Should mental health issues be addressed in primary care, and can it be done? Views of rural general practitioners in Queensland

Heidi Sturk, David Kavanagh, Cindy Gallois, David King, Merrill Turpin, Robert King and Helen Bartlett

Objective: *The aim of this paper was to examine self-efficacy and perceived appropriateness among rural general practitioners (GPs) in regards to screening and intervention for physical, lifestyle and mental health issues.*

Method: *Fifty GPs from 25 practices in eight rural Queensland towns completed a written survey designed for the study.*

Results: *General practitioners rated opportunistic screening or assessment for smoking and for detection of relapse of mental disorders as the most appropriate, with even cardiovascular and diabetes risk falling behind these. Self-efficacy was highest for medical disorders for smoking assessment. It was significantly lower for alcohol, mental health issues, and addressing risks of physical disorder in people with mental disorders.*

Conclusions: *High appropriateness ratings suggest that current strategies to boost self-efficacy of GPs in addressing mental health issues are timely.*

Key words: *alcohol, mental health, primary care, self-efficacy, smoking.*

Heidi Sturk
Research Officer, School of Medicine, University of Queensland, Herston, QLD, Australia.

David Kavanagh
Professor, School of Medicine, University of Queensland, Herston, QLD, Australia.

Cindy Gallois
Professor of Psychology and Deputy Executive Dean, Faculty of Social and Behavioural Sciences, University of Queensland, St Lucia, QLD, Australia.

David King
Senior Lecturer, School of Medicine and General Practitioner, University of Queensland, QLD, Australia.

Merrill Turpin
Lecturer, School of Health and Rehabilitation Sciences, University of Queensland, St Lucia, QLD, Australia.

Robert King
Associate Professor, School of Medicine, University of Queensland, QLD, Australia.

Helen Bartlett
Professor and Director, Australasian Centre on Ageing, University of Queensland, St Lucia, QLD, Australia.

Correspondence: Ms Heidi Sturk, School of Medicine, University of Queensland, K Floor, Mental Health Centre, Royal Brisbane & Women's Hospital, Herston, QLD 4029, Australia. Email: h.sturk@uq.edu.au

Current mental health policies in Australia are heavily reliant on interventions within primary care, because of the accessibility of general practitioners (GPs), the GPs' potential to detect and treat common disorders, and to provide opportunistic preventive intervention or routine management. Given the heightened risk of serious physical disorders in people with mental health problems[1] and their greater tendency to smoke and engage in other health-risk behaviours, monitoring and preventive interventions that address the potential for comorbidity assume particular importance. General practice is the obvious venue for addressing this interface.

Screening and intervention in primary care for smoking[2] or alcohol use[3] can have significant impact, and moderate changes in other health-risk behaviours can be achieved.[4] Furthermore, GPs can effectively provide pharmacological treatment for depression,[5] although dosage and follow-up regimens may not always be optimal.[5,6] However, mental disorders and substance misuse are often missed,[7,8] and appropriate intervention is not always provided.[5]

There are many potential reasons for not routinely screening and intervening in these areas, including consultation time, perceived ineffectiveness,[9] and competing opportunistic targets. However, two key reasons are likely to be: perceived appropriateness and acceptability of opportunistic

action,[10] and confidence and skills in engaging patients in screening and behaviour change.[9] Self-efficacy assesses confidence in undertaking tasks, and is highly predictive of performance in a wide range of domains.[11] GPs tend to have relatively low self-efficacy in diagnosing and treating patients with depression as well as patients with psychosis, eating disorders or personality disorders.[12,13]

The current study examined GPs' self-efficacy concerning physical, lifestyle and mental health issues, and their ratings of perceived appropriateness in opportunistically addressing them. We anticipated that both self-efficacy and perceived appropriateness would be particularly high for cardiovascular and diabetes risk, and perhaps also for smoking. We expected these ratings to be higher than for mental health issues, but had no hypothesis about the size of the difference.

