Author: G. Hodgins, F. Judd, J. Davis and A. Fahey
Author Address: ghodgins@csu.edu.au
Title: An integrated approach to general practice mental health training: The importance of context
Year: 2007
Journal: Australasian Psychiatry
Volume: 15
Issue: 1
Pages: 52-57
Date: February
ISSN: 1039-8562
DOI: http://dx.doi.org/10.1080/10398560601083019
Keywords: education
general practice
mental health
rural and remote psychiatry
Abstract: OBJECTIVE: The high prevalence of mental disorders and the barriers to detection and treatment of these in general practice are well recognized. As such, the government has placed great emphasis on training general practitioners (GPs) in primary care mental health and on the provision of support for GPs in the delivery of such services. The current paper aims to evaluate a local, rural training program in mental health for GPs. We hypothesized that local 'context-driven' training would lead to increased knowledge and reported change in practice by GPs with mental health patients. METHOD: Locally developed and delivered 'Level 1' training was offered to GPs through the Better Outcomes in Mental Health Care initiative. The training was provided with 6-hour workshops covering mental health assessment and management planning. The training was evaluated through pre- and 6-week post-questionnaires assessing attitudes and practice with respect to treatment of patients with mental health problems. RESULTS: Forty-nine GPs from the Loddon Campaspe Southern Mallee region of Victoria participated in the training. Following the 6-hour workshop, there was an increase in reported use of psychoeducation for patients with depression, use of cognitive behavioural therapy for patients with anxiety, and ease in obtaining advice to assist with the management of psychosis. CONCLUSIONS: GP mental health education should take into consideration the local context, cover systems issues as well as skills development, and aim to develop personal relationships between mental health clinicians and GPs to enhance outcomes.

An integrated approach to GP mental health training:

the importance of context

Gene Hodgins, Fiona Judd, Julian Davis and Anne Fahey

Gene Hodgins [1], Lecturer

Fiona Judd [2], Professor of Rural Mental Health

Julian Davis [2], Associate Professor

Anne Fahey [2], Manager Education and Training

1. School of Humanities and Social Sciences, Charles Sturt University, Wagga Wagga, NSW

2. Centre for Rural Mental Health, Bendigo Health Care Group, and School of Psychology, Psychiatry and Psychological Medicine, Monash University, Bendigo, VIC

Correspondence:

Dr Gene Hodgins, School of Humanities and Social Sciences, Charles Sturt University, Locked Bag 678, Wagga Wagga, NSW, 2678. Phone: (02) 6933 2746, Fax: (02) 6933 2792, Email: ghodgins@csu.edu.au

Objective: *The high prevalence of mental disorders and the barriers to detection and treatment of these in general practice are well recognised. As such, the government has placed great emphasis on training general practitioners (GPs) in primary care mental health and on the provision of support for GPs in the delivery of such services. The current paper aims to evaluate a local, rural training program in mental health for GPs. We hypothesised that local 'context driven' training would lead to increased knowledge and reported change in practice by GPs with mental health patients.*

Method: *Locally developed and delivered 'Level 1' training was offered to GPs through the Better Outcomes in Mental Health Care (BOiMHC) Initiative. The training was provided through 6-hour workshops covering mental health assessment and management planning. The training was evaluated through pre- and 6-week post-questionnaires assessing attitudes and practice with respect to treatment of patients with mental health problems.*

Results: *Forty-nine GPs from the Loddon Campaspe Southern Mallee (LCSM) region of Victoria participated in the training. Following the 6 hour workshop, there was an increase in reported use of psychoeducation for patients with depression; use of CBT for patients with anxiety; and ease in obtaining advice to assist with the management of psychosis.*

Conclusions: *GP mental health education should take into consideration the local context, cover systems issues as well as skills development, and aim to develop personal relationships between mental health clinicians and GPs to enhance outcomes.*

Key words: *education, general practice, mental health, rural and remote psychiatry*

Anxiety and mood disorders in the community are common and are associated with high levels of burden. Surveys have found 12-month prevalence rates of anxiety disorders in the community of 9.7% (females 12.0%, males 7.1%), and for depression of 6.3% (females 7.4%, males 4.2%) [1]. Of concern, only a minority of those with a mental disorder had sought or received treatment [1].

