Increasing general practitioner skills with patients with serious mental illness

Margaret Tobin, Ian B Hickie and Amanda Urbanc

Margaret Tobin is Director, Division of Psychiatry, St George Hospital and Community Health Service, and Conjoint Lecturer, School of Psychiatry, University of New South Wales. Ian B Hickie is Professor of Community Psychiatry, School of Psychiatry, University of New South Wales, and Director, Academic Department of Psychiatry, St George Hospital and Community Health Service. Amanda Urbanc is a Research Officer, Mental Health Evaluation Unit, St George Hospital and Community Health Service.

Abstract

This report describes a clinical training program designed to increase general practitioner involvement with a public mental health service. The program involved one half-day clinical session per week and one two-hour formal training seminar per month, over a six-month period. Prior to training, participants demonstrated major clinical and theoretical skill deficits when assessing patients with serious mental illnesses. While specific knowledge of psychiatry increased by the end of the training program, little change in clinical interview skills was evident. Current initiatives to enhance general practitioner involvement in mental health care may be hampered if these skill deficits are not directly addressed in relevant shared care programs.

Introduction

The need for more effective community-based mental health care is well recognised (National Health Strategy 1991, 1993). The National Mental Health Policy (Australian Health Ministers 1992) calls for reforms in service delivery, with increasing emphasis on primary and secondary prevention and development of innovative programs for treatment in primary care. A report to the Australian Health Ministers' Advisory Council (Medical Workforce Working Group on Hospital Training and Career Development 1993) noted, however, that the current role for general practitioners in public hospitals is limited. It suggested

that the organisational structure of hospitals be reorganised to provide more integrated hospital and community service enterprises. Mental health may provide an appropriate discipline for general practitioners to work within such integrated services as the majority of mental health problems are assessed and treated solely within the primary care sector (Whiteford 1992). Further, the relevant professional organisations acknowledge the need for a closer working relationship (Joint Consultative Committee in Psychiatry of the Royal Australian College of General Practitioners and the Royal Australian and New Zealand College of Psychiatrists 1997).

Unfortunately, there are a number of barriers to improved working relationships between mental health services and general practitioners. First, a large proportion of mental illness is not detected and/or treated by general practitioners (Ormel et al. 1990; Poynton & Higgins 1991; Goldberg et al. 1993; Harris et al. 1996). Such untreated morbidity continues to impose personal, social and financial costs on the community (Smith, Monson & Ray 1986; Pallak et al. 1993). The need for general practitioners to become more effective in assessing and managing mental illnesses is widely recognised (Dowrick 1992; Nazareth et al. 1993; Tippett 1994) and the key clinical competencies required are sophisticated interview and communication skills (Millar & Goldberg 1991; Goldberg et al. 1993; Goldberg & Gater 1996). Such skills are not simply acquired as a consequence of years of clinical experience, but need to be specifically learnt and developed (Gask et al. 1988; Bowman et al. 1992; Goldberg & Gater 1996). General practitioners in Australia rate the development of diagnostic and counselling skills as an educational priority (Phongsavan et al. 1995).

Second, patients with mental illnesses display a wide range of deficits in communication, social skills and cognitive function. Unless general practitioner education programs deal with these specific deficits, and target skill development in the engagement and treatment of patients with mental disorders, it is unlikely that the current initiatives to increase general practitioner involvement in mental health care will succeed (Goldberg & Gater 1996).

Third, the current highly structured nature of many general practice settings, with an emphasis on multiple brief consultations, creates an additional barrier to detection and adequate management.

Fourth, the current system of care in many public sector mental health services may exacerbate the difficulties faced by general practitioners. When patients do reach public mental health services, there has been a tendency to treat the patient independently. Thus the opportunity for sharing care and increasing the general practitioner's skill base is often lost.

Research related to the involvement of general practitioners in mental health care has generally focused on identifying these barriers (Adeyemi & Jegede 1994; Phongsavan et al. 1995; Salokangas, Poutanen & Stengard 1995), and various interventions have been proposed. These include:

(i) a liaison attachment model (Carr & Donovan 1992) whereby experienced mental health professionals work as consultants within designated general practices

(ii) improved access to community-based mental health teams (Warner et al. 1993)

(iii) the provision of needs-based education seminars (Phongsavan et al. 1995; Kerwick et al. 1997)

(iv) the provision of regular consultant psychiatrist supervision to small groups of general practitioners (many of which are currently funded via the Commonwealth Divisions and Projects Grants Program.

