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Needs assessment in mental health care in general practice

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Edith Cowan University

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INTRODUCTION

Current practices in mental health care among general practitioners (GPs) servicing part of the rural South West region of Western Australia were ascertained in a survey on psychosocial morbidity in rural general practice (Aoun et al 1995a,b). The survey identified the patient and illness profiles and the patterns of treatment and referral to mental health services.

The preponderance of female patients with psycho-social problems (3:1) in this survey and the under-representation of adolescents and youth raised the implication of high-risk groups in general practice. Over three-fifths of all cases were diagnosed with neurotic conditions. The majority of patients complained of feeling anxious/nervous or depressed/hopeless and half of these conditions were chronic. Relationship difficulties with partners or with other members of the family were the most frequently reported social problems the GPs were dealing with (45%). The treatment in the form of advice and reassurance (for three-quarters of the patients) had played a part at least as important as that of psychotropic medication (for half of the patients). Although one in four patients were referred to the local mental health services, this did not reflect the compliant proportions of patients nor the level of support provided to GPs by these services.

Similar evidence from other surveys that patients with psychosocial problems consult more frequently than other types of patients (Shepherd 1979), take up more time for consultations (Verhaak & Tijhuis 1992), half of their illnesses are chronic (Cooper et al 1969, Mann et al 1981) and that 75% of them are treated by the GPs (Andrews 1995), concentrates the bulk of psychosocial disorder in general practice. Against this background of information it is clear that any improvement in the delivery of mental health services cannot be achieved without enhancing and supporting the central role of the GP in primary mental health care.

Several needs analysis surveys have highlighted the requirement of GP "upskilling" in this field (Donovan 1995). In fact, Joukamaa et al (1995) reported that the ability

of general practitioners to detect mental disorders in primary health care is more associated with further psychiatric training, than with any other GP characteristic. Recognising and treating psychological problems and providing supportive counselling were identified as high priorities for continuing medical education, in the Swan Hills division of general practice (1996). However, counselling & mental health services were ranked the lowest by the GPs in terms of the level of inter-professional communication and service delivery. In a similar study conducted in the Fremantle division of general practice (1994), over half of the GPs also indicated a poor professional communication with counselling services. However, three quarters of the GPs perceived that they will be required themselves to deliver a more counselling role in the near future.

The objective of this needs analysis is to explore the educational and training needs of general practitioners in specified areas of mental health. This would serve as a basis for the local Division of General Practice to plan any future programs tailored to the local needs.

METHOD

This needs assessment survey was undertaken in the rural South West region of Western Australia, namely in Bunbury, Busselton, Harvey and Collie. All of the 55 GPs servicing these areas were asked to participate in November 1995, by completing a questionnaire and returning it in a reply-paid envelope. It was this same group of GPs who took part earlier in the psychosocial morbidity survey in rural general practice (Aoun et al 1995a,b), to ascertain their current practices.

The questionnaire used was adapted from a similar study conducted in New South Wales on a sample of 534 GPs (Phongsavan 1995). The GPs were asked:

- To rank their level of interest in improving five approaches to the management of nine psychosocial problems. This was ranked on a scale of 1 to 5, with 1 representing the approach GPs were most interested in improving and 5 that with

the least interest. Analysis of ranks was done using the Kendall coefficient of concordance, W.

- To state factors which prevent them from referring patients to mental health services.
- To report on the perceived difficulty in detecting and treating mental health problems in different groups of the population.
- To state their opinion about attitudes towards mental health care in general practice.
- To rate the usefulness of eight educational strategies to provide better mental health care.
- To indicate their priority among potential topics for further mental health training.
- To identify the most preferred format of any training program and the preferred expert teachers in the field of mental health.

RESULTS

The participation rate of GPs was 56.4% as 31 of them responded. 83% were men and 17% were women. The mean age was 47.6 years (SD=11.3 years) and the mean time in general practice was 18.7 years (SD=11.2 years). 58.1% of responding GPs were from Bunbury, 19.4% from Busselton, 16.1% from Collie and 6.5% from Harvey.

GPs were most interested in improving their supportive counselling approach particularly for family/relationship problems, social/economic problems, addictive and sexual problems (Table 1). Similarly, improving diagnosis and assessment scored a good ranking for all problems, especially for psychosomatic problems. The referral process to mental health services needed particular improvement for sexual abuse, suicide attempts and the major psychiatric problems. Prescribing medication was of least concern with the exception of the major psychiatric disorders.

