Peer reviewed article

Delay of diagnosis and treatment in psychiatric patients applying for a disability pension – a challenge for all of us

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Summary

In an earlier study in 2002 [1] we showed that of 101 persons applying for a disability pension for psychiatric reasons, a psychiatric diagnosis that affected their ability to work, could only be confirmed in 83%. Furthermore, and even more importantly, only 64% of these cases were receiving any psychiatric treatment and only 20% adequate drug therapy.

Since this time there has been a great deal of discussion on the increasing numbers of people receiving a disability allowance in Switzerland.

Questions under study: We evaluated whether, compared to the 2002 situation, application behaviour, expressed in more accurate diagnoses and treatment plans before filing the application for disability pension, has changed.

Methods: We examined 124 of 132 subjects who were assessed for the Swiss Invalidity Insurance at the psychiatric outpatient department of the University Hospital, Basel in 2004. Eight persons did not agree to participate in the study. The results were compared with the results of our earlier study.

Results: There were some significant differences between the 2002 and 2004 applicants. In 2004, there was a tendency to an even lower proportion of subjects with a psychiatric diagnosis affecting their ability to work (73% *vs* 83%, p <.1). Of these applicants, significantly more than in the previous study reported taking specific psychiatric medication (74% *vs* 50%, p <.01).

However, the proportion of patients, who were sufficiently medicated as documented by adequate drug serum levels (37%) or who were receiving any form of psychotherapy in a broad sense (30%), was still fairly low.

Furthermore, there was a lower proportion of affective disorders as the primary diagnosis (49% *vs* 62%, p <.1).

Conclusions: The findings from our earlier study, namely, that psychiatric applicants for a disability pension were not sufficiently diagnosed and treated before the application, could largely be replicated. Only minor changes could be observed over the last couple of years, with psychotropic medications being taken by more applicants, which might partly be due to the ongoing discussion.

Key words: Swiss invalidity insurance; disability insurance; disability pension; psychiatric expertise; compliance; drug monitoring; delay of diagnosis and treatment

Introduction

The Federal Invalidity Insurance (IV) is one arm of the social insurance network of Switzerland. Invalidity insurance contribution is mandatory. An insured person may apply for diverse benefits. The main benefits provided by the IV system are in the form of rehabilitation measures, aimed at promoting the professional (re)integration of disabled individuals and thus improving/restoring their earning capacity. The guiding principle is "rehabilitation before pension". Rehabilitation measures are medical measures, supply of appliances, occupational measures and daily cash benefits as ancillary benefits. A person is only entitled to an invalidity pension if the rehabilitation option has been exhausted. The degree of disability (at least 40%) determines the type of pension [2].

The total number of people claiming an IV-pension has increased steadily in recent years, both in terms of the overall number of pensions awarded and pensions awarded specifically for mental health reasons. In both groups the number of new pensions granted has declined since 2004 (fig. 1), but

No financial support declared.

as the number of new pensions granted still exceeded the number of pensions discontinued, the overall number has continued to climb [3].

A similar trend has been observed in other countries, such as Belgium, Canada, Germany, The Netherlands and Sweden [4]. For example, in Finland the number of disability pensions granted due to depression tripled between 1987 and 1994, despite improved drug therapies and other means of treatment [5]. The reasons given for this include the economic recession, changes in the diagnostic system, improved diagnostic skills or a significant deterioration in the functional ability to cope with stress [4, 5].

In Switzerland in 1985, 24% of newly issued pensions were granted for mental illness [6]. In 2004 and 2005 this figure climbed to 40% [7]. Various factors were cited as possible reasons for this increase. These include the mounting psychological stress to which people are exposed in their workplace and at home with a related increase in mental illness, more liberal approaches to assessing mental illness and granting pensions, an increasing tendency to grant disability pensions to alleviate social problems such as unemployment, an increasing belief among insured persons that after having paid insurance contributions for a number of years they are fundamentally entitled to a pension, the higher proportion of immigrants and their attendant psychosocial problems such as difficulties in adjusting to a new culture and, finally, the process of determining the pension entitlement itself, which can drag on for several years and itself be a cause of emotional/psychological distress [8–10]. Little attention has so far been paid to examining the role played by the pension applicants and their treating physicians.