General practitioners (GPs) are the major mental health workforce in the Australian community, especially in rural areas where there is a shortage of both specialist mental health practitioners and primary care clinicians [2]. The majority of people with anxiety and depression who engage in treatment do so with a GP in the first instance [3-5]. As such, GPs play a pivotal role in the diagnosis and management of such patients. Once patients are seen by a GP, referral to more specialist mental health professionals occurs infrequently [6]. Reasons for this include greater patient comfort with a GP, the desire to avoid being labelled as mentally ill, and long waits for psychiatric consultation [3,5-7]. In rural areas there is also a lack of more specialist mental health professionals to whom general practitioners may refer.

General practitioners often have difficulty, however, in providing effective diagnosis, documentation or treatment of mental illnesses [7,8], particularly in rural and remote settings [9,10]. This is despite there being a research base of evidence-based guidelines and reports available for the detection and management of anxiety and mood disorders (NH&MRC Guidelines [11]).

Identified barriers to the provision of effective treatment by GPs include both individual and systemic issues. Individual issues include the personal and professional beliefs, attitudes and experience of the GP [12] (eg. that evidence-based practice is 'too hard', that it does not work, that good doctors do not need extra training) [13]. Other individual barriers may include lack of knowledge on behalf of the GP, how busy GPs are in their practice, being presented with 'too much' information, and that pharmaceutical companies are much better equipped to outmarket other (psychological) interventions (eg. aggressive use of outreach visits, or academic detailing). Also, a lot of evidence tends to be presented to GPs through education sessions, despite it being well known that education on its own is not enough to change clinical practice [14,15].

Systemic issues include poor uptake of training and other developments at divisional level, because of poor interest, lack of staff to implement training, the feeling that convincing GPs of the merits of particular interventions is a problem, or cost constraints [13]. Other systemic barriers may include financial disincentives for GPs to implement evidence-based practices that may be more time-consuming (eg. cognitive behavioural therapy), and the pathway through which evidence-based practice is directed from the research literature, through bureaucracies, to GPs.

The Better Outcomes in Mental Health Care (BOiMHC) initiative aims to address a number of these barriers. Specifically, it provides access to mental health education and training for GPs; provides incentives for effective management of mental health problems with remuneration for longer sessions to enable assessment, the development of mental health plans, and reviews; encourages appropriately trained GPs to provide evidence-based focused psychological strategies through MBS rebates; enables GPs to more easily access psychological and other allied health services; and, enables easier access to psychiatrist support for case conferencing and emergency advice.

While a number of the components of the BOiMHC initiative aim to change systemic issues, a cornerstone of the initiative is education and training. This component is made up of 'Level 1' training, which covers *Mental Health Assessment, Management Planning & Review*, and 'Level 2' training, which covers *Focussed Psychological Strategies*. As of recently, 15% of GPs nationally had received 'Level 1' training or it's equivalent, and 2% had completed 'Level 2' training [16].

This paper will describe locally developed and delivered 'Level 1' training offered to GPs, and the evaluation of this training through pre- and 6-week post-questionnaires examining attitudes, satisfaction and practice. Our hypothesis is that locally 'context driven' training will lead to some increased knowledge and reported change in practice with mental health patients in GPs who attended the training.

METHOD

The education and support to GPs described below was developed and delivered in the Loddon Campaspe Southern Mallee (LCSM) region, a large geographical area in Victoria (Figure 1).

****

Insert Figure 1 about here

****

Our education program for GPs was designed as one component of a broader education and training agenda that also includes community health service (non GP) clinicians, and clinicians working in the Area Mental Health Service (AMHS) (see [17-19]). The education and training is built on a stepped collaborative care model and designed to develop a system-wide shared language to support the integration and continuity of care in the treatment of patients suffering from common mental disorders [19].