While there has been recognition of perceived educational needs (Phongsavan et al. 1995; Kerwick et al. 1997), less attention has been paid to the ways in which relevant skills can be taught and assessed. Typical approaches have focused on the use of 'self-tests' of psychiatric knowledge (Kendrick, Burns & Freeling 1995) and audits of practice records (Joukamaa, Lehtinen & Karlsson 1995). While relevant, these approaches focus on improving confidence and knowledge and do not address specifically the acquisition of clinical interviewing skills. The notable exception has been the system developed by the University of Manchester which focuses on intense teaching of interview techniques and direct evaluation of clinical skills (Goldberg et al. 1993). This approach, however, is labour-intensive and requires a long-term commitment if it is to have any impact on a district mental health service.

Most service development programs do not openly differentiate the various types of mental health issues presenting in primary care. Most programs focus on general practitioners increasing their skill in the management of those patients with mild to moderate psychological morbidity and disability (Goldberg & Gater 1996). Such programs, however, are less likely to have an impact on the treatment of those with more severe, chronic and disabling disorders (Jackson et al. 1993). It is precisely this latter group which dominates the public mental health sector and which has the greatest need for close collaboration between mental health service providers and general practitioners. Such patients are in great need of primary medical care as a consequence of very high rates of untreated medical morbidity, but also have the greatest difficulty in establishing long-term treatment relationships with family practitioners.

A pilot training program

As a consequence of these barriers to care, the St George mental health service developed a training program which focused primarily on the acquisition of clinical skills relevant to patients with severe mental illness. Such patients typically have a psychosis, bipolar disorder or major depression, but their illnesses are also frequently complicated by concurrent substance abuse, social disadvantage and chronic and severe disability. The project was based within three community mental health centres belonging to the district mental health service. The program had three other practical objectives:

(i) to ensure that general practitioners would undertake more of the routine medical care of these patients – this would not only improve the medical health of these patients but also, potentially, create additional psychiatrist and psychiatry registrar time for the provision of specific mental health interventions

(ii) to shift the focus of care in these patients from chronicity and disability towards health promotion and secondary prevention

(iii) to increase the overall level of communication between the mental health sector and general practice, largely by exposing the two groups to each other in the community mental health environment (Warner et al. 1993).

Methods

Fourteen general practitioners in Southern Sydney were recruited to work three hours per week for six months. Their remuneration was consistent with other Division of General Practice programs (approximately $91 per hour during the day and $45 per hour for the evening tutorials). The participants comprised nine men and five women, largely in full-time general practice. They had responded to advertisements and information provided at mental health education seminars, and were from diverse language backgrounds. The group consisted of both Australian and overseas medical graduates, of whom only one had had any formal postgraduate training in mental health. During their weekly attendance, participants received a variety of experiences, including one-to-one tuition by a consultant psychiatrist, direct assessment of patients referred by the community health centre staff, participation in clinical review meetings, access to the psychiatric admission ward and attendance at emergency assessments in the community. Monthly evening tutorials for the whole group with a consultant psychiatrist concentrated on consolidating specific psychiatric knowledge. Topics included psychosocial assessment, interviewing style, mental state examination, diagnosis, and discussion of specific disorders.

The overall outcomes of the project were assessed in a variety of qualitative ways. Prior to commencement, and at the conclusion of each stage of the project, participants were interviewed regarding their views of the operation of the community mental health service. Similarly, the views of the community mental health staff with regard to the roles of the general practitioners were obtained.

Evaluation of clinical skills

The principal aim of the project, namely, to discover whether the program would improve actual clinical skills, was subjected to a more rigorous evaluation procedure. This evaluation took the form of a clinical viva and was based on the format used to assess the clinical psychiatry skills of fifth year undergraduate medical students of the University of New South Wales. Previous research has indicated that assessment of relevant clinical skills for the detection and management of psychological disorders requires some form of direct observation (Goldberg et al. 1993). Our clinical viva consisted of the participant conducting a 30-minute psychiatric interview in the presence of two consultant psychiatrists. At the conclusion of the interview, the participant presented the essential historical and mental state findings, suggested provisional and relevant differential diagnoses, and discussed key management issues. Two marks, each rated between 0 and 100, were given. The first mark was for general interviewing skills, while the second was for specific knowledge of psychiatry. The viva examination was repeated at the end of the six-month attachment. One examiner (IH), who had designed the initial evaluation schedule for medical students, participated in all pre- and post-training viva examinations. One general practitioner declined to participate in the post-training evaluation viva.