METHOD

Participants

GPs from eight rural towns or regional centres in Queensland were invited to participate in the survey. These towns formed four pairs of similar size, nature of population and location. Data were collected in face-to-face interviews during the second half of 2003, after written consent was obtained.

Demographic data

GP details comprised gender, age, years of experience, training location (Australian or overseas), full- or part-time work, number of GPs in their practice and any specializations or patient restrictions.

Perceived appropriateness of opportunistic screening and intervention

GPs were asked to imagine that a patient with a mental disorder had consulted them for management of an upper respiratory tract infection. They rated how appropriate it would be for them to conduct screening and, if indicated, brief intervention within that consultation, for each of seven health issues. The first six health issues corresponded to the first six self-efficacy topics listed below. The final health issue was 'early signs of mental health relapse'. Ratings were from 0 (not at all) to 10 (very appropriate).

Self-efficacy

GPs rated their own confidence from 0 (not at all) to 10 (completely) in assessing and managing each of 11 health issues: cardiovascular risk, diabetes risk, smoking, hazardous alcohol use, exercise/active leisure, unhealthy diet, risk of relapse in anxiety disorders, major depression or dysthymia, schizophrenia or bipolar disorder, suicide risk, and physical disorder risk in people with mental disorders.

Primary analyses

Analyses of appropriateness and self-efficacy used multivariate analysis of variance (MANOVAs), with gender and training location (Australian vs overseas) as the independent variables, and with the assessment versus management and health issue as the within-subject variables. Tests of within-subjects effects used Wilks' Lambda.

RESULTS

Participants

One hundred and thirty-five GPs from 36 practices were invited to participate. Fifty (37%) GPs provided informed consent and completed the survey. They were from 25 (69%) of approached practices, which had from one to nine full-time GPs (mean = 3.7, SD = 2.0). GPs' ages ranged from 29 to 63 years (mean = 45, SD = 8.2), and 28 (56%) were men. Four men (14%) and 11 women (50%) were working part-time. Twenty (40%) were trained overseas.

Analyses of self-efficacy and appropriateness used MANOVAs, with gender and training location (Australian vs overseas) as the independent variables, and with the assessment versus management and issue as the within-subject variables. Tests of within-subjects effects used Wilks' Lambda.

Appropriateness of opportunistic screening and intervention

Neither GP gender, age, years of experience, location of training, practice size, nor part- or full-time status was associated with perceived appropriateness. The effect of health issue was highly significant (Wilks' Lambda = 0.520, $F(6, 40) = 6.16$, $p < 0.001$, $\eta^2 = 0.48$). As Figure 1 shows, GPs indicated that assessment and management of smoking was the most appropriate screening. Using that as a reference category, all health issues except for assessment and management of early signs of mental health relapse ($F(1, 45) = 0.08$, n.s., $\eta^2 = 0.002$) had significantly lower appropriateness, although all average ratings were above the midpoint. An apparent effect for assessment to have greater perceived appropriateness than management did not reach the 0.05 level of significance (Wilks' Lambda = 0.929, $F(1, 45) = 3.46$, $p < 0.10$, $\eta^2 = 0.07$). There was no interaction between health issue and assessment versus management.

Self-efficacy

Preliminary analyses showed that the only GP characteristic to be associated with self-efficacy ratings was training location. A multivariate analysis examining the role of health issue and assessment versus management found that GPs were more confident about undertaking assessment (mean = 7.6, SE = 0.17) than management (mean = 7.1, SE = 0.16;
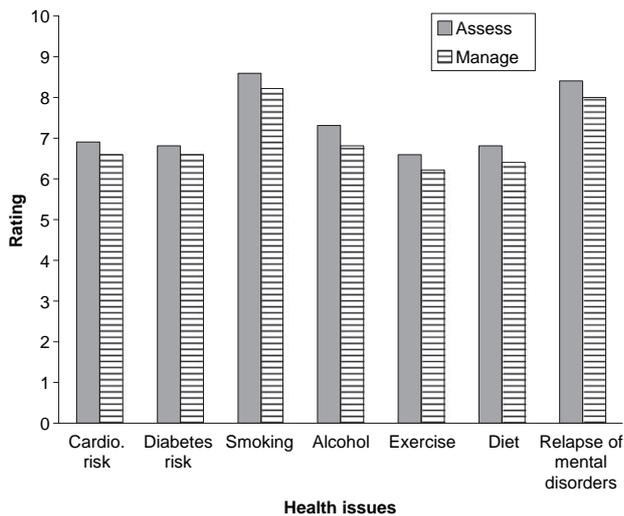
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Figure 1: *Average rated appropriateness of opportunistic assessment and intervention.*

