Who gets mental health treatment from the GP? Results from the Israel National Epidemiological Mental Health Survey

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Background. In view of the pending mental health (MH) reform, an increase in demand of MH services is expected. Primary care physicians will presumably be involved in meeting this expected increased demand.

Objectives. To identify the preferable route of service use of populations with MH problems based on data from the Israel National Health Survey (INHS).

Methods. The sample was drawn from the INHS which assessed mental disorders as well as the existence of chronic physical diseases in the population and the use of services for MH problems (specialty and primary care). The examined variables were (i) the existence of any mood or anxiety disorder and its severity, (ii) suffering from a chronic physical disease, (iii) use of MH services and (iv) use of general health services for MH problems.

Results. Fifty-one per cent of all those treated for MH problems were treated in the MH specialty sector and 49% in the general sector. Among those who met the diagnostic Composite International Diagnostic Interview criteria of any mood or anxiety disorder, the percentages were 62% and 38%, respectively. Irrespective of diagnosis, the proportion of those using the services of the GP is significantly greater among people above the age 50 years than among younger people.

Conclusions. People with emotional problems above the age of 50 years are more likely to prefer help for their problems from their GP regardless of the presence of any mental disorder or of a chronic medical disease.

Keywords. Anxiety disorder, GP, mental health services, mood disorder.

Introduction

In a recent national survey of the general population in Israel, ~9% of the general population was found to have consulted a professional about problems related to their mental or emotional health during the year prior to the survey.¹ This figure is close to those in Western Europe (Germany 8%, France 11.3% and Netherlands 10.9%) but much lower than in the USA (17.9%).²

General health (GH) care in Israel is a publicly administered and financed system of managed care and most curative care is delivered through four non-profit health maintenance organizations (HMOs). Mental health (MH) services in Israel are not included in the mandatory basket of services provided by the HMOs but are provided by the state free of charge. Since, however, the provision is not based on legislation, there are considerable differences in the availability of services in various parts of the country. Public outpatient MH facilities operate as walk-in clinics and

their services are provided free of charge to all residents. Outside the MH sector general primary care is easily accessible from the HMOs and completely free of charge.³ A pending reform in MH services, designed to be implemented in 2012, will add MH services to the mandatory basket provided by the HMOs.⁴

An increase in the demand of services for MH problems is expected mainly among people suffering from non-psychotic disorders, i.e. common mental disorders. The increase could happen for various reasons: (i) there will be one insurer/provider for mental and physical health and the right to demand MH services will be covered by legislation and (ii) the integration of MH into overall medical care might lead to a reduction in the stigma of getting help for MH problems. Primary care physicians will presumably be involved in meeting this expected increased demand. The findings of the National Co-morbidity Replication Study in the USA⁵ point to such a trend; that study showed that the proportion of respondents who reported

a 12-month use of MH services was higher than a decade before (17.9% versus 13.3%) but the increase occurred mostly in the general medical sector. About half of those who were in treatment for any psychiatric disorder were treated in the general medical setting.⁶ In the European Study of the Epidemiology of Mental Disorders, one-third of the individuals with any mental disorder consulted a GP for their emotional problems during the previous 12 months and a further 29% consulted both a GP and a psychiatrist.^{7,8}

Two possible explanations are relevant: (i) the development and heavy promotion of new antidepressants and other psychotropic medication with improved safety profiles spurred the treatment of mental disorders exclusively in general medical settings⁵ and (ii) the tendency of managed care shifted patient care from specialty MH services to primary care physicians, who are more likely to use pharmacological treatment rather than psychotherapy to manage depression or anxiety.⁹

Given the fact that in Israel, there is now free access to MH services without gate keeping by primary care physicians, the question is—who among the patients tend to consult the GP exclusively rather than the specialty MH professionals. It is reasonable to expect that patients with more severe psychiatric symptoms will be referred and treated more often by the specialty MH services. Recent results, however, are inconsistent in confirming this expectation.^{10–12} On the other hand, psychiatric patients with general medical co-morbidity may seek treatment more often from their GP as was shown in the STARD study.¹³

The Israel National Health Survey (INHS) assessed both mental disorders and chronic medical diseases in the population and the use of services for MH problems in specialty and primary care. The findings offer the possibility of identifying the groups with MH disorders and checking their current use of services.