Results

Clinical skill and knowledge ratings

Prior to training, the rating of the general practitioners' interviewing skills (mean 48 per cent; SD 10.4; range 30–60 per cent) was below the pass mark for undergraduate medical students. Disappointingly, this value was only marginally improved by the training (mean 54 per cent; SD 8.0; range 30–65 per cent; t-value 1.33; NS, see Figure 1). For specific knowledge in psychiatry, the pre-training mark (mean 34 per cent; SD 11.1; range 20–50 per cent) indicated a serious deficiency in basic psychiatric knowledge. This factor was, however, improved significantly by the training (post-training mean 56 per cent; SD 6.1; range 50–65 per cent; paired t-test: t-value = 4.07; $P < 0.01$, see Figure 2).

Figure 3 shows the combined effects of these two scores. The examining psychiatrists noted that after the training the general practitioners showed an improved ability to elicit relevant medical, neurological and cognitive factors, were generally able to take an adequate history of longitudinal course, family history and treatment issues, and were more respectful and courteous towards the patients. However, too few opportunities were provided for patients to relate their own story. There remained an over-reliance on highly structured interviewing techniques and poor differentiation between history taking and mental state assessment tasks. General practitioners tended to accept many psychiatric symptoms at face value and, consequently, failed to explore adequately the actual nature and importance of key behavioural phenomena.

Attitudes of general practitioners to community mental health services

As a consequence of the training experience, the general practitioners indicated an increased awareness of the range of services offered by the public mental health system, reported greater confidence in referring patients as a result of the knowledge that they would be kept informed of their progress, and noted significantly less difficulty gaining access to the public psychiatry system. Additionally, they described improved working relationships with mental health case managers. Overall, they were satisfied with the training program and believed that it had increased both their skills and their knowledge in psychiatry.

Attitudes of community mental health staff to general practitioners

According to feedback from community mental health staff, the general practitioners who received the training were noticeably more specific in the information provided in referrals they subsequently made to the service and in the requests they made of the service. Furthermore, as a result of the exposure of the community mental health staff to the general practitioners in the program, relationships with general practitioners as a whole improved. This was reflected in greater interest from case managers in making referrals to primary care, and in positive comments about the service from other general practitioners at subsequent education seminars. It was also noted that the enthusiasm of the community mental health staff for involvement with the second intake of general practitioners was noticeably higher than it had been for the first intake, reflecting the beginnings of a change of culture in the public sector towards primary care. All of these attitudinal changes in community mental health staff were reinforced by policy changes which served to emphasise the importance of an active collaboration with general practitioners.