Wilks' Lambda = 0.721, F (1, 47) = 17.24, p < 0.001, η^2 = 0.27). There was also a significant effect for health issue (Figure 2; Wilks' Lambda = 0.214, F (10, 38) = 13.95, p < 0.001, η^2 = 0.79). As shown in Figure 2, GPs indicated the highest self-efficacy for cardiovascular and diabetes risk and smoking, and the lowest for schizophrenia. A series of contrasts compared cardiovascular risk with every other health issue. In all cases except for smoking (F (1, 47) = 1.40, n.s., η^2 = 0.03), GP self-efficacy was significantly lower than for cardiovascular risk. The greatest comparative reductions in self-efficacy were for schizophrenia (F (1, 47) = 57.62,
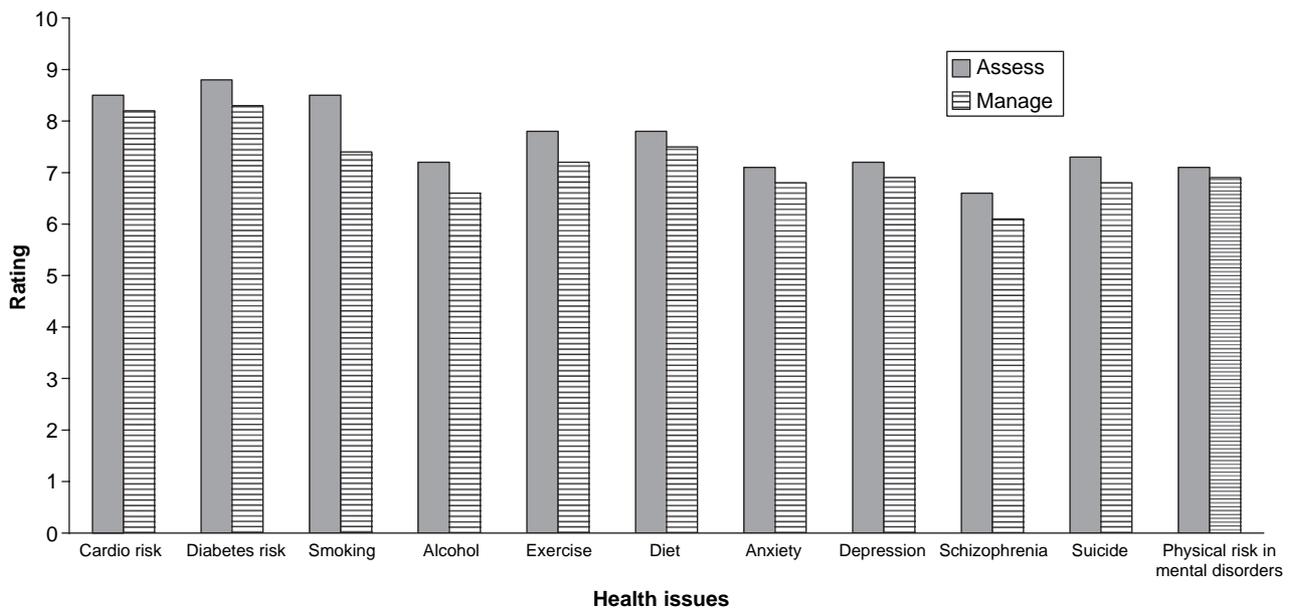
p < 0.001, η^2 = 0.55), alcohol (F (1, 47) = 42.90, p < 0.001, η^2 = 0.48), anxiety (F (1, 47) = 30.79, p < 0.001, η^2 = 0.40) and physical risk in people with mental disorder (F (1, 47) = 29.71, p < 0.001, η^2 = 0.39). However, average self-efficacy across all health issues was above the midpoint of moderate confidence. The interaction between assessment versus management and health issue was not significant (Wilks' Lambda = 0.693, F (10, 38) = 1.68, n.s., η^2 = 0.31).