Education and Training Program

Our education and training package was developed locally, to fit in with and inform GPs about local services, and was delivered by local clinicians (psychiatrist, clinical psychologist and GP). The use of and linking with local resources aimed to 'value add' to the training by increasing cooperation between the GPs and the local AMHS, and to provide a specific rural context, especially for isolated GPs. Follow-up to the training is provided to interested GPs through psychiatrist visits to the GP's surgery [20], GP supervision with a clinical psychologist [21], and referral pathways for consultation and assessment (and treatment where needed) [19]. For interested GPs, follow-up shorter modularised training for specific disorders is also offered, as well as the opportunity to access Focussed Psychological Strategies (Level 2) training.

Training was delivered through day long (6 hour) workshops and included didactic and case-based learning, as well as written material regarding assessment, care planning and review. We developed an expanded version of the generic 3-step mental health plan BOiMHC proformas with further treatment and referral choices tailored to the availability of local service providers. This provided education regarding the local service system, as well as making them more relevant and appropriate, an identified issue from GPs about the standard proformas[16]. The workshops provided an opportunity for discussion of the use of screening and symptom severity measures, the use of patient self-monitoring forms, and patient educational material (which were provided in paper copy and also electronically). All of the materials used are freely available (i.e. not copyright) and were chosen to be user-friendly and readily utilised by non-specialist clinicians [19].

Four workshops were held, two in Bendigo, one in Echuca, and one in Kyneton. The pre-questionnaire assessing attitudes, satisfaction and practice, was given before the commencement of the workshop, and the post-questionnaire was posted to the GPs 6-weeks later. To investigate the impact of the 6-hour workshops, comparisons were made between pre-test and post-test responses to questions about: how often they saw patients with depression, and anxiety; what treatments they used with these patients (IPT, CBT, counselling, psycho-education, medication); how often they refer patients with mental disorders on (to counsellors, psychiatrists, psychologists, GPs, AMHS); the ease to get advice on mental disorders; their attitude regarding mental disorders about their own competence, effectiveness, comfort, satisfaction, and stress. These responses were compared to identify any significant shifts between pre- and post-training.

RESULTS

Fifty-two GPs participated in the training; three were excluded from this study as they did not return the post-questionnaire. Demographic information is shown in Table 1. There were slightly more female attendees, nearly half the GPs practised in a town of less than 10,000 people, they were quite experienced, and the mean number of hours worked was quite low (consistent with the fact of female GPs working more part-time). With approximately 250 GPs in the region, our sample comprises 20% of the total.

****

Insert Table 1 about here

****

Table 2 outlines the characteristics of participants. Approximately half had some contact with the local Primary Mental Health Team (PMHT), mostly through referral and shared care. Most intended to use the new BOiMHC MBS items, but 10 did not. About half were interested in Focussed

Psychological Strategies (FPS) training. A number of GPs reported problems with attending training in mental health, the main difficulties being time and distance to travel.

****

Insert Table 2 about here

****

Table 3 outlines the interactions that the GPs reported with their patients who had mental disorders. Participants indicated that they saw 8-10 patients with depression and/or anxiety per week. The majority of these were reported as mild-to-moderate cases. GPs in this sample also reported seeing a significant number of patients with psychotic disorders. Surprisingly, they reported seeing few patients with both drug and alcohol problems and mental disorder, and as expected indicated seeing a small number of patients with eating disorders.

****

Insert Table 3 about here

****

Comparison of pre-training and post-training responses to questions about: how often GPs saw patients with depression and anxiety; what treatments they used with these patients; how often they refer on patients with mental disorders; the ease of getting advice on mental disorders; and their attitude about their own competence regarding mental disorders, effectiveness, comfort, satisfaction, and stress, showed that only 3 responses significantly changed between pre- and post-test. The reported use of psychoeducation for patients with depression increased, $t(44)=-2.10, p<0.05$, the reported use of CBT for patients with anxiety increased, $t(42)=-2.10, p<0.05$, and the reported ease in obtaining advice to assist with the management of psychosis increased, $t(45)=2.32, p<0.05$. All other differences did not reach statistical significance.

DISCUSSION

The demographics of this sample are consistent with what is known about GPs interested in mental health. More females attended than males, a number were part-time, and they were quite experienced. Most had already had some education in mental health. A number of the GPs who attended the training were from small rural areas. This was not unexpected as GPs in smaller and more distant rural areas need to be multi-skilled and able to manage many problems without readily available specialist support. These findings suggest that such training was attracting GPs already interested in mental health, not GPs with few skills, for whom some argue training is most important.