Factors which were regarded as barriers to mental health services consisted of difficult communication, long waiting lists, a shortage of services and the patient's

stigma in consulting other professionals (Table 2). A third of the GPs experienced communication difficulties with mental health specialists. Nearly two thirds regarded the waiting lists for community mental health services too long. A half to two thirds of GPs felt that their patients were often uncomfortable about consulting mental health specialists or psychiatrists respectively. The majority (84%) expressed the need for more local mental health services.

Over 80% of GPs found it moderately to very difficult to detect and manage the mental health problems of Aboriginals, migrants, adolescents and children under 12. Over half of the GPs had difficulties with youth. Men patients were more difficult to manage than women patients (61.3% vs 35.5%). The terminally ill and people over 65 years were the easiest to manage (Table 3).

While two thirds of GPs felt that they had very little time to spend on counselling their patients, all of them agreed that the diagnosis and management of mental health problems were part of their job. Also, nearly all of them believed that they should develop the necessary skills to deal with mental health problems (Table 4). However, only 43% of GPs have participated in a mental health related program in the last 5 years, mainly talks sponsored by medical companies.

Medium to high priority for further mental health training were assigned, by over 80% of GPs, to suicide prevention, crisis, individual and family counselling. Also, between 70% and 80% of GPs rated the following as potential topics for continuing education programs: supportive psychotherapy, strategies to prevent GP burn out, managing post-natal depression, cognitive-behaviour therapy, parenting and marital counselling and psychopharmacology (Table 5).

80% of GPs perceived that more opportunities for discussion with mental health specialists would help them quite a bit or a great deal to improve mental health care of their patients. This was followed by more continuing education programs (77.4%), on-the-job training supervised by a mental health specialist (73.3%) and better remuneration for counselling patients (71.0%). Also, 58% of GPs regarded

that more up to date and comprehensive information about local mental health services would be helpful (Table 6).

The most preferred format of any training or education program in mental health was a once-a-month session (1 to 3 hours) in the evening of a week day. The second preferred format was a whole day workshop on a weekend, 4-6 times a year.

Expert teachers in the field of mental health were nominated by only 10 GPs (32%). The most frequently nominated teachers were psychiatrists and psychologists followed by trained counsellors and psychiatric nurses.

Some of the GPs made additional general comments or suggestions to improve the mental health care service locally. These were:

- An extended hour service for the mental health services with an immediate access for crisis.
- More child and adolescent health services to deal with childhood behavioural disorders.
- Support for eating disorders, anorexia and bulimia.
- Programs to stop binge drinking in youth and substance abuse.
- Programs in schools to build self-esteem.
- More groups for stress/relaxation.
- Better liaison with mental health specialists. Lack of coordination of services is a problem.
- To attract psychiatrists to the area.

DISCUSSION & RECOMMENDATIONS

The results from this study are remarkably similar to those of the New South Wales study (Phongsavan 1995), considering the vast difference in the sample size (31 GPs vs 534 GPs respectively).

The unmet educational needs

The educational needs of the GPs that are a common priority between this study and the New South Wales study, consist of 5 types of counselling: Crisis, individual, family, marital, parenting, and supportive psychotherapy. This possibly reflects the lack of any formal training for these skills in the medical education system in general. In fact, most of the GPs agree that they are better qualified in the management of the physical disease than that of mental health problems (Table 4). However, more important is the awareness of the GPs that they need to acquire these skills to fulfill an unmet need in the community. Very often patients who benefit from such skills face a gap in the service because of restrictive selection criteria of the mental health services. These are often dictated by costs restraints. Similarly the management approach that the GPs are most interested in improving is the supportive counselling ranging from emotional, psychosomatic, relationship problems to addictive and sexual problems. However, strategies to prevent GP burn out are just as important if the GPs are to take on a more counselling role in the future.

More continuing education programs and better remuneration for counselling patients were two strategies cited by the GPs for improving mental health care, that are common to the two studies. However, local GPs are much more interested in opportunities for discussion with mental health specialists and on-the-job training supervised by a mental health specialist. This is probably a reflection of the rural isolation and lack of exposure and support of the local GPs in this field. The GPs agreed on the most preferred format of sessions for continuing education programs and named some preferred teachers in the field, namely ones that they have been exposed to. However, their main concern was that some specialists were sometimes unaware of the type of patients seen in non-specialist practice.