The effect for health issue was moderated by an interaction with training location (Wilks' Lambda = .577, F (10, 38) = 2.79, p = 0.01, η^2 = 0.42). Locally trained GPs were more confident in assessment of hazardous alcohol use, diet, anxiety, depression or schizophrenia relapse risk and in the management of depression. Overseas-trained GPs were more confident in other areas.

Relationship between self-efficacy and appropriateness

The only significant correlation between self-efficacy and related appropriateness was for screening or assessment for smoking, where higher appropriateness was associated with higher self-efficacy, r = 0.30, p < 0.05.

DISCUSSION

The results of the study were encouraging in that self-efficacy and perceived appropriateness of opportunistic intervention for both substance use and for mental disorders were relatively high. Of particular interest was the very high appropriateness rating for strategies on prevention of relapse in mental disorders.

Figure 2: *Average self-efficacy of general practitioners.*

As anticipated, and consistent with previous research,[13] GPs had lower confidence for mental health health issues than for physical disorder risk. Of some concern was a relatively low self-efficacy for addressing physical disorder risks in people with mental disorders, and the reasons for this observation clearly merit further study. However, differences in self-efficacy ratings across domains were relatively small, which suggested that strategies to address the differences can work from a solid foundation.

As expected, ratings for screening or assessment tended to be greater than those for management across the board. The current study did not clarify the contribution of perceived time pressures or treatment effectiveness to this finding, and future research will try to disentangle these factors from perceived ability to address the health issues.

Also as expected, self-efficacy and appropriateness ratings for core GP tasks of addressing cardiovascular and diabetes risks were high. Notably, smoking assessment and appropriateness of opportunistic screening and intervention for smoking also received high ratings, and in fact were highest in appropriateness. These results demonstrate the success in highlighting the importance of opportunistic smoking interventions in primary care. The high self-efficacy scores relative to other health-risk behaviours is consistent with past research,[4] and show that similar findings are obtained in a rural setting as in other contexts. However, there appear to be continuing challenges in boosting confidence in managing smoking in a GP setting.

Some self-efficacy differences emerged between locally trained and overseas-trained doctors, suggesting that screening and intervention methods for substance use and mental health problems may require additional targeting in some GP subgroups.

Interestingly, there was little relationship between self-efficacy and perceived appropriateness, except for smoking. This suggests that if a GP believed that a focus on smoking was important, they had potential access to ways they could assess and manage it. However, many GPs who thought that alcohol use and mental health issues should be addressed in primary care apparently lacked self-efficacy in addressing them.

Together, these data suggest that many GPs may be ready for training and other support to address mental health and substance use issues. However, there is potential for sampling bias, given the response rate and the likelihood that volunteering GPs may have had a greater interest in mental health than those who did not. GPs were also aware that the survey was being conducted by mental health researchers and this might have led to additional bias in rating the appropriateness of mental health assessment and intervention.

Training in management of mental disorders can increase related self-efficacy and skills.[8,14,15] The emphasis on training in this area within the Australian Integrated Mental Health Initiative project appears well founded, as are other recent Australia-wide initiatives to increase primary care capacity and boost access to allied health consultations. This is particularly relevant to the rural context where GPs are faced with many demands due to the lack of specialist medical services. The current study suggests that training on engaging mental health patients in preventive strategies might usefully build on existing skills and confidence in addressing smoking, diabetes and cardiovascular risk. Physical health maintenance may also provide a model for routine mental health assessment and intervention in primary care – brief screening and assessment, and guidelines for opportunistic intervention that are compatible with the constraints of primary care.[16]

ACKNOWLEDGEMENTS

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