Methods

The Israeli National Health Survey (INHS) followed the procedures established by the World Mental Health Survey Initiative of the World Health Organization.¹⁴

Sample

The sample¹⁵ was extracted from the National Population Register and comprised non-institutionalized residents, $\geq$ aged 21 years. The sample was designed to reflect a fixed distribution of respondents combining gender, age groups and the three main cultural different population groups: (i) Jewish Israelis and others [born in Israel, pre-1990 immigrants and post-1990 immigrants from countries other than the former Union of Soviet Socialist Republics (USSR)]; (ii) Arab Israelis and (iii) post-1990 immigrants to Israel from the former USSR.

The interviewed sample was weighted back to the total population to compensate for unequal selection probabilities resulting from disproportionate stratification, clustering effects and non-response. The weights were adjusted to make sample totals conform to known population totals extracted from Israel Central Bureau of Statistics (CBS) sources.¹⁵

Face-to-face interviews in the respondents' homes were conducted from May 2003 to April 2004 in Arabic, Hebrew or Russian. The survey was administered using laptop computer-assisted personal interview (<http://www.cbs.nl/en-GB/menu/informatie/onderzoekers/blaise-software/default.htm>) methods by professional survey interviewers, trained and supervised by the CBS. Interviews took an average of 60 minutes and the overall response rate was 73% (88% among Arabs, 71% among Jews and 70% among immigrants), totalling 4864 completed interviews. There were no replacements. A Human Subjects Committee approved the study.¹⁵

Measures

Use of MH services. Respondents were asked whether they talked to health professionals (psychologist, psychiatrist, social worker) about problems with their 'emotional or MH like psychological pressures, nerves bad mood or problems with drugs or alcohol'. Respondents who indicated that they had seen a MH professional in the past 12 months were classified as 'using MH services', even if they also used GH services for MH problems. Among all utilizers of MH services, only five had more than two visits to a GP for MH problems. Treatment provided in the alternative treatment sector (healers, religious counsellors, etc.) was not included.

Use of GH services. Respondents not included in those using 'any MH' services and who consulted GPs/other doctors or other health professionals, whether or not they also consulted religious or other traditional agents, were included in this group.

This group included also respondents who were prescribed psychotropic drugs for >180 days and who admitted taking them for emotional or mental problems under the supervision of a health professional but did not acknowledge any consultation with MH professionals or traditional healers.

In order to remove respondents with primarily sleep problems, those with only the following cluster of characteristics were excluded: taking sedatives exclusively, having sleep problems, $\geq$ aged 65 years and not having had any mood or anxiety disorder in the last 12 months.

Any mood or anxiety disorders. Yearly prevalence of Diagnostic and Statistical Manual of Mental Disorders Fourth edition (DSM-IV) mood or anxiety disorders was assessed with the Composite International

Diagnostic Interview.¹⁵ The following disorders were assessed: panic disorder, generalized anxiety disorder, agoraphobia without panic disorder, post-traumatic stress disorder, major depressive disorder, dysthymia and bipolar disorder.

Clinical severity. Respondents with any mood or anxiety DSM disorder in the past 12 months were divided into three groups, reflecting the severity of the disorder:

Severe cases. Respondents with either bipolar 1 disorder or substance dependence with a physiological dependence syndrome or admitting a suicide attempt during their lifetime or reporting at least two areas of role functioning with severe role impairment due to mental disorder (scored ≥ 7 on a 10-point severity scale on at least one of the disorder-specific Sheehan Disability Scales).¹⁶

Moderate cases. Respondents not classified in the above category and who scored >4 on a 10-point severity scale on one of the Sheehan Disability Scales.

Mild cases. All other respondents with any mood or anxiety disorder.