In 2002 we had therefore conducted a study on all 101 applicants for a pension for psychiatric reasons, who were referred to our psychiatric department for a psychiatric expertise by the Swiss Invalidity Insurance. This study revealed that a psychiatric diagnosis could be confirmed in only 83% of the applicants. At the time of the expertise only 64% of the applicants were in regular psychiatric treatment and only 20% were receiving adequate drug therapy [1].

Since this time there has been considerable discussion in both the Swiss public and between health professionals and psychiatrists on the practice of granting disability pensions.

In the current study we therefore tried to replicate the results of the 2002 study, with special emphasis on the question of whether application behaviour had changed since then. We hypothesized that as a result of the ongoing discussion, assessment of diagnosis and of the ability to work would have improved and that treatment would have been maximised prior to the application for pension.

Patients and methods

Every year the cantonal office of the Swiss Invalidity Insurance in Basel refers a certain number of applicants, especially immigrants and women, to our psychiatric outpatient department for a psychiatric expertise regarding the question of disability pension. The referral pattern has not changed over the years.

In the current study we included 124 of 132 subjects referred in 2004. Eight persons declined participation in

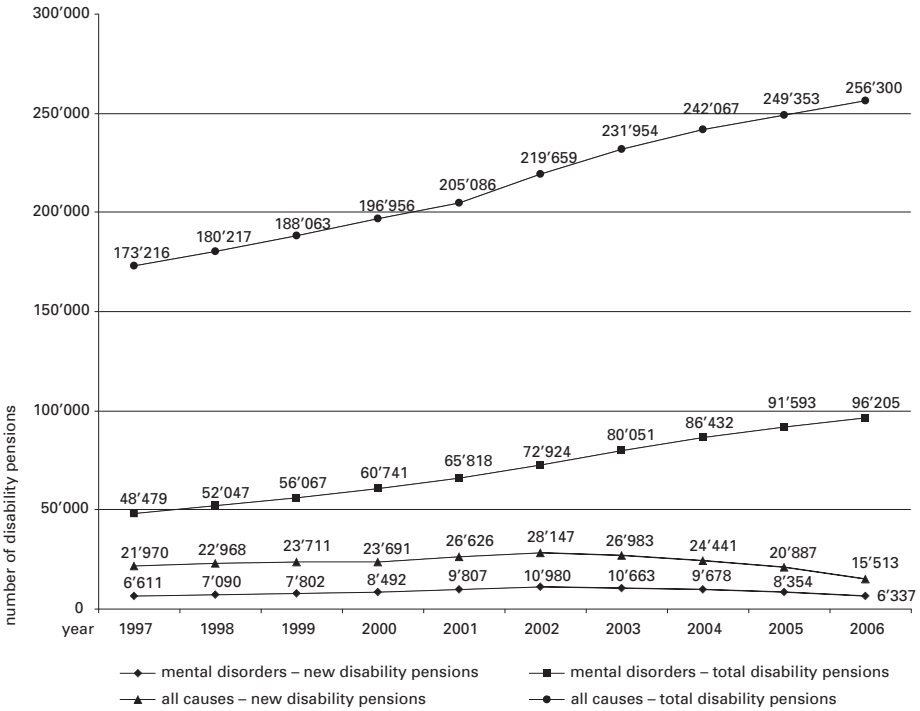

Figure 1

New disability pensions and total number of disability pensions issued in Switzerland due to mental disorders and due to all causes, 1997–2005 [3].

the study. Five of these were concerned that their data could be misused and three did not want to "support the Invalidity Insurance". 32 subjects (26%) were already in receipt of a partial or full disability pension. All applicants were examined thoroughly by at least two psychiatrists, of whom at least one was fully qualified. The psychiatrists had six, respectively, eight years of experience.

