The management of mental disorders:

A small sample of Auckland based general practitioners

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ABSTRACT

Background

With the trend toward increased numbers of psychiatric patients being treated by primary care physicians, it is understandable that concerns exist about general practitioner (GP) confidence and skill levels in recognising and treating psychiatric disorders in their patient population. The aim of this paper is to report and discuss results of a small pilot sample of Auckland-based GPs involved in the development and piloting of the Attitudes, Reported Confidence and Behaviour Questionnaire (ARCBQ).

Methods

The questionnaire was distributed to a convenience sample of 43 GPs working in the Auckland area.

Results

There was a high use of non-standardised diagnostic criteria for detecting psychiatric disorders as 36% of the GPs were using their own classifications. Twenty-three per cent of GPs were 'very confident' in prescribing antidepressants, however none reported feeling 'very confident' in prescribing antipsychotic medication (p=0.005). Also, 51% felt skilled or very skilled at counselling. Clinical colleagues were the major information source when encountering difficult clinical questions. Eighty-one per cent reported formal CME programmes as being most effective in keeping up-to-date with psychiatric literature. GPs reported reading twice as many articles on psychiatric illness compared to other physical illnesses. Depression, anxiety and alcohol/drug issues were those most likely to be pursued by GPs for their own reading.

Conclusions

The ARCBQ raises a number of issues that may require further investigation. These include: appropriate diagnostic criteria for general practice, clarification of GP confidence in initiating and maintaining antipsychotics and the role of GPs and mental health specialists in the management of mental disorders. There may also be scope for the teaching of brief interventions such as problem-solving to GPs.

Key words

Knowledge, attitudes, general practice, mental health.

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Introduction

In an effort to control the costs of mental health care, many medical care systems have emphasised the management of psychiatric illness by primary care physicians and curtailed specialty mental health referrals. While this trend mandates that primary care physicians have expertise in the diagnoses and treatment of psychiatric disorders, evidence indicates that not only are psychiatric disorders under recognised in primary care settings, but also that treatment is often inadequate and accompanied by less than optimal outcomes.[1–5] However, studies in both New Zealand and Australia challenge the view that lack of recognition and treatment is primarily the fault of the GP, instead they have reported a range of patient, doctor and service factors contributing to the ongoing problems of under recognition and under treatment of mental disorders in primary care.[6–9] Nevertheless the reality is that most people with psychiatric disorders present in

primary care, although many are not diagnosed or treated.

Given the high rates of psychiatric illness in the primary care setting[10–14] and reported low rates of recognition and sub optimal treatment[15–17] along with the relationship of psychiatric illness to disability, it is important that training about common mental disorders and their management is emphasised both within medical schools and in vocational training schemes for GPs, as most disorders will continue to be managed entirely within primary care.

There are numerous factors that contribute to the lack of recognition and appropriate diagnosis of psychiatric disorders by GPs. GPs vary in competencies, skills, communication skills, knowledge base, time and attitudes about their patients, and about symptoms.[18,19] There are also differences in the type of patients who present to a GP, which is important because research suggests that patients with major depressive disorders in primary care have different aetiology, pathophysiology and natural history than those of psychiatric inpatients or outpatients.[20,21] Often, depressed primary care patients present with somatic complaints rather than describing non-somatic symptoms.

In order to provide good primary care training in the mental health area, greater understanding is required about how GPs really see themselves, their clinics, their patients, and the management of psychiatric patients.

We believe that strategies for increasing the frequency and accuracy with which GPs diagnose psychiatric illness are best designed within an educational framework specifically tailored to GP needs. Such a framework should include elements of knowledge relevant to managing mental disorders in general practice, interviewing skills and clinical decision-making processes.

The amount of available educational time in training programmes to prepare primary care physicians for this task is limited and competes with other areas of medicine for teaching time. Therefore, it is essential to specifically identify and prioritise the major areas of focus for the psychiatric education of primary care physicians.

In response to this we developed a questionnaire to:

1. explore current practice, GP perceived confidence, attitudes and skill level in the management of mental disorders in general practice, and
2. identify and prioritise the major areas of focus for mental health education of GPs.

The aim of this paper is to report the pilot results of a small sample of Auckland-based GPs involved in the development and piloting of the ARCBQ.[22]

Method

Participants

Forty-three GPs in the Auckland region completed the ARCBQ.

Design

GPs involved in this pilot study were selected from three samples of convenience from the Auckland area. Twenty-two GPs involved in a share-care programme were invited to complete the ARCBQ. A further eight GPs attending a continuing medical education course were asked to completed the ARCBQ, and finally 13 GPs already involved in another study with researchers were invited to complete the ARCBQ. A total of 43 GPs completed the ARCBQ. For the purpose of this study, data collected from all three groups were pooled, analysed and written up as one group.

