-5] Suggestions abound for the use of diagnostic questionnaires, incorporating the biopsychosocial model, and other related approaches. The evaluation of primary care physicians' effectiveness in managing mental disorders has also tended to focus on case identification and diagnostic accuracy. However, the latter approaches fail to acknowledge the undifferentiated nature of patient presentations in primary care settings and that diagnostic clarity might be delayed by the challenges in eliciting phenomena and by their ambiguity. A review of the literature also reveals a complete absence of articles specifically focused on the identification and management of risks in undifferentiated mental disorders in primary care. Undifferentiated mental disorders are those for which the diagnosis is unclear, the symptoms might be in evolution, and there is an overlap with multiple conditions. This is a common situation facing primary care physicians.

Risk assessment versus diagnostic clarity

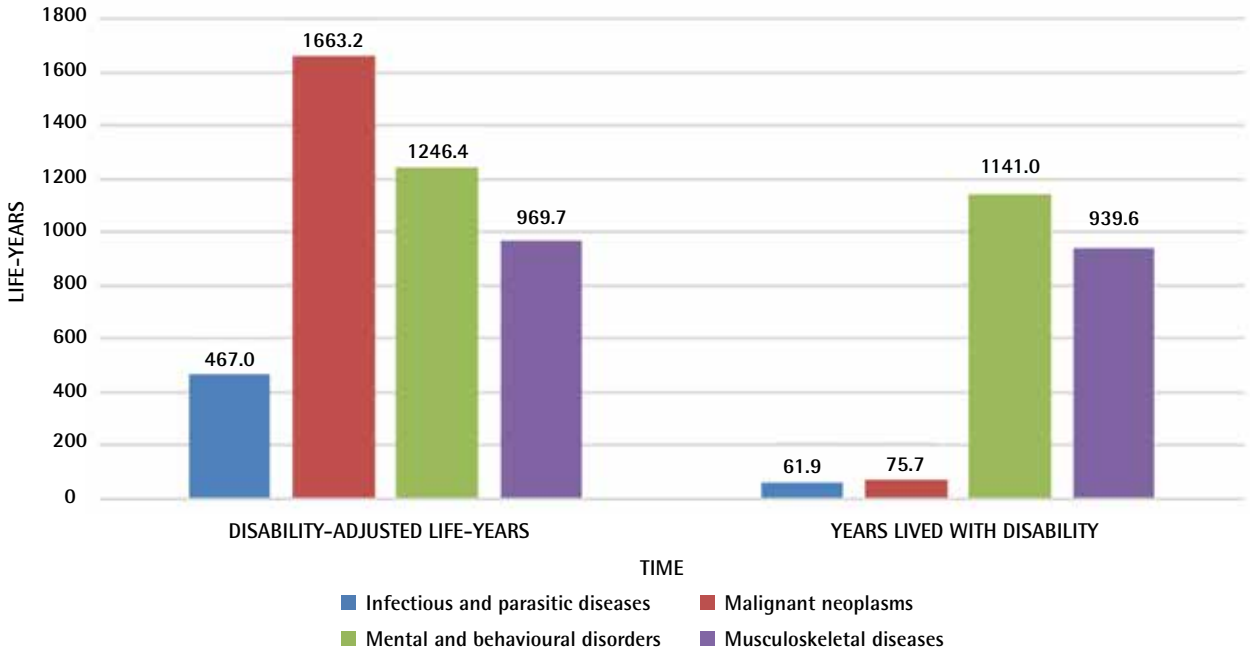
The challenge of diagnostic clarification when considering a mental or addiction disorder is extreme given the overlap in symptoms, the relatively unstructured nature of history taking, the negative effect of stigma on patients reporting psychiatric phenomena, and the absence of

Figure 1. Top 3 disease-related causes of death in those aged 15-24 years in Canada



Data from Statistics Canada.[1]

Figure 2. Disease burden in Canada, 2012



Data from the World Health Organization.[2]

objective investigations to assist the physician in ruling in and ruling out the range of possible diagnoses. This is to say nothing of the presence of medical comorbidities. Psychiatric assessments are primarily subjective, use few objective measures, and are prone to cognitive errors and biases. Key aspects of the patient's condition pertaining to risk, functional impairment, and symptoms of distress might be missed and treatment delayed while the clinician searches for a diagnosis. This diagnostic preoccupation can be a problem, and can paradoxically contribute to the frequency of preventable adverse events, if it precludes attention to aspects of the clinical presentation that require urgent management decisions independent of the diagnosis.