Psychopathological symptoms were routinely monitored using the AMDP-Scale (Arbeitsgemeinschaft für Methodik und Dokumentation in der Psychiatrie) [11], a well validated instrument commonly used in German speaking countries. Psychiatric diagnoses were established according to the International Classification of Diseases (ICD-10) [12].

All subjects also completed a questionnaire measuring their physical and mental symptoms (SCL-90-R) [13]. In cases where further information was needed in order to confirm diagnosis or to assess the subject's capacity to work, further questionnaires and/or psychological testing were conducted.

The data on medical history, previous treatment, diagnosis and appraisal of capacity to work were obtained in a psychiatric interview and were recorded in a standardized form. These data were checked against the individual psychiatric-medical file and gaps in information were filled accordingly. Copies of missing medical reports were obtained from the institutions in question after obtaining patient consent.

If the subjects reported that they were currently on psychiatric medication, blood serum levels were routinely checked with his or her consent. If somatic conditions that could conceivably influence the psychiatric diagnosis were present, a somatic expertise was ordered. Upon conclusion of the examination and after obtaining disclosure permission, the assessee and the treating physician and/or psychotherapist were verbally informed of the results of the expertise and our treatment recommendations.

In the case of non-German-speaking subjects, a native-speaking interpreter was present, unless the subject expressly refused. This procedure is consistent with the relevant guidelines for assessing mental disorders [14].

For ethical reasons we ensured that participation or non-participation in the study could not influence the recommendations of the experts. To this end the consent forms were managed by a neutral third person and the patient's decision whether or not to participate in the study was not communicated until after the expertise had been completed.

The data were collected so as to preserve anonymity. They were evaluated using version 11.0 of the SPSS statistics program. To compare proportions we used the Chi-Square test. As level of significance we took 0.1.

Concerning the limitation of the study one should consider that the two year interval between the first study 2002 and the second study 2004 is rather short.

The study was approved by the Research Ethics Committee of the Cantons of Basel-Stadt and Basel-Land. Written informed consent was obtained from each of the 124 study participants.

Results

Results of the current 2004 study

Of the 124 subjects examined, 63 were women (51%) and 61 men (49%). Their ages ranged from 20 to 62 years, the average being 43.7 years (median = 44 years).

Subjects whose mother tongue was a language spoken in former Yugoslavia were most numerous (37 = 30%), followed by German (35 = 28%), Turkish (27 = 22%) and Italian (10 = 8%). The remaining subjects originated from Spain (4), France (3), Algeria, Finland, India, Israel, Liberia, Portugal, Sri Lanka and Vietnam (1 each).

In 34 of the 124 subjects (27%) no psychiatric diagnosis, which might be expected to impair their capacity to work, could be made.

In the remaining 90 cases, a total of 104 psychiatric diagnoses were made, the largest proportion of these were affective disorders (49%), followed by neurotic and somatoform disorders (25%). Table 1 shows the percentage of applicants with the respective diagnosis.

Of the 90 subjects with a current psychiatric diagnosis, 67 (74%) reported that they regularly took specific psychiatric medication (antidepressants, neuroleptics or mood stabilizers). In 53 of these cases, blood serum levels were measured (the remaining subjects did not agree to submit to a blood test). The serum levels of the drugs in question were within the therapeutic range in 26 (49%) of the subjects tested, but were significantly below the therapeutic range in 20 (38%) of the subjects. In 7 (13%) cases, no traces of the drug in question were detected. This means that only 37% of the 90 subjects could be demonstrated to be taking psychiatric drugs in sufficiently high doses.