We estimate that 20% of GPs in the region attended our training. This is higher than the national average of 15% and the Victorian average of 16%, but is consistent with the national large rural centres' (20%) and small rural centres' (39%) data [16]. In addition to this, GPs in the region may have attended training delivered by other providers. Consistent with the demands on GPs to provide more services with less opportunity for specialist referral and/or support rural, GPs appear more likely to engage in mental health training than their urban counterparts.

The aim of the BOiMHC initiative [16]is: the expansion of treatment choices in general practice; access to effective forms of psychological therapy; an integration of primary and secondary care mental health services; and, a provision of more evidence-based treatment. Our results show that a 6-hour education and training workshop for GPs on assessment and management planning for mental disorders led to an increase in reported use of psychoeducation for patients with depression, and an increase in the reported use of CBT for patients with anxiety. Such treatment changes occurred specifically in relation to the 'high prevalence disorders' i.e. anxiety and depression, a group that GPs could and should be able to increasingly treat with evidence-based methods (especially mild-to-moderate cases).

It can be argued that such positive changes occurred as the training was not straight education, but covered skills development (assessment) as well as systems issues (local mental health care plan – who to involve, who they are, where to refer, when to refer). Moreover, we argue that the locally driven, face-to-face 'personal' relationship development through the implementation of the training

may have led to a greater interaction with services post-training, as evidenced by the increased reported ease in obtaining advice to assist with the management of psychosis, thus going towards achieving some integration of mental health services. The benefit of such context driven strategies has also been advocated recently for primary care mental health guidelines [22].

In the past, one-off workshops and lecture formats have been the preferred ways of 'training' GPs in mental health. These modalities have sometimes been found useful in increasing GP knowledge (such as in detection of mental illness), but are not enough on their own to change clinical practice [14,15]. It is thought that to achieve greater change in GP practice and patient outcomes, more focus needs to be placed on: allowing GPs the opportunity to rehearse and fine tune new skills; providing more flexible learning that addresses the GPs' attitudes, skills, clinical competence and performance, and; improving links with specialist providers (Blashki G. Unpublished MD thesis, 2001). The findings of this research provide some evidence for this; however, a limitation of the current study is that only reported changes in practice were measured, not actual changes.

CONCLUSION

The primary care setting, particularly in rural areas, provides the greatest opportunity to offer effective treatment to a large proportion of people with mental health problems. If this is to occur, improved detection and provision of effective treatments by GPs is required. This can begin to be achieved by provision of education and service integration support to general practitioners (GPs), who can see some of these patients themselves. Such interventions should take into consideration the local context, cover systems issues as well as skills development, and aim to develop personal relationships between mental health clinicians and GPs, to enhance outcomes. Further research is needed to evaluate whether the addition of ongoing support to GPs, combined with systemic change such as through a stepped collaborative care model (eg. improved access to psychological therapies and psychologists), leads to a more lasting change in GP attitudes and practice, and ultimately better patient outcomes.

REFERENCES

1. Andrews G, Hall W, Teesson M, and Henderson A. S. The mental health of Australians. National Survey of Mental Health and Wellbeing Report II. Canberra :Mental Health Branch, Commonwealth Department of Health and Aged Care, 1999.

2. Judd FK, Humphreys JS. Mental health issues for rural and remote Australia. *Australian Journal of Rural Health* 2001; **9**:254-258.

3. Regier DA, Narrow WE, Rae DS, Manderscheid RW, Locke BZ, Goodwin FK. The de facto US mental and addictive disorders service system. Epidemiologic catchment area prospective 1-year prevalence rates of disorders and services. *Archives of General Psychiatry* 1993; **50**:85-94.

4. Schurman RA, Kramer PD, Mitchell JB. The hidden mental health network. Treatment of mental illness by nonpsychiatrist physicians. *Archives of General Psychiatry* 1985; **42**:89-94.

5. Thompson TL,Thomas MR. Teaching psychiatry to primary care internists. *General Hospital Psychiatry* 1985; **7**:210-213.