Special needs groups

The varying degrees of difficulty in managing mental health problems of different groups in the community highlight three points:

- Twice as many GPs found it easier to detect and manage mental health problems in women compared to men. This is a further emphasis that the over-representation of female patients in general practice surveys (eg. 75% of the sample in Aoun et al, 1995b) is not an indication that males suffer less from psycho-social problems, but rather that females are more likely than males to have their illnesses identified by their GPs (Marks et al 1979). Therefore, particular attention needs to be given to this "negative" stereotype in general practice. Blacker & Clare (1987) have pointed out that the predominance of men in substance abuse and personality disorders is just a different way of expressing their depression.

- Adolescents and youth whose problems are perceived difficult to detect and manage in general practice, are a high risk group for suicide. Yet a lot of potential suicide is missed in general practice as reported by Silburn et al (1991) in Perth and by Hawton et al (1982), and Barraclough et al (1974). These studies have shown that many cases who committed suicide, have contacted their family physician shortly before death. The Health Dept of WA (1994) has called for GP-based interventions to reduce this risk by improving the effectiveness of the GP in the early detection, assessment and management of people who are at risk of suicide. Local GPs are aware of this need as 90% of them indicated that suicide prevention is a medium to high priority for further mental health training (Table 5). Videos, manuals and information for GPs in suicide prevention have already been developed and used (Commonwealth Dept of Human Services and Health 1995).

- Aboriginals were perceived as the most difficult group to manage by 85% of GPs in this study, compared to a third of GPs in the New South Wales study. Migrants followed next. This highlights the need for cross-cultural training and how it could impact on the health status of the local Aboriginal and migrant communities, when some of the cultural barriers are overcome.

Development of closer working relationships between GPs and other mental health specialists

The perception of GPs that patients are often uncomfortable about consulting psychiatrists and mental health specialists is comparable in the two studies. It is supported by the fact that some patients refused to be referred in the study by Aoun et al (1995b). This further emphasises that the bulk of psychosocial disorder will continue to be treated in general practice, awaiting for more community programs to de-stigmatise the referral process.

The poor communication with mental health specialists is a concern for the GPs in this study, the New South Wales study (1995), and the Swan Hills and Fremantle divisions of general practice (mentioned in the introduction). While the lack of services and long waiting lists were the most important complaints, the communication difficulty is probably the only barrier that can be improved in the short term.

A proposed strategy is to open up channels of communication between GPs and other professionals by bringing them together to seminars to discuss common case studies. Some of the continuing education programs could be addressed by local professionals in their own areas of expertise eg. marriage guidance, domestic violence, alcohol and drug abuse, suicide prevention, etc. This would create more opportunities for discussion between GPs and mental health specialists, a strategy supported by 80% of the GPs (Table 6).

The Geelong Division of General Practice (1995) has successfully conducted such seminars, attended by general practitioners and by members of the psychiatric services, private, public and voluntary organisations. These seminars provided a fertile ground for interaction between the various professionals in mental health.

CONCLUSION

The perceived need of GPs (in this study and other mentioned studies) to acquire or improve their counselling skills, seems to stem from a combination of factors. If these factors are dealt with, this need would not probably be as pronounced: The shortage of mental health services to meet the demand, which ultimately falls back into general practice; the patients who are uncomfortable about being referred; the difficulties in the inter-professional communication with other mental health specialists.

While on the short term, the GPs could ease off some of the pressure by acquiring these skills, the practicality of applying them within the time constraints of general practice, particularly rural practice, and the inadequate remuneration, might be a disincentive on the long-term.

Nevertheless, acquiring these skills is a much needed frontline measure, until other services take on a bigger share of the unmet need in the community, and therefore the unmet support for GPs. It is then that the GPs are able to concentrate on their important and major role of early detection and intervention in mental health problems, with focus on the high-risk groups. No other health professional is in a position to fulfil this role as the GP is.

Table 1: The mean rank of approaches in mental health care (the lowest the rank, the more interested GPs are in improving the approach.)

Approaches / Problems	Diagnoses/ assessment skills	Prescribing medication	Conducting cognitive-behaviour therapy, eg relaxation, stress management	Conducting supportive counselling	The referral process to mental health services	W *	P
Emotional/psychological problems (eg anxiety, depression, bereavement)	2.62	3.67	2.40	2.21	4.10	0.30	0.00
Psychosomatic problems (eg insomnia, headache)	2.22	3.50	2.54	2.50	4.24	0.30	0.00
Family/relationship problems (eg marital, children's behavioural problems)	2.66	4.30	2.88	1.84	3.32	0.34	0.00
Social/economic problems (eg money, retirement, unemployment, housing)	2.69	4.26	2.81	1.59	3.65	0.43	0.00
Addictive problems (eg sedatives, alcohol, cigarette smoking)	3.02	3.96	2.44	2.04	3.54	0.26	0.00
Sexual problems	2.26	4.22	2.78	2.15	3.59	0.34	0.00
Sexual abuse	2.50	4.52	3.09	2.15	2.74	0.36	0.00
Suicide attempts or tendencies	2.94	4.00	3.09	2.54	2.43	0.17	0.00
Major psychiatric problems (eg dementia, schizophrenia)	2.28	2.56	3.98	4.00	2.19	0.37	0.00

* W is the Kendall coefficient of concordance.