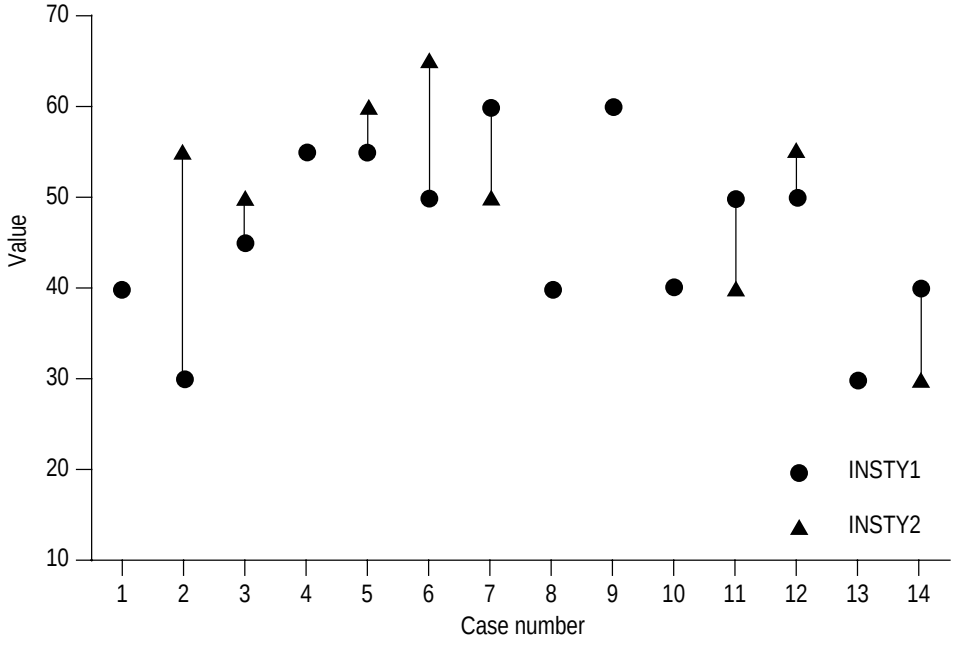

Figure 1: Interview skills

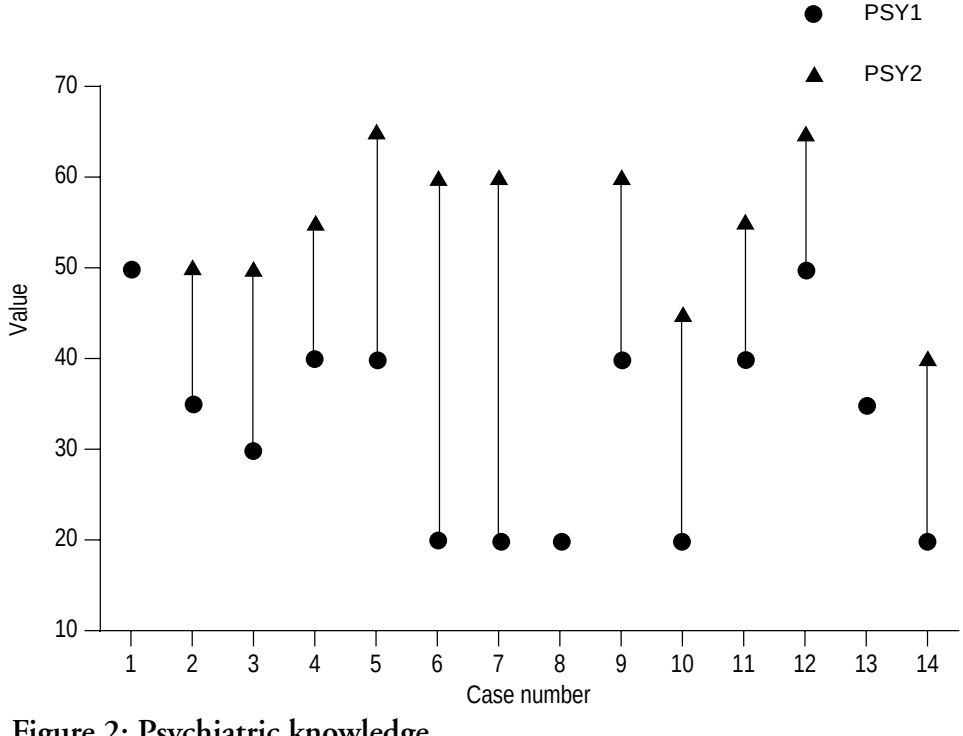

Figure 2: Psychiatric knowledge

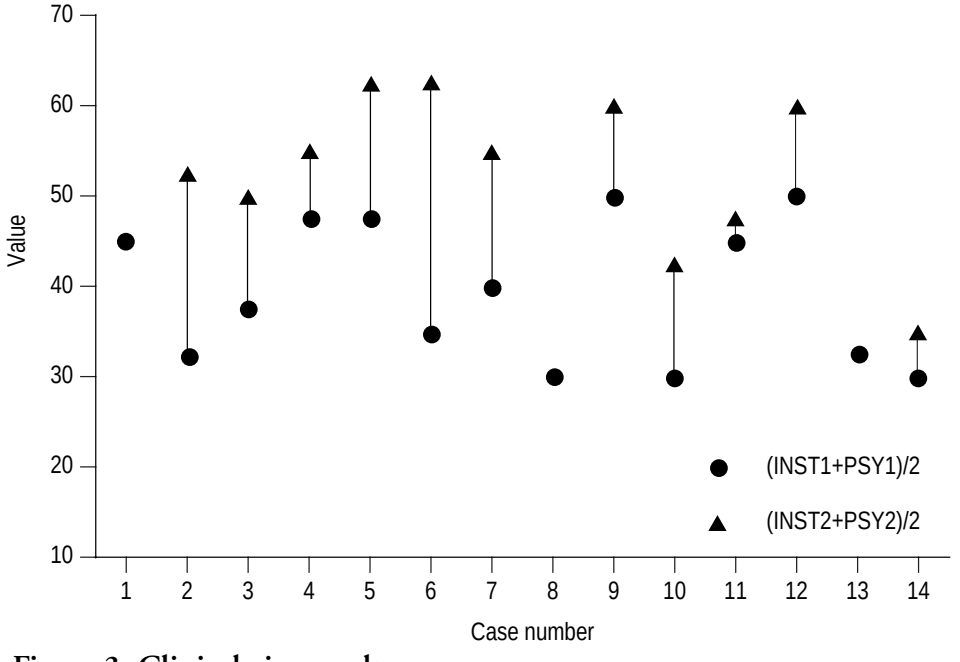

Figure 3: Clinical viva result

Discussion

Current government policies designed to encourage general practitioners to care for people with mental illness have spawned many programs designed to provide essential knowledge for the task. Few have focused, however, on a discrete improvement in clinical skills or placed a specific emphasis on those severely disabled patients treated largely within the public mental health sector. This pilot program demonstrated that while theoretical knowledge relevant to these patients can be increased substantially, such knowledge gains are not necessarily matched by an increase in key clinical skills.

We had expected experienced general practitioners to demonstrate better interviewing skills than medical undergraduates. Given the pivotal role of general practitioners in the detection of mental illness (Whiteford 1992; Goldberg & Gater 1996), this lack of clinical skills is of great concern. More importantly, although an apprenticeship model of clinical training was provided, the program had only a small effect on these core skills. Since most of the current shared care initiatives in Australia do not assess clinical skills directly, the actual impact of such projects on national health policy objectives may be limited. In relation to the method of clinical skills evaluation, the participants did not express major concern about the process. Generally, they accepted the procedure as a common

method in medical education for assessing actual clinical competencies. General practitioner managers and clinical academics did suggest that, in future, it would be more appropriate for a general practitioner to participate as a co-examiner.

In mental illness, the interaction between the patient and the doctor has enormous impact on diagnostic reasoning and treatment planning. Patients with mental illness frequently deny or minimise the nature of their distress. This fact provides some of the explanation for the reduced rates of detection (approximately 20–50 per cent of possible cases) described in the literature (Ormel et al. 1990; Poynton & Higgins 1991; Goldberg et al. 1993; Goldberg & Gater 1996; Harris et al. 1996). Practitioners, however, must have interviewing techniques which encourage patients to tell their own stories and, thereby, provide an entry point to their private world. Highly structured interviews, especially those with a limited medical focus, do not encourage the