using the GHQ-12 and those scoring greater than 2 were then evaluated using the MINI. Following this those interviewed with the MINI were then evaluated by a psychiatrist within a 3-day period.

Results: Out of the total of 126 patients 78 scored greater than 2 on the GHQ-12. The mean age of these 78 patients was 47.8 (SD 16.4), 28.2% were male, 66.7% were married and 25.6% were employed. The diagnoses most frequently found on the MINI were major depression (50%) followed by generalised anxiety disorder (44.9%) and social phobia (17.9%). The most common diagnoses made by the psychiatrist were major depression (21.8%) followed by generalised anxiety disorder (16.7%) and dysthymia (16.7%). The sensitivity and the specificity of the most common diagnoses were major depression 94.1 and 62.2, generalised anxiety disorder 92.3 and 64.6, and social phobia 100 and 84.2 respectively. The positive predictive value and negative predictive for these disorders were as follows: major depression 41.0 and 97.4, generalised anxiety disorder 34.2 and 97.6, and social phobia 14.2 and 100 respectively.

Conclusion: The agreement between the MINI and the psychiatrist's diagnostic judgement may be considered as acceptable for the most prevalent disorders at the level of primary health care.

SEC55-3

THE MIND: AN UPDATE ON RATING SCALES FOR THE MINI COMPENDIUM

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During the 1970's the diagnostic criteria for mental disorders changed from an etiological principle (e.g. endogenous versus reactive depression) to a symptom-based principle. Thus, the Feighner criteria (Feighner et al 1972) introduced the screening diagnosis of mental disorders based on symptoms alone. A few years later the Research Diagnostic Criteria (Spitzer et al 1978) were released, which provided the foundation for the third edition of the Diagnostic and Statistical Manual for Mental Disorders (DSM-III, APA 1980). At the beginning of the 1990's the World Health Organization accepted the DSM-III principle when the tenth revision of the International Classification of Disease (ICD-10) was released (WHO 1993). However, both ICD-10 and DSM-IV (APA 1994) are still separated classification systems for mental disorders.

The MINI (International Neuropsychiatric Interview) developed by Sheehan and Lecrubier (1994) has both a DSM-IV and an ICD-10 version. The MINI was designed as a very brief structured interview for mental disorders to be used by clinicians after a brief training session. The MINI is mainly a tool for psychiatrists analogue to the PRIME-MD developed by Spitzer et al (1994) for general practitioners.

The objective of the MIND has been to offer quantitative assessments of mental disorders from DSM-IV or ICD-10 following as close as possible the MINI. The scales are all designed for clinicians (psychiatrists, psychologists, physicians as well as family doctors). The reference to DSM-IV or ICD-10 has been essential for the scale collection. It should be emphasized that this collection of rating scales is no attempt to replace MINI, DSM-IV nor ICD-10. The MIND is a collection of rating scales with a content validity equal to DSM-IV or ICD-10 but with a quantitative objective, e.g. to measure outcome of neuropsychiatric therapies.

SEC55-4

PRIME-MD: THE ICD-10 VERSION

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Aim of Study: To validate the Primary Care Evaluation of Mental Disorders (Prime-MD) diagnoses against ICD-10 diagnoses made by The Schedules for Clinical Assessment in Neuropsychiatry (SCAN) in patients commonly seen in primary care.

Methods: Current diagnoses were assessed by the Prime-MD and SCAN interviews in 36 women with somatoform disorders (fibromyalgia or functional dyspepsia) and 33 female random sample controls.

Results: Agreement and sensitivity showed great variability among the different diagnostic groups with highest degree of agreement and sensitivity for somatoform disorders and depressive disorder. Agreement and sensitivity was low for anxiety disorders (sensitivity = 0.36). Overall sensitivity for any psychiatric diagnosis was 0.41, specificity was 0.89. Specificity was high for all diagnostic categories and overall efficiency was good.

Comments: The validity of Prime-MD diagnoses in this population was good for depressive disorders, but not for anxiety disorders. This was mainly due to low sensitivity and might be related to the high prevalence of non fearful panic and somatized anxiety in this special population.

SEC55-5

PRIME-MD: FROM DSM-IV TO ICD-10

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It is well documented that primary care physicians constitute a low threshold service for patients suffering from mental disorders. For instance, panic disorder has a life time prevalence between 1 and 3% in the general population, but 7% of all patients attending general practitioners suffer from panic disorder, and some studies show that among frequent attendees of GPs the prevalence of panic disorder is over 20%. Yet knowledge and skills for recognising and treating mental disorders are not well developed in primary care and many patients suffering from depression, anxiety disorders and substance abuse remain undiagnosed - and therefore untreated. PRIME-MD (= Primary Care Evaluation of Mental Disorders) is a structured tool, tailored to assist the busy general practitioner in recognising the most common mental disorders among patients attending their surgery. After a short training period most GPs can use PRIME-MD reliably. It takes between 8 to 10 minutes to arrive at a diagnosis. The presently available DSM-IV version covers 5 diagnostic groups: major depression, anxiety disorders (panic disorder and generalised anxiety disorder), alcohol abuse, eating disorders and somatoform disorder. The system consists of a one page screen form, which the patient may fill in as a self-assessment device (but which can alternatively be used in the form of assisted self-rating). It takes 3 minutes on average to apply this screening sheet. In a second step, the GP carries out a short structured interview covering only those modules, which get a positive rating in the screening questionnaire. This interview takes around 5–8 minutes, depending on the number of suspected disorders. The application of PRIME-MD to 1000 GP patients in the US has shown that it is feasible to use the instrument in routine work and that it is valid when compared to diagnoses made by mental health

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