6. Hartley D, Korsen N, Bird D, Agger M. Management of patients with depression by rural primary care practitioners. *Archives of Family Medicine* 1998; **7**:139-145.

7. Jones LR, Parlour RR. The psychiatric role of the rural primary care practitioner. *Psychiatric services for the underserviced rural populations,* New York: Brunner/Mazel, 1985; 92-102.

8. Goldberg D. Detection and assessment of emotional disorders in a primary care setting. *International Journal of Mental Health* 1979; **8**:30-48.

9. Kaufmann IM. Rural psychiatric services. A collaborative model. *Canadian Family Physician* 1993; **39**:1957-1961.

10. Wang Q, Gong Y, Niu K. The Yantai model of community care for rural psychiatric patients. *British Journal of Psychiatry - Supplementum* 1994;107-113.

11. Nathan PE, Gorman JM. *A guide to treatments that work*. New York: Oxford University Press, 1998.

12. Freeman AC,Sweeney K. Why general practitioners do not implement evidence: qualitative study. *BMJ* 2001; **323**:1100-1102.

13. Penrose-Wall, J. To their full potential: The National General Practice Guideline Implementation Program. 2000. Sydney, To their full potential: Evidence-based guidelines uptake in primary mental health care. 2000.

14. Rutz W, von Knorring L, Walinder J, Wistedt B. Effect of an educational program for general practitioners on Gotland on the pattern of prescription of psychotropic drugs. *Acta Psychiatrica Scandinavica* 1990; **82**:399-403.

15. Thompson C, Kinmonth AL, Stevens L, Peveler RC, Stevens A, Ostler KJ, Pickering RM, Baker NG, Henson A, Preece J, Cooper D, Campbell MJ. Effects of a clinical-practice guideline and practice-based education on detection and outcome of depression in primary care: Hampshire Depression Project randomised controlled trial. *Lancet* 2000; **355**:185-191.

16. Hickie IB, Pirkis JE, Blashki GA, Groom GL, Davenport TA. General practitioners' response to depression and anxiety in the Australian community: a preliminary analysis. *Medical Journal of Australia* 2004; **181**:S15-S20.

17. Donoghue A, Hodgins G, Judd F, Scopelliti J, Grigg M, Komiti A, Murray G. Training case managers to deliver focused psychological strategies. *International Journal of Mental Health Nursing* 2004; **13**:33-38.

18. Hodgins G, Murray G, Donoghue A, Judd F, Petts A. Introducing a professional development programme to a rural area mental health service: the importance of context. *Australasian Psychiatry* 2004; **12**:153-160.

19. Judd F, Davis J, Hodgins G, Scopelliti J, Agin B, Hulbert C. Rural Integrated Primary Care Psychiatry Programme: a systems approach to education, training and service integration. *Australasian Psychiatry* 2004; **12**:42-47.

20. Judd F, Cockram A, Davis J, Fahey A, Hodgins G, Jackson H, Scopelliti J. First year of practice visits for the Rural Depression Anxiety Research and Treatment General Practice program. *Australian Journal of Rural Health* 2003; **11**:175-180.

21. Hodgins G, Judd F, Kyrios M, Murray G, Cope A, Sasse C. A model of supervision in mental health for general practitioners. *Australasian Psychiatry* 2005; **13**:185-189.

22. Hickie IB, Blashki GA. Evidence into practice: the mental health hurdle is high. *Medical Journal of Australia* 2006; **184**:542-543.

