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DIAGNOSTIC TOOLS IN PRIMARY CARE MENTAL DISORDERS

P. Bech

There are many reasons why primary care physicians fail to recognize major depression. Along with the tendancy to somatize symptoms inadequate training in psychiatric issues -including the discomfort of dealing with emotions as a medical disorder- is a great problem. To overcome this problem there have recently been developed tools for the recognition of major depression in the primary care setting. Both PRIM-MD (1994) and SDDS (1995) are based on Goldberg's two-stage model: a screening questionnaire to be completed by the patient and a diagnostic manual to be used by the family doctor A three-stage tool (MASTERING DEPRESSION) has just been developed to include also the measurement of outcome to antidepressive therapy, namely a Major Depression Inventory (to be completed by the patient) and the Major Depression Rating Scale (to be used by the family doctor) (Bech 1996).

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PRIME-MD: THE ICD-10 VERSION

Dr. A. Bertelsen

The majority of patients with common mental disorders are cared for by primary health care physicians. They, however, often fail to diagnose and treat these patients because of inadequate knowledge of psychiatric diagnosis criteria and time limitations in busy office settings. "Prime-MD" (for Primary Care Evaluation of Mental Disorders) has been developed to facilitate accurate diagnosis of the most common mental disorders in short time. Prime-MD was originally developed with DSM-IV criteria and validated for use in the United States For universal use an international version using WHO ICD-10 criteria has been provided, covering the four main groups of mental disorders most frequently seen in general practice: mood, anxiety, somatoform and alcohol-use disorders. Prime-MD has two components: a one-page patient questionnaire and a structured interview form used by the physician following the indications given by the patient in the questionnaire. The interview form has four modules for each of the four main groups of the disorders Each module has symptom questions corresponding to the diagnosis criteria, arranged as a flow chart leading to the major diagnostic categories within each group Prime-MD US Version has been shown to be easy to use and to complete in average within 10 minutes with satisfactory diagnostic validity. A major reliability and validity study of the international version is in preparation.

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THE DEVELOPMENT OF SDDS-PC

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The Symptom-Driven Diagnostic System for Primary Care (SDDS-PC) is a fully computerized instrument which allows primary care physicians to screen, diagnose and track patients suffering from a mental disorder or from a substance use disorder. The SDDS has two main components: 1) a 5-minute patient-administered screening questionnaire and 2) 5- to 10- minute physician-administered diagnostic interview modules based on DSM-IV criteria.

The SDDS-PC screen consists of 16 items and covers five types of mental disorders commonly seen in primary care. Patients who screen positive for a disorder receive the corresponding interview module. Following the screening responses, the SDDS-PC programme generates the appropriate module interview questions.

The SDDS-PC has been developed by Weissman et al. Several major studies have been conducted with the instrument. The present authors have translated the SDDS-PC into French. They intend to present the French version and to review work done with the instrument up to now.

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THE MINI IN PRIMARY CARE

Y. Lecrubier

The Mini International Neuropsychiatric Interview (MINI) is a short diagnostic structured interview developed in France and the USA to explore 17 disorders according to DSM-IV diagnostic criteria. It is fully structured to allow administration by non-specialized interviewers. In order to keep it short it focuses on the existence of current disorders. For each disorder, one or two screening questions rule out the diagnosis when answered negatively.

A validation study was conducted on 346 inpatients (296 psychiatric and 50 non-psychiatric) with the CIDI as the gold standard. The mean duration of the interview was 22 minutes with the MINI and 83 for corresponding sections of the CIDI. Kappa coefficient, sensitivity and specificity were good or very good for most diagnoses as were inter-rater and test-retest reliability.

A validation study was also conducted in primary care in four European countries. In a first stage, consecutive primary care patients completed a brief questionnaire (GHQ-12). Treating physicians were then asked to administer the MINI to all patients with GHQ scores higher than 3. After the consultation, patients were referred to a psychiatric expert who reported DSM-IV diagnoses blind of MINI results

Four hundred and eight patients completed the study, of whom 62% were females The concordance between the MINI administered by general practitionners and the experts was good for most diagnoses as reflected by Kappa coefficient ranging from 0.62 to 0.69 with the exception of Dysthymia (0.41) and Panic disorder (0.21). These low Kappa coefficients were due to an excess of diagnoses given by the experts compared to the MINI.

Because of its simplicity and ease of use, the MINI needs only brief training time Because of its brevity, it can easily be incorporated into a routine GP consultation

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