Chronic physical conditions. The INHS included a checklist of chronic physical disorders and chronic pain. Respondents were asked whether they ever experienced having any of this conditions. If yes, they indicated if they experienced them at any time in the past 12 months. In the case of conditions typically identified as a medical diagnosis, respondents also reported whether a doctor or other health professional ever told them they had the condition and, if so, whether they still had the condition in the past 12 months. The 12-month follow-up questions were omitted for conditions that persist throughout the life course, e.g. chronic physical conditions: cardiovascular conditions (heart attack, heart disease, stroke, high blood pressure), respiratory conditions (asthma, chronic obstructive pulmonary disease, emphysema or other lung disease,

tuberculosis), diabetes, kidney disease, neurological conditions, thyroid disease and cancer.

Prior research has shown that such checklists provide useful information about treated or currently untreated chronic conditions¹⁷ and also that self-report of chronic physical conditions shows moderate to high agreement with medical records data.¹⁸

Results

A total of 438 of the 4859 adult subjects (9%) reported using any type of service for MH problems in the previous year (Table 1). Of these, 51% received treatment in the MH specialty sector and 49% in the GH sector.

Among those meeting the criteria for any mood or anxiety disorder, the proportion was 62% and 38%, respectively. This preference for MH services was slightly more prominent among severe and moderate cases than among the cases with a mild severity of any mood or anxiety disorder.

When the differences in service use were examined separately by sex, age group and the coexistence of a chronic physical disease (Table 2), the main findings were the following: a relatively greater proportion of patients above the age of 50 years used the GH services for MH reasons compared to the younger age group. More females than males used the GH services in all age groups. The coexistence of a chronic illness also increased the proportion of those using the GH services for MH reasons. This was true for both sexes. Subsequent analysis examined whether age and diagnosis $\times$ chronicity predicted which utilizers preferred MH treatment by GP's exclusively.

A logistic regression showed that the odds of receiving treatment from a GP only are almost six times higher among respondents ≥ 50 years, regardless of mental or physical health status. It is only two times higher if the respondent suffers from a chronic medical condition (Table 3).

TABLE 1 Use of services by presence of common mental disorders and severity level: 12-month rates per 100 population and distribution within each category of users

Total sample (N)	Total in care for MH problems (N)	Rates (SE)			Distribution of users	
		Total MH services	Total GH services	Any professional health services	Total MH services (%)	Total GH services (%)
Total (4859)	438	4.6 (0.3)	4.4 (0.3)	9.0 (0.4)	51	49
AMAD ^a (470)	141	18.6 (1.9)	11.4 (1.6)	30.1 (2.2)	62	38
Severe (168)	76	26.5 (3.5)	17.9 (3.3)	44.4 (4.1)	60	40
Moderate (166)	45	18.6 (3.2)	8.5 (2.2)	27.1 (3.6)	69	31
Mild (136)	20	8.0 (2.5)	6.4 (2.0)	14.4 (3.1)	56	44
No AMAD ^a (4389)	297	3.1 (0.3)	3.6 (0.3)	6.7 (0.4)	46	54

^aAny mood or anxiety disorder.

TABLE 2 Use of MH, GH or any type of services for MH reasons by AMAD^a, chronic condition (CC), age and gender