Instruments

The general practitioner attitudes, reported confidence and behaviour questionnaire (ARCBQ) was developed between 1999 and 2003. The final version of the ARCBQ contained 46 questions. Questionnaire development and reliability and validity issues have been reported previously.[22]

Results

Practice site characteristics

All forty-three GPs from the Auckland area who were asked to complete the questionnaire responded. All of the GPs worked full-time and 39 of the 43 were members of an IPA.[a] The average age of GPs was 45 years (ranging from 34 through to 73 years); 25 were male and 18 female. On average the GPs in this study had been practising for 22 years, 54% (n=23) in either solo or partnership practices and 42% (n=18) in a group or medical centre.

Twenty-two (51%) of the GPs reported having a special interest in mental health issues, 11 (27%) GPs stated that they had received previous mental health training but it is unclear as to whether this included training at medical school. GPs recorded 21 minutes as the average consultation time for a new patient visit, and 14 minutes for a follow-up visit.

GPs reported seeing on average 115 patients per week, of which 13 (11%) were estimated to be patients with psychiatric disorders.

All but one clinic had access to a computer. Sixteen GPs – 44% (n=19) – had access to e-mail in their clinic and 40% (n=14) had access to the internet.

Forty-one GPs (95%) used specialised computer software, the two most commonly used software packages were 'Medtech' and 'GP Dat'. Confusion was apparent among this sample of GPs regarding the 'expert system', which is especially helpful in diagnosing and assessing potential psychiatric patients, embedded within some of the specialised software packages. Those GPs who reported having an expert system reported never or only occasionally using it. GPs in this sample reported that in many cases no formal software training was offered to them.

Diagnostic criteria

The use of diagnostic criteria varied amongst GPs. Seventeen (40%) reported using various versions of DSM[b]

a. Independent Practitioner Association (IPA): This is a voluntary ad hoc collection of GPs who come together to provide share management of resources and contracting with funding organisations

alone and 9% (n=4) used ICD-10[c] alone. Fifteen (36%) reported using their own experience or impression, five were unable to answer (put a question mark next to the question) and two reported using no specific criteria.

GPs' own assessment of confidence

In identifying and recognising psychiatric disorders in their patients, 14% of GPs rated themselves 'very confident'. Only one GP rated him/herself confident in making assessments and appropriately categorising psychiatric disorders (see Table 1). A marginal significant difference was found using Fisher's exact test, between GP confidence in identifying and recognising psychiatric disorders and making assessments and categorising psychiatric disorders (p=0.055).

GPs were asked to rate how confident they felt in prescribing different types of medication specific to psychiatric disorders. Twenty-three per cent reported feeling 'very confident' in prescribing antidepressants. No GPs felt 'very confident' in prescribing antipsychotics (see Table 2). Significant differences were found using Fisher's exact test, between GP confidence in using antidepressants and antipsychotics (p=0.0005).

GP self-assessment of skills level

GPs were asked to rate their skills in four areas:

1. providing counselling and education
2. providing a diagnosis
3. providing medication, and
4. making referrals.

Over 80% of GPs felt 'lightly' to 'somewhat' skilled in providing counselling, education, medication and making a diagnosis in their patient population. Seventy-four per cent reported being 'somewhat skilled to very skilled' in making referrals (see Table 3).

GPs were asked whether they thought they needed to improve the way they evaluated and managed their patients. Eleven (28%) felt they 'definitely' needed to improve, 20 (47%) felt they 'probably' needed to improve and nine (21%) felt 'maybe' they needed to improve; two did not answer.

Table 1. GP self-reported confidence in identifying/recognising and making assessments/categorising psychiatric disorders

	Identifying & recognising psychiatric disorders	Assessments and categorising of psychiatric disorders
Not confident		2 (5%)
Slightly confident	6 (14%)	10 (23%)
Somewhat confident	31 (72%)	30 (70%)
Very confident	6 (14%)	1 (2%)
Missing	0	0
TOTAL	**43**	**43**

Table 2. Confidence in prescribing medication for psychiatric disorders

	Antidepressants	Antipsychotics
Not confident		14 (32%)
Slightly confident	4 (9%)	19 (44%)
Somewhat confident	29 (67%)	10 (23%)
Very confident	10 (23%)*	0
Missing	0	0
TOTAL	**43**	**43**

