# Preventive psychiatry and the stance of the clinician

DAVID GOLDBERG

Although clinical psychiatrists have a good record in the tertiary prevention of mental disorders, evidence that they are effective in secondary prevention is hard to come by, and good evidence that our activities as clinicians result in primary prevention is non-existent.

Prevention is advocated by central governments because it is hoped that it will reduce health expenditures: however there is remarkably little evidence that this is so.

In the United Kingdom the Department of Health has set itself the target of reducing the suicide rate by 15% in 5 years (Department of Health, 1992), and a joint campaign by the Royal Colleges of Psychiatry and General Practice entitled «Beat Depression» aims to improve the detection and treatment of depressive illnesses in primary care settings (Paykel & Priest, 1992). The suicide rate was chosen as a target because it is a relatively objective outcome indicator, not because there is any good evidence that the increasing emphasis on community care is likely to lower the rate. Indeed, with mental health services under-resourced in most large British cities, it is even possible that the suicide rates will go up rather than down, despite community care. There is rather a better chance that the suicide rate among those discharged from hospital can be lowered than the rate in the community at large, as this might be achieved in some places by better co-ordination between primary and secondary care services, and more assertive follow-up of recently discharged patients.

The task of reducing the suicide rate in the community at large is left as a task for the «Beat Depression» campaign, and information and training packs for general practitioners have been made widely available (Wright, 1993; Royal College of Psychiatrists, 1993). However, the task is a formidable one, as recent data from the WHO collaborative study on Mental Disorders in General Medical Settings has shown that there is a very poor correspondence between psychiatrist's concepts of depression as measured by a research interview, and those patients identified by their general practitioner as suffering from depression (Sartorius *et al.*, in press). The need for good practice protocols for depressive illness is underlined by the finding that only a small minority of those diagnosed by their doctor as depressed actually received anti-depressants, with rather more being prescribed sedatives. It seems likely that more than an information pack will be required to have any impact on the problem.

Evidence that extending mental health care to primary care settings will reduce admissions to hospital - and thus costs - is conflicting. Gater *et al.* (1992) showed that while treated inceptions trebled, that there was no effect on admissions to hospital. The cost per treated case of the mental health service based in primary care settings was appreciably less, but the total cost of the service was substantially greater - as cost savings did not occur in the hospital sector. However, a detailed comparison between Gater's study in Manchester and the community service in Verona suggests that close integration between hospital and community staff in Verona results in shorter admissions, and thus the prospect of cost reductions (Gater *et al.*, in press).

Clinicians face conflict between their responsibility for sick individuals and the need to provide care at minimum cost to as many people as possible. When a famous surgeon operates on the heart of a sick child, he or she is expected to do so without thought of the cost involved. This was also typical

Indirizzo per la corrispondenza: Professor D. Goldberg, Institute of Psychiatry, De Crespigny Park, Denmark Hill, SE5 8AF London.

Fax (+44) 71-7035.796.

of the best care available under the British NHS to psychiatric patients until relatively recently: the patient stayed as long as it took (often too long), and the patient had help from whichever member of the multi-disciplinary team that his condition required. We didn't count the cost.

However, this is the antithesis of the public health approach - where we are concerned with interventions that cost as little as possible, and which hold promise for whole groups rather than particular individuals. The advent of the internal market in health care in the UK is likely to mean that rival providers compete with one another to offer just acceptable care at minimal unit cost. Louise Russell (1984) has reviewed the economics of prevention and concluded that few preventive programmes reduce medical expenditures; and that even when prevention costs less than acute care, its medical costs per unit of health benefit can be great or greater.

Anderson *et al.*, (1993) have argued that if we are to reduce the prevalence of disorder in a population it is necessary to take steps which will lower the population mean for psychological symptoms in that population, and that to do this «psychiatric epidemiology and prevention merge into social policy - they cannot exist apart». They show that the associations between variables such as gender, region of the country and employment status remain robust even when all those with high scores on a screening questionnaire are removed from the sample, and end by asking what are the psychiatric equivalents of the public health measures that effectively reduced the prevalence of cholera.

If we are to take primary prevention seriously, we have to raise public awareness about putative social factors associated with common mental disorders. Jenkins (1992) stresses the importance of good nutrition during pregnancy, the risks of teenage pregnancy, the importance of education about parenting skills and the avoidance of drugs, and the importance of social networks. It is clear that the public health stance involves making value judgements, and taking decisions which may impair individual freedoms. Some of these are non-controversial, like clean drinking water, safe public transportation systems, and reducing air pollution.

Others were originally controversial, like the Pasteurisation of milk, fluoridation of drinking water, or prohibiting smoking in public places.

The psychiatric equivalents of these should have regard to events in childhood. Maternal deprivation and neglect, and physical or sexual abuse of children are all related to later disorder (Goldberg & Huxley, 1992). Parental discord is likely to be associated with persistence of childhood problems into later life, whole children who were well during childhood are likely to remain well during adult life (Quinton *et al.*, 1990). It would make sense, and be non-controversial, to provide parenting lessons to adolescents while they are still at school - but it is not generally done. Advice about safe limits to alcohol intake now seems acceptable to the public, and is not in conflict with the role of the clinician. However, other recommendations would make many clinical psychiatrists uncomfortable. These would involve clear teaching about the harm done to children by divorce and broken families (for review, see Cherlin *et al.*, 1991), and opposing the use of recreational drugs.

There is a tension here between the non-judgemental stance of the clinician and the value laden approach of the advocate of greater public health. As clinicians, we are expected to show understanding to patients who have a wide variety of anti-social impulses: patients come to us for understanding and constructive help, not for judgement. Clinical psychiatrists lack the moral fervour of the reformer of public morals, and are often also troubled by the complexities of the issues involved. The harm done to children from broken homes may to some extent be counter balanced by the harm done to children by parents trapped in unhappy marriages.

Just as public health physicians once insisted upon proper nutrition in childhood, the psychiatrist interested in primary prevention must advocate that children are provided with emotional security and care, and that their education includes instruction about the harm done by alcohol and drugs as well as advice on the essential components of good parenting. Parents should be warned of the harmful effects of divorce on their children's later development. It is also necessary for education to lead to employment or some useful role in society. It is difficult to resist the conclusion that effective prevention cannot be done from the clinic, and is in any case inconsistent with the clinician's usual approach. It is judgemental where he is morally neutral. Effective prevention will typically involve non-psychiatrists and will necessarily impinge upon social policies.

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