The most common nondiagnostic approach to assessing patients emphasizes George L. Engel's biopsychosocial model.[6] While it expands the clinician's view beyond diagnostic criteria, the biopsychosocial approach prompts physicians to consider antecedents to the presenting conditions. The biopsychosocial model might be helpful in facilitating comprehensive thoughtfulness about our patients, but it assumes either an absence or a resolution of time-sensitive concerns, such as risks or functional impairment requiring immediate attention. It also, as do other forms of assessment, tends to focus the clinician's attention on the patient's story and the need to understand it. To be clear, these are not criticisms of the biopsychosocial model; it was simply not developed to highlight risks, assess functional impairment, or address urgent patient needs.

No theoretical approach

When faced with undifferentiated presentations suggestive of mental disorders, there is no theoretical approach to assist clinicians in thinking about risk. More important, there is an alarming lack of attention in the literature to the identification of risks associated with mental or addiction disorders and to strategies to assist primary care providers in identifying these risks. The literature and most continuing professional development directs the attention of primary care providers to diagnosis. Unfortunately, directing attention to diagnosis is neither sufficient nor even necessary in risk identification and contrasts with recommendations from organ-specific specialties, such as cardiology, in which risks are more tightly related to accurate diagnosis. For instance, suicide is a nonspecific risk associated with numerous mental and addiction disorders, as are motor vehicle accidents, insufficient child care, and so on. Indeed, novice mental health practitioners, as well as those physicians who do not see enough cases to practise their mental health care skills and deepen their knowledge, might have attentional demands that leave them susceptible to missing risk owing to a primary focus on diagnosis. It is possible that we are missing an opportunity for risk identification and management in primary care settings and are not fully harnessing the opportunity for population-level risk reduction by adequately directing the primary care network of our health system.

We are not suggesting there are no clear assessment tools for specific risks such as suicide, but the assessment of a specific risk is different than a thorough process of recognizing the complete set of risks with which a patient presents. One must first identify risks before they can be assessed. The closest analogy is the comprehensive initial survey of patients used in modern trauma suites. To avoid the cognitive error of anchoring, the primary survey for life-threatening injuries does not stop when the first injury is found. Instead, the search for additional injuries continues until the body is surveyed in its entirety. We argue that there is a need to create an approach for primary care providers to broad risk identification in managing mental and addiction disorders that precedes the initiation of deeper assessments of specific risks. In the absence of such an approach, providers will be vulnerable to anchoring their focus on a single risk and missing others.

Conclusion

We believe that clinical medicine needs an approach to risk identification in mental and addiction disorders. Such an approach cannot rely on diagnoses if it is to be optimally effective in primary care and emergency department settings, where cases present in an undifferentiated manner. In collaboration with others, we describe a possible approach in this issue (**page 972**).[7] It is the first time that an approach to risk identification has been formally described in the English literature. We hope that this will provide primary care providers with a framework for assessing risk and addressing the urgent needs of their patients presenting with mental and addiction disorders.

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Competing interests
None declared

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References

1. Statistics Canada. *Table 102-0561. Leading causes of death, total population, by age group and sex, Canada.* Ottawa, ON: Statistics Canada; 2014. Available from: **www5.statcan.gc.ca/cansim/a26?lang=eng&id=1020561**. Accessed 2016 Feb 15.
2. World Health Organization. *Global health estimates 2014 summary tables: DALY by cause, age and sex, by World Bank income category and WHO region, 2000-2012.* Geneva, Switz: World Health Organization; 2014. Available from: **www.who.int/entity/healthinfo/global_burden_disease/GHE_DALY_WHOReg7_2000_2012.xls?ua=1**. Accessed 2016 Nov 7.
3. Kroenke K, Taylor-Vaisey A, Dietrich AJ, Oxman TE. Interventions to improve provider diagnosis and treatment of mental disorders in primary care. A critical review of the literature. *Psychosomatics* 2000;41(1):39-52.
4. Parker J. A broad diagnostic framework to simplify the approach to mental disorders in primary care. *S Afr Med J* 2014;104(1):69-71.
5. Jacob KS, Patel V. Classification of mental disorders: a global mental health perspective. *Lancet* 2014;383(9926):1433-5.
6. Engel GL. The clinical application of the biopsychosocial model. *Am J Psychiatry* 1980;137(5):535-44.
7. Silveira J, Rockman P, Fulford C, Hunter J. Approach to risk identification in undifferentiated mental disorders. *Can Fam Physician* 2016;62:972-8 (Eng), 983-90 (Fr).