71 (79%) of the 90 subjects with a psychiatric diagnosis reported that they were currently undergoing "some sort of psychiatric-psychotherapeutic treatment". This included, for example, short sessions with a general practitioner and included prescription of medication. 39 (43%) reported being in current "psychotherapy". However, only 27 (30%) fulfilled the minimal criterion of having had at least one psychotherapy session per month for at least six months. 26 (29%) of the subjects reported having been hospitalized in a psychiatric clinic because of the actual disorder.

Capacity to work judged from a psychiatric perspective by our experts is summarised in table 2. From this the experts derived the attendant recommendation concerning disability pension entitlement. Pensions were subsequently granted or denied by the disability insurance office on the basis of these recommendations together with their own experience. In 20 (22%) of the cases with a psychiatric diagnosis, the condition was not considered serious enough to warrant recommending a pension. In 17 (19%) of the cases, a full disability pension was recommended.

Of the 124 subjects who applied for disability insurance benefits, eight requested rehabilitation measures, three job placement and 113 a disability pension.

Comparison of the 2004 results with the results of the 2002 study

The age structure of the group of subjects in this study (2004: average age = 43.7 years, range 20–62 years) was very similar to that of the subjects examined in the earlier study [1] (2002: average age = 43.3 years, range 21–65 years, p = n.s.). For other comparisons between the two groups, see Tables 3 a and 3 b.

There were some statistically significant differences between the 2002 and 2004 groups. In 2004 there was a lower proportion of subjects with a psychiatric diagnosis affecting the ability to work (73% *vs* 83%, p <.1), a lower proportion of affective disorders as primary diagnosis (49% *vs* 62%, p <.1), and highly significantly more patients reporting taking specific psychiatric medication (74% *vs* 50%, p <.01).

Discussion

This study shows, firstly, that there is still a high proportion (more than a quarter) of applicants for disability pension for mental reasons who do not fulfil the diagnostic criteria for a psychiatric disorder impairing their working capacity. As there is a risk of medicalizing social problems, for example, unemployment, social stress and financial problems, the general practitioners or psychiatrists of patients, who consider applying for a pension for psychiatric reasons, should be aware of this and decide if this patient really fulfils the criteria of a mental disorder. In future a new procedure, developed by the Swiss Invalidity Insurance allowing a voluntary early registration of subjects certified unfit for work for more than four weeks, may be helpful in reducing this risk.

Table 1

105 Psychiatric diagnoses affecting capacity to work in 101 applicants for disability pension for psychiatric reasons, 2002.
104 Psychiatric diagnoses affecting capacity to work in 124 applicants for disability pension for psychiatric reasons, 2004

Diagnosis	2002 study (n = 101)		2004 study (n = 124)	
	n	(%)[1]	n	(%)[1]
F 0× (Organic mental disorders)	1	(1)	3	(2)
F 1× (Mental and behavioural disorders due to psychoactive substance use)	7	(7)	3	(2)
F 2× (Schizophrenia, schizotypal and delusional disorders)	3	(3)	10	(8)
F 3× (Mood disorders)	65	(64)	51	(41)
F 4× (Neurotic, stress-related and somatoform disorders)	22	(22)	26	(21)
F 6× (Disorders of adult personality and behaviour)	7	(7)	8	(6)
F 7× (Mental retardation)	0	(0)	2	(2)
F 9× (Behavioural and emotional disorders with onset in childhood and adolescence)	0	(0)	1	(1)
No psychiatric diagnosis affecting capacity to work	17	(17)	34	(27)

[1] % of applicants, multiple diagnoses possible

Table 2

Assessed capacity to work and the resulting pension recommended by the expert

Assessed capacity to work	Number of subjects		Disability pension recommendation of expert	
	n	(%)	n	(%)
	2002 / 2004	2002 / 2004	2002 / 2004	2002 / 2004
90%	0 / 4	(0) / (4)	No pension: 34 / 20	(40) / (22)
80%	12 / 6	(14) / (7)		
75%	5 / 5	(6) / (6)		
70%	17 / 5	(20) / (6)		
60%	19 / 16	(23) / (18)	¼ disability pension: 19 / 16	(23) / (18)
50%	19 / 25	(23) / (28)	½ disability pension: 19 / 25	(23) / (28)
40%	9 / 12	(11) (13)	¾ disability pension: 9 / 12	(11) / (13)
30%	3 / 7	(3) / (8)	Full disability pension: 3 / 17	(3) / (19)
25%	0 / 2	(0) / (2)		
20%	0 / 3	(0) / (3)		
10%	0 / 1	(0) / (1)		
0%	0 / 4	(0) / (4)		

Table 3 a

Results of the expertises – comparison between 2002 and 2004: all subjects.