Figure 1: Map of Victoria showing Loddon Campaspe Southern Mallee region

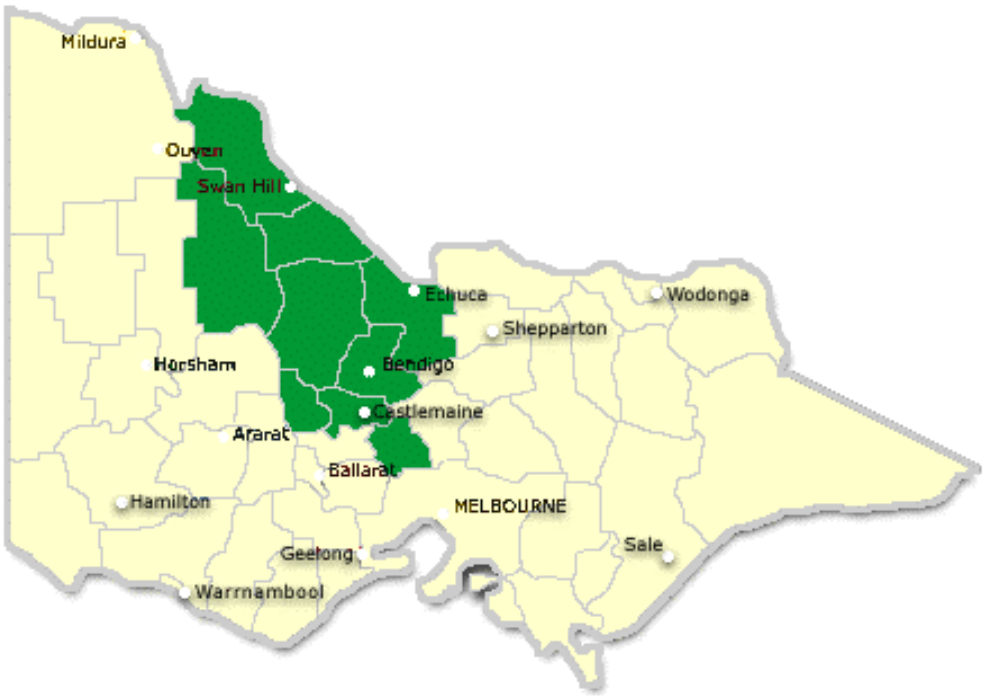

Table 1: Demographic Information

	Number (N=49)	Mean (SD)	Range
Male : Female	23 : 25		
Age – 25 – 30	2		
31 – 35	3		
36 – 40	5		
41 – 45	12		
46 – 50	11		
51 – 55	3		
56 – 60	10		
61 – 65	3		
66 +	0		
Town Size –			
> 20,000	16		
10,000 – 19,999	9		
2,000 – 9,999	16		
< 2,000	7		
Years in GP		15.40 (10.91)	1 - 40

Consultations (last month)		42.38 (30.45)	9 - 200
Hours Worked (per week)		8.88 (7.66)	3 - 50
Number GPs in Practice		4.06 (2.60)	1 - 10
Postgrad Training in MH	38		
Workshops/Seminars in MH	25		
Also work in –			
Hospital	10		
Div of GP	3		
University	3		
Community based service	5		

Table 2: Characteristics of Participants

	Number (N=49)
Difficulties Attending MH Training	35
Time	30
Distance	22
Information	10
Family	17
Workload	9
Contact with PMHT	27
Advice	14
Patient referral	20
Patient consultation	8
Shared patient care	17
Intend use	
BOMHC MBS items	39
3 step process	32
Focussed psych strategies	23
Refer to support services	

CASA	37
Drug & alcohol	46
Employment	28
Accommodation	28
PDRS	27
Community health	33

Table 3: GP Interactions with Patients with Mental Disorders

	Mean (SD) **(N=49)**	**Range**
Pts Treated for -		
Depression (/ week)	9.72 (8.93)	0 – 50
Anxiety (/ week)	8.18 (8.82)	1 – 50
D & A (/ month)	4.97 (5.48)	0 – 20
Psychosis (/ month)	10.18 (21.39)	0 – 100
Eating Disorders (/ month)	1.03 (1.22)	0 – 5
% Patients with Depression –		
Mild	54.87 (23.10)	0 – 90
Moderate	31.32 (17.34)	0 – 75
Severe	8.11 (6.40)	0 – 30
% Patients with Anxiety –		
Mild	56.30 (24.30)	0 – 90
Moderate	27.98 (15.68)	0 – 75
Severe	7.04 (7.17)	0 – 33
% Patients with Comorbid D&A –		

Mild	25.35 (28.58)	0 – 85
Moderate	21.68 (23.61)	0 – 75
Severe	11.28 (19.37)	0 – 80