Table 2: The factors preventing GPs from referring to mental health services (percent).

	Yes	No
Communication difficulties between mental health specialists and myself	32.3	62.7
Waiting lists for community mental health services are too long	63.3	36.7
I am unaware of local mental health services	6.5	93.5
There are not enough local mental health services	83.9	16.1
Patients are often uncomfortable about consulting psychiatrists	64.5	35.5
Patients are often uncomfortable about consulting other mental health specialists	54.8	45.2

Table 3: Current levels of confidence in treating mental health problems in 10 special needs groups (percent).

	Not at all Difficult	A little Difficult	Moderately Difficult	Very Difficult
Women	22.6	41.9	35.5	-
Men	6.5	32.3	45.2	16.1
Adolescents	3.2	12.9	41.9	41.9
Children under 12	-	17.2	41.4	41.4
Youth (18-24)	10.0	33.3	33.3	23.3
People over 65	20.0	46.3	33.3	-
Migrants	-	17.9	39.3	42.9
Aboriginals	-	15.4	30.8	53.8
Chronically ill	16.1	41.9	32.3	9.7
Terminally ill	16.7	56.7	20.0	6.7

Table 4: GPs attitudes towards mental health care in their practice (percent).

	Agree	Disagree
I have very little time to spend on counselling my patients	66.7	33.3
I am better qualified in the management of physical disease than in the management of mental health problems	61.3	38.7
Mental health problems are difficult to treat in general practice	38.7	61.3
Treating patients with mental health problems is time consuming	100.0	-
The diagnosis of mental health problems is part of my job	100.0	-
The management of mental health problems is part of my job	96.7	3.3
I have found that counselling patients is usually ineffective	6.7	93.3
I believe GPs should develop the necessary skills to deal with mental health problems	96.8	3.2
I believe patients do not want GPs asking them about their mental health problems	10.0	90.0
People with mental health problems are more likely to follow the advice of a counsellor than that of a GP	14.8	85.2
I get job satisfaction from counselling my patients	83.9	16.1
I feel comfortable discussing a patient's mental health problems with him/her	90.3	9.7
I am worried about being accused of 'overservicing' if I charge too many Level C, or long, consultations for counselling services	23.3	76.7

Table 5: The perceived helpfulness of potential topics for continuing education programs (percent).

	Low Priority	Medium Priority	High Priority
Psychosocial assessment	45.2	38.7	16.1
Psychological theories	74.2	22.6	3.2
Supportive psychotherapy	22.6	45.2	32.3
Brief dynamic psychotherapy	32.3	41.9	25.8
Cognitive-behaviour therapy	25.8	48.4	25.8
Psychopharmacology	29.0	45.2	25.8
Crisis counselling	12.9	45.2	41.9
Individual counselling	16.1	48.4	35.5
Family counselling	16.1	48.4	35.5
Marital counselling	29.0	38.7	32.3
Parenting counselling	25.8	51.6	22.6
Strategies to prevent GP 'burn-out'	23.3	40.0	36.7
Other more specific issues: such as:			
Suicide prevention	9.7	54.8	33.5
Managing post-natal depression	25.8	45.2	29.0
Obsessive-compulsive disorder	41.9	38.7	19.4

Table 6: The perceived usefulness of eight educational strategies to provide better mental health care (percent).

	Not at all	A little	Quite a bit	A great deal
More opportunities for discussion with mental health specialists	-	20.0	43.3	36.7
On-the-job training supervised by a GP experienced in the management of mental health problems	13.3	36.7	43.3	6.7
On-the-job training supervised by a mental health specialist	3.3	23.3	63.3	10.0
Better access to information (eg printed, audiovisual materials) on how to deal with mental health problems	12.9	54.8	29.0	3.2
Better access to scientific information concerning mental health care	19.4	61.3	19.4	-
More up-to-date and comprehensive information about local mental health services	9.7	32.3	38.7	19.4
More continuing education programs	-	22.6	64.5	12.9
Better remuneration for counselling patients	6.5	22.6	32.3	38.7

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