Criterion	2002 study (n = 101)		2004 study (n = 124)		absolute difference (90% CI)	p-value#
	n	(%)	n	(%)		
Subjects with a psychiatric diagnosis affecting their ability to work (capacity to work <100%)	84	(83)	90	(73)	–10 (–19.0 to –1.0)	0.06
Subjects with psychiatric diagnosis resulting in disability (capacity to work ≤60%)	50	(50)	70	(56)	6 (–5.0 to 17.0)	0.30

Chi-Square test, level of significance 0.1

Table 3 b

Results of the expertises – comparison between 2002 and 2004: subjects with a psychiatric diagnosis generally affecting their ability to work (capacity to work <100%).

Criterion	2002 study (n = 84)		2004 study (n = 90)		absolute difference (90% CI)	p-value#
	n	(%)	n	(%)		
Number of psychiatric diagnoses	105		104			
Affective disorder as primary diagnosis	65	(62)	51	(49)	–13 (–24.2 to –1.8)	0.06
Somatoform disorder as primary diagnosis	22	(21)	26	(25)	4 (–5.5 to 13.5)	0.49
Use of specific psychiatric medication reported	42	(50)	67	(74)	24 (12.3 to 35.7)	<0.01
Blood serum concentration of psychiatric medication in the therapeutic range	16 of n = 40 tested	(40)	26 of n = 53 tested	(49)	9 (–8.0 to 26.0)	0.39
Any psychiatric-psychotherapeutic treatment			71	(79)		
Current "psychotherapy" reported	29	(35)	39	(43)	8 (–4.1 to 20.1)	0.24
Psychotherapy in the broadest sense (at least one session per month)			27	(30)		

Chi-Square test, level of significance 0.1

The target of this registration is early examination, diagnosis, treatment and rehabilitation [15]. Social problems are incorporated into the differential diagnosis. In 2004 even fewer subjects than in 2002 could be diagnosed with a psychiatric condition, according to ICD-10. However, among those diagnosed, the conditions were more debilitating. Hence, over the period 2002–2004, in our assessees a tendency was observed that, if someone did in fact receive a psychiatric diagnosis, he was more likely to be suffering from a more serious psychiatric condition and receive better treatment. Several reasons for this can be put forward, such as the increased awareness concerning psychiatric disorders and treatment, a change in behaviour, the change in referral behaviour of the Swiss Invalidity Insurance/cantonal office of Basel, or even coincidence, considering the small number of subjects included in the current study.

Secondly, amongst those with a psychiatric disorder the proportion of subjects who receive psychiatric-psychotherapeutic help in the broadest sense of the term (30%), i.e. at least one psychotherapy session per month, including general practitioners as potential providers, and of those who were sufficiently medicated (37%) are still fairly low. "Psychotherapy" in the strict sense with a higher frequency of sessions (once per week) was not mentioned by any of the patients.

In both studies most of the psychiatric diagnoses were in the group of affective or somatoform disorders, which can be effectively treated with medication and psychotherapy [16–19]. This however, does not seem to be realised or accepted by all physicians and their patients. Thus, education of general practitioners and also other colleagues on special therapies may help them to improve their motivation to refer such patients to psychiatrists for specific psychotherapy and medication. Especially in patients with somatoform disorders, short-term interventions focussing on the perception of feelings and a psychosomatic understanding of illness may influence the motivation for psychotherapeutic treatment positively [20]. Compliance with medication can be influenced by a good doctor-patient relationship, by choosing a medication with high efficacy and lack of side effects and by sufficient information on mechanisms of action [21].

