South African Family Practice 2015; 57(4):259–260
http://dx.doi.org/10.1080/20786190.2014.978094

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S Afr Fam Pract
ISSN 2078-6190 EISSN 2078-6204
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RESEARCH

Common mental disorders are not diagnosed commonly in community health centres

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Background: Very limited published data exist on the spectrum of mental health disorders encountered at primary health care (PHC) facilities in South Africa.
Methods: The original data from a recent study were analysed with regard to its useful set of data on patients with mental disorders in primary care clinics in Cape Town.
Results: Schizophrenia and bipolar disorder accounted for the majority of visits, with common mental disorders (depression, anxiety disorders, substance use disorders) accounting for only a minority of visits. Furthermore, the mental health population in the study had significantly fewer chronic disease co-morbidities than the non-mental health patients.
Conclusion: There is an urgent need to screen better for common mental disorders in primary care patients in South Africa, and to screen for chronic medical diseases in patients with serious mental illness.

Keywords: co-morbidity, costs, mental health, non-communicable diseases, prescriptions, primary health care

Isaacs et al.[1] recently published a cross-sectional study describing the profile of non-communicable diseases (including costs of prescriptions per patient) at 10 primary health clinics in Cape Town.[1] There are relatively few data on mental disorders in primary care settings in South Africa. In one study, serious yet treatable psychiatric disorders like posttraumatic stress disorder (PTSD) were found to be missed by primary care clinicians.[2] The data of Isaacs et al. (collected from chart reviews) provide some important insights on mental disorders, and we therefore provide the current further analysis.

Altogether, 6.67% of the patients had mental disorders.[1] Of these, 58.4% were female, 74.1% were older than 35 years, and 54.4% had at least one chronic mental illness.[3] There was a significantly higher proportion of males aged ≤35 years.[1] Schizophrenia was the most prevalent diagnosis (35.3%) followed by depression (15.5%) (Table 1). A total of 46.6% of the patients with mental illness were viewed by their clinicians as stable and received pre-packaged monthly medication from the chronic dispensing unit (CDU), compared to 61.7% of the general study population ($P = 0.011$, 1-sided Fisher's exact test).

It is important to note that these are patients who are known to suffer from mental illnesses as diagnosed and followed up in the mental health clinic by the mental health nurses, with the dual-diagnosis cases followed up by outreach psychiatry registrars. Nonetheless, this suggests mental health users have less access to the chronic dispensing unit services. In the Community Health Centres, these users are often seen monthly by the mental health nurses, and their prescriptions are repeated at every visit. This may be less because they are truly unstable, and more a reflection of primary care clinicians' discomfort with treating mental disorders.

The high rates of serious mental disorders in these clinics are not unexpected. Nevertheless, given that rates of mental disorder in clinical settings are generally higher than in community settings, the low rates of common mental disorders are concerning. For example, the South African Stress and Health Study (SASH) found the highest 12-month prevalence disorders to be major depressive disorder (4.9%), agoraphobia without panic (4.8%), and alcohol abuse (4.5%), and so we can expect that these diagnoses should also be common in our clinic patients.[4]

In this group 45.6% had one or more additional chronic illnesses, compared to the total study population where 65% had co-morbidities ($P < 0.001$ Pearson chi-square).[1] It is important to note that the two groups were not age-matched in the analysis. Nonetheless, it has frequently been reported in the international literature that medical disorders are underdiagnosed in those suffering from mental disorders. Standard preventive medical care (including screening for medical conditions) has been found to be of lower quality among mental health patients.[5] The reasons for poorer medical care have been variously ascribed to numerous factors, including discrimination and stigmatization.[6] Similarly, in the SASH data, it was found that medical disorders are far more commonly treated than psychiatric disorders, despite the finding that mental disorders were associated with greater impairment.[4]

We would like to re-emphasise the importance of screening for medical disorders in patients with serious mental disorders. The roll-out of the Primary Care 101 (PACK) manual should be helpful in both increasing screening for mental disorders in primary care, and screening for medical disorders in patients who present with psychiatric disorders. The manual provides easy-to-use algorithms for rapidly diagnosing and initiating treatment of

Table 1: Rates of mental disorder diagnosis

Diagnosis	*n*	%
Anxiety	11	4.0%
Bipolar mood disorder	36	12.9%
Dementia	13	4.7%
Depression	43	15.5%
Intellectual impairment	13	4.7%
Schizophrenia	98	35.3%
Borderline Personality disorder (PD)	1	0.4%
Cerebral palsy	1	0.4%
Psychoactive substance abuse	6	2.2%
Psychosis	7	2.5%
Blank	49	17.6%
Total	278	100.0%

depression, anxiety, and other mental health disorders in a busy primary care setting.[7] At the same time, additional resources are likely needed for such work to proceed. There is a growing literature on collaborative care in primary care settings which provides a strong evidence base for the value of such an approach.

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Received: 26-04-2014 Accepted: 09-09-2014