Any professional health services										MH services					GH services						
Total group	Total	21-49		50+		Total group	Total	21-49		Total	Total group	Total	21-49		Total	50+					
		M	F	Total	M			F	M				F	M			F				
No CC + no AMAD																					
Sample size	2879	2121	1096	1025	758	392	366	2879	2121	1096	1025	758	392	366	2879	2121	1096	1025	758	392	366
% Treated	4.3	4.0	2.5	5.6	5.3	3.6	7.1	2.8	3.1	2.2	4.1	2.0	1.1	2.8	1.5	0.9	0.3	1.5	3.4 ^b	2.5 ^b	4.2 ^b
SE	0.4	0.4	0.5	0.8	0.8	1.0	1.3	0.3	0.4	0.4	0.7	0.5	0.6	0.9	0.2	0.2	0.2	0.4	0.6	0.8	1.0
CC + no AMAD																					
Sample size	1510	488	232	256	1022	457	565	1510	488	232	256	1022	457	565	1510	488	232	256	1022	457	565
% Treated	12.0	10.2	10.2	10.1	13.3	10.9	13.6	3.6	6.0 ^c	7.6 ^c	4.8 ^c	2.4	2.9	1.8	8.0	4.1	2.6	5.4	10.1 ^b	7.9 ^b	11.8 ^b
SE	0.8	1.4	2.1	2.0	1.1	1.5	1.4	0.49	1.13	1.9	1.32	0.47	0.79	0.56	0.7	0.9	1.1	1.5	1.0	1.3	1.3
No CC + AMAD																					
Sample size	273	213	99	114	60	24	36	273	213	99	114	60	24	36	273	213	99	114	60	24	36
% Treated	26.8	24.3	20.5	27.6	35.6	21.7	44.4	20.33	21.06	18.61	23.1	17.68	11.42	21.66	6.4	3.3	1.9	4.5	17.9 ^b	10.3	22.8 ^b
SE	2.9	3.2	4.4	4.5	6.4	8.8	8.6	2.61	2.94	4.29	4.07	5.16	6.52	7.24	1.8	1.7	1.3	2.8	5.3	6.9	7.3
CC + AMAD																					
Sample size	197	80	38	42	117	42	75	197	80	38	42	117	42	75	197	80	38	42	117	42	75
% Treated	34.8	32.5	26.0	38.2	36.4	35.8	36.7	16.2	18.8	17.4	20.1	14.4	20.2	10.7	18.5	13.6	8.7	18.1	22	15.6	26
SE	3.4	5.3	7.2	7.7	4.6	7.7	5.7	2.67	4.3	6.12	6.03	3.43	6.56	3.7	2.79	4.03	4.78	6.25	3.82	5.36	5.17

^a Any mood or anxiety disorder.

^bSignificantly higher than in the corresponding 50+ age group $p < 0.05$.

^cSignificantly higher than in the corresponding 21–49 age group $p < 0.05$.

TABLE 3 Predictors of getting treatment in the GH sector among those treated for emotional problems

Characteristics	N	Odds ratio	95% Confidence interval	Significance
Age (years)				0.000 (Wald $F = 66.5$)
≤49	262	1		
50+	253	5.96	3.88–9.16	
Diagnosis of AMAD and presence of chronic somatic disease				0.000 (Wald $F = 5.13$)
No AMAD No chronic disease	112	1		
No AMAD Chronic disease	247	2.23	1.28–3.88	
AMAD No chronic disease	40	0.63	0.25–1.56	
AMAD Chronic disease	116	1.22	0.63–2.39	

Logistic regression.

Discussion

The purpose of this study was to find which factors explain the preference of primary care over specialized MH service for the treatment of MH problems.

In developed countries, it is often required to see the GP before visiting a MH specialist.¹⁹ In Israel, where access to MH services is free, there is a real choice between MH and GH services.

The most important factor predicting the choice of a GP for emotional problems was older age, even after controlling for chronic diseases which are more prevalent among the older age group. These findings are similar to results reported by Kovess *et al.*²⁰ and the ESEMeD study⁷ who also showed a preference of the elderly to consult only a GP for their MH problems. The findings may reflect the fact that visits to the GP are more common among the elderly, even for mild physical disorders. They therefore have more opportunities to raise emotional problems with the GP. Moreover, elderly people might avoid seeking MH care because of the greater perceived stigma of mental disorder and treatment for people in this age range compared to those who are younger.² The possibility of a cohort effect cannot be ruled out.

A tendency for those with severe or moderate mood or anxiety disorder to seek treatment in the MH specialty services was observed. This contrasts with findings in the STARD study, where minimal differences in severity in psychiatric symptoms were reported between the two settings.¹³ On the other hand, suffering from emotional problems concomitantly with chronic physical disease predicts the preference for seeking treatment by the GP, irrespective of age. It seems that physical problems are more likely to be discussed than emotional problems.²¹

In general, this findings raise special concern in view of a recent report in Israel²² documenting that '43% of primary care physicians have reservations treating patients with depression and anxiety and 85% identified time constraints as a major barrier to care of depression and anxiety in primary care'. Providers of primary care services need to promote programmes that enable better

communication and consultation between GPs and MH professionals to enhance the quality of care.^{23,24}

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Declaration

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Conflict of interest: none.

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