In the 2004 study as compared to the 2002 study, treatment numbers were considerably higher with respect to reported current psychiatric-psychotherapeutic treatment in the broadest sense of the term, use of psychiatric drugs, sufficient dosage of psychiatric drug treatment and psychiatric hospitalisation (table 3). Reasons for this difference might be that in the 2004 study, 26% of the subjects were already receiving a partial or full disability pension, in contrast to 11% in the 2002 study. In several cases, when the pension had been granted some time previously, the cantonal office may have imposed an obligation

for a consequent therapy, which the invalidity pensioner had to prove after a specific time. In addition, knowledge of treatment options has grown among both patients and doctors and public discussion in recent years has heightened awareness of the need for treatment, which may also have played a role. An important finding, however, is that there is still a high proportion of patients without sufficient psychiatric treatment. Similar findings were reported by a Swiss study [22] on 131 severely depressed outpatients with algorithm-guided antidepressant treatment. In this study the dropout rate was 66%, the prevalence of non-compliance, as documented from measured plasma levels, was 23%.

It is an internationally recognized phenomenon that treatment of persons who apply for benefits for psychiatric reasons, tends to be insufficient. In a Norwegian study involving 150 people, who had applied for a disability or war pension on psychiatric grounds, none of the applicants had received prior psychiatric treatment [23]. A Polish study involving 109 subjects, who had requested a disability pension for psychiatric reasons, showed that 28% of these people had had no contact whatsoever with a psychiatrist and only 18% had previously been in a psychiatric clinic [24]. A Finnish study examined 277 subjects who had been granted a disability pension due to depression. Only two thirds of these people had been prescribed medication in an adequate dosage. How many actually took the medication is not known. Only 9% had psychotherapy on a weekly basis [25]. A German study of 30 subjects diagnosed with depression or chronic pain and for whom psychiatric expertises were prepared, showed that blood serum levels of medication were in the therapeutic range in only 30% of the cases and in the vast majority no traces of the drug were detected [26]. A meta-analysis on international research on the prevalence of treatment for depression in the general population revealed a similar trend, independent of requested psychiatric expertises. Of the cases diagnosed with depression, only about one quarter were provided with adequate drug treatment [27].

Even though 74% of our 2004 subjects reported taking specific medication, this could be confirmed in only 37%. We reason that this might be explained by malcompliance [26] or the fact that the patients knew that a specific medication could be important, which led them to falsely report consumption during the expertise. Other possibilities are the prescription of insufficient doses by treating physicians [26]. In individual cases a plasma level below the so-called therapeutic range might have shown a sufficient clinical improvement, as the "therapeutic range" is only a statistical device describing the daily dosage range within which the plasma levels of most patients lie. A clear relationship between plasma concentration and clinical effect has not been established [28, 29]. Finally, some subjects may be fast metabolizers and thus might have blood levels below the therapeutic range. If this is not tested for, they might be wrongly suspected of lack of compliance.

In conclusion, we are far from early diagnosis and treatment. If we want to avoid a further increase of disability pensions with all its negative consequences for society and especially the individuals themselves, physicians should urgently review their referral practice and refer patients with mental problems and/or unexplained somatic complaints to the psychiatrist much more often and much earlier. Regarding the subjects claiming a disability pension without a confirmed psychiatric diagnosis impairing their working capacity, physicians and psychiatrists should become aware of the risk of medicalizing social problems and avoid raising false expectations in their patients. In order to promote mental health and improve working capacity, mental health diagnoses should only be made in subjects actually suffering from such disorders and adequate treatment must be offered to those so diagnosed as early as possible.

We thank Mr Paul Meier, head of the Cantonal Invalidity Insurance office in Basel-Stadt, and his staff for their cooperation and support.

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