*p = 0.0005

Table 3. Skill in providing psychiatric treatments

	Providing counselling/ education	Providing a diagnosis	Providing medication	Making referrals
Not skilled	4 (9%)		1 (2%)	
Lightly skilled	17 (40%)	13 (30%)	16 (37%)	5 (11%)
Somewhat skilled	19 (44%)	29 (67%)	25 (58%)	27 (63%)
Very skilled	3 (7%)	1 (2%)	1 (2%)	11 (26%)
Missing	0	0	0	0
TOTAL	**43**	**43**	**43**	**43**

Prescribing practices

The GPs were asked to estimate the percentage of different types of treatments used in a typical month for their depressed patients. Factors such as: prescribing different medication (tricyclic antidepressants, selective serotonin reuptake inhibitors (SSRIs), anxiolytics/sedatives) counselling and education, referrals to a mental health specialist and scheduled follow-up visits without starting treatment were rated by GPs. In an average month SSRIs and counselling were more likely to be provided by GPs for depressed patients than other types of medication, referrals or scheduling a follow-up visit without starting treatment.

b. Diagnostic and Statistical Manual of American Psychiatric Association (DSM)
c. International Classification of Disease number 10 (ICD-10)

Table 4. GP prescribing practices for severe psychotic disorders at least once in a typical month

Prescribing practices in a typical month	Antipsychotic	Atypical generation	Mood stabiliser	Personal counselling	Refer to MH specialist before treating	Follow-up
None 0%	21 (49%)	29 (67%)	21 (49%)	11 (26%)	1 (2%)	25 (58%)
25% or less	17 (40%)	8 (19%)	14 (33%)	17 (40%)	14 (33%)	11 (26%)
26–50%	1 (2%)	3 (7%)	2 (5%)	4 (9%)	7 (16%)	2 (5%)
51–75%	1 (2%)	1 (2%)	4 (9%)	7 (16%)	5 (12%)	2 (5%)
76–100%				3 (7%)	16 (37%)*	1 (2%)
Missing	3	2	1	1		1
TOTAL	**43**	**43**	**43**	**43**	**43**	**43**

* p=0.00001

Similarly, the GPs were asked to estimate the percentage of different types of treatments used in a typical month for psychotic disorders in their patients. Factors such as: medication (antipsychotics,[d] atypical generation antipsychotics,[e] mood stabilisers[f]), counselling and education, referrals to a mental health specialist and scheduled follow-up visits without starting treatment were rated by GPs (see Table 4). For more severe psychotic disorders GPs are more likely to refer patients to a mental health specialist and less likely to prescribe medication, provide personal counselling or schedule follow-up without starting treatment. A significant difference was found between GP antipsychotic prescribing practice and making referrals to mental health specialists (p=0.00001).

GP learning strategies

When clinicians encountered a problem that they could not answer, the sources of information they relied on were mainly reported to be discussions with colleagues. Thirty-seven GPs (95%) reported using their clinical colleagues in conjunction with medical textbooks (56%), continuing medical education (CME) courses (61%) and reviewing articles in journals (44%) – see Table 5.

Table 5. Reported resources used by GPs when encountering a problem.

	GP reported use %	GP reported use N
Discussion with colleagues	95	41
Review articles in journals	44	19
Medical textbooks	56	24
CME courses	61	26
Computer aided literature searches	19	8
Pocket notes	7	3
Other	7	3
Clinical practice guidelines	33	14
Missing		1
TOTAL	**100**	**43**

GPs were asked about types of strategies that they see as most effective in keeping up-to-date with the management of psychiatric disorders. Eighty-one per cent of GPs reported formal CME programmes as being most effective, 63% considered that education materials and 47% that academic detailing were effective in keeping them up to date (see Table 6).

Continuing Medical Education courses

Twenty-four GPs reported participating in a CME course specifically for the care of patients with psychiatric disorders. A mean of 11 hours in the last six months was reported to be spent on CME for each of the 24 GPs.

Thirty-three GPs reported reading an average of seven articles about psychiatric disorders, four articles on diabetes, three on hypertension and two articles on arthritis in the last six months.

Of the articles read on psychiatric disorders, topics covered by GPs were schizophrenia, bipolar affective disorder, depression, anxiety, eating disorders, drug/alcohol, gambling, attention deficit disorder and youth suicide. The most popular topic was depression (n=19) followed by drug and alcohol (n=14) and anxiety disorders (n=13).

d. Chlorpromazine, Haloperidol, Fluphenazine
e. Risperidone or Olanzapine
f. Lithium, Sodium Valproate, Carbamazepine

Sixty per cent of GPs reported being visited by a pharmaceutical representative in the last six months. Information provided to GPs by the pharmaceutical representatives was reported to be on psychiatric disorders, diabetes, hypertension, and arthritis. Twenty-three GPs reported being visited by a pharmaceutical representative about diabetes, 28 for hypertension, and 27 for arthritis and psychiatric disorders. GPs reported being visited approximately twice in the previous six months for psychiatric disorders and diabetes, and four visits for hypertension and arthritis in the last six months. The pharmaceutical representative visits for psychiatric disorders were targeted to two main areas, depression and anxiety.

Overall, 74% of GPs reported speaking to a specialist about the treatment of their patient suffering from diabetes, hypertension, arthritis, or psychiatric disorder. Thirty-seven GPs reported speaking to a psychiatric specialist on average 11 times a year. Other specialists were consulted about diabetes six times a year, hypertension and arthritis four times a year. Discussion involving a psychiatric specialist was reported to be about anxiety, depression, drug/alcohol abuse, schizophrenia, bipolar affective disorder and anorexia.

When GPs were asked about their preference on dissemination of CME material, formal CME programmes were reported to be the most desirable (see Table 7).

Table 6. Effective strategies to keep up-to-date reported by GPs

	GP reported use %	GP reported use N
Formal CME programmes	81	35
Educational material	63	27
Academic detailing[g]	47	20
Guidelines	37	16
Reminders[h]	21	9
Audit and feedback[i]	19	8
Other	16	7
TOTAL	**100**	**43**

Table 7. Dissemination of CME material reported by GPs

	GP reported use %	GP reported use N
Via post	30	13
Academic detailer	28	12
CME via internet website	26	11
Reminders	23	10
Formal CME programmes	58	25
Other	9	4
Missing		2
TOTAL	**100**	**43**

Perceived barriers to care

GPs reported factors such as patients or family reluctance to accept diagnosis or treatment, medical problems being more pressing, and mental health professionals not being available, as being 'somewhat limiting' to recognising or providing optimal treatment for patients with psychiatric disorders. Resource issues such as 'limited consultation time for counselling and education', 'inadequate time to provide follow-up' and 'poor reimbursement or lack of patient insurance' were seen to 'limit a great deal' clinicians' ability to recognise and provide optimal treatment for psychiatric patients in their practice.

Discussion

The questionnaire was designed to assess GP attitudes in the management of patients with psychiatric disorders. The researchers acknowledge that the small convenience sample of GPs used in this study is a limiting factor, however the aim of the pilot study was not to generalise the findings of this study to represent all GPs. Instead the intention was to assist in the development and testing of the validity and internal consistency of the ARCBQ and to argue its usefulness for future large scale surveys of this kind. Nevertheless, even in this small sample, statistically significant findings were found suggesting that there are some areas that may be a concern for GPs. These include the relationship between experience in psychiatry and the ability to meet mental health needs in general practice, the use of diagnostic criteria for psychiatric disorders in primary care, GP perceived confidence and actual confidence in recognising and treating psychiatric disorders and time and cost issues acting as barriers to providing optimal treatment for primary care patients.

g. One on one visit by a professional educator to provide information to practitioners
h. Brief notes embedded in computer information systems or prompt cards to remind clinicians of information and/or desired actions
i. Review of the performance of a health care provider and the provision of this information to the provider

Another methodological limitation that deserves consideration is that the results reported in this study reflect GPs' self report, and are not actual behaviour observation.

The themes identified from the results of this pilot study are certainly worth pursuing. Future research might involve exploring GP confidence with a wider representative sample of New Zealand GPs. We anticipate reported confidence levels would be lower in a random sample of GPs than was reported in this current convenience sample, because many of the GPs in this sample had a special interest in mental health issues.

Recent literature suggests depression and anxiety to be the most common types of mental disorders among primary care attendees in New Zealand general practice[8] therefore future research may involve a more detailed investigation of GP confidence with specific mental disorders, i.e. depression and anxiety, to explore whether GP confidence is associated with the amount of exposure to such disorders in general practice.

There is growing support in the literature for a view that diagnostic criteria used in specialist settings are not adequate to detect mental disorders in general practice.[16,23–27] GPs in this current study appear not to share universal diagnostic criteria (e.g. DSM, ICD-10). The reason for this may be due to the suggested inappropriateness of the standard measures. This area deserves further investigation.

Further inquiry may also involve clarifying whether GPs are in fact not confident in 'initiating' antipsychotics or not confident in 'maintaining' already prescribed antipsychotics. We speculate that it is initiating that is more of a concern.

Finally, results from this pilot study raise questions about perceived confidence and actual confidence of GPs and has implications about using subjective measures of confidence and skill. It is also important to consider training implications, as motivating GPs to receive training in areas where confidence is high and perceived need is low poses particular and important challenges to mental health educators and deserves further investigation.

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