exploration of relevant psychological symptoms (Goldberg et al. 1993). If general practitioners are not sensitive interviewers, valuable opportunities for early and cost-effective interventions may be lost. This program attempted to increase clinical skills largely via exposure to experienced clinical psychiatrists. The failure to achieve significant gains via the 'apprenticeship' training model emphasises the need for more intensive and/or more prolonged educational experiences which require the acquisition of relevant interviewing techniques (Goldberg et al. 1993). Although such programs may be costly and labour-intensive, their long-term impact may be considerable (Bowman et al. 1992).

When the results of the study were discussed with the participants, a number of relevant factors were highlighted. Participants noted their widely different undergraduate experiences in psychiatry and the general lack of attention paid to the formal teaching of interviewing skills in medical schools. A particularly relevant issue was the present fee-for-service payment system in Australia which, in the view of the participants, simply reinforces poor interviewing behaviour by encouraging closed, goal-directed approaches to clinical history taking.

It was of concern to the mental health service managers that the combination of poor interviewing skills and limited psychiatric knowledge at the commencement of the program meant that the general practitioners were not able to enter the service as equal partners with other mental health personnel. Consequently, only small numbers of selected patients with severe mental illness were eventually transferred to primary care settings. As a result, there was less ability to offset the large cost of the training through more cost-effective patient care. Whether the improved relationships between the mental health service and general practitioners justified the expense of the program is questionable.

Conclusion

Many mental health training programs currently being offered to general practitioners focus simply on increasing specific areas of knowledge. Whether such programs succeed in improving actual clinical skills is rarely directly measured. The program described here attempted to address this issue, but highlighted simply the need for more intense, prolonged and targeted interventions. This program indicated that our expectations of greater general practitioner involvement in the public mental health sector were unrealistic within the time frame of the project. The study raises important questions about the ongoing training of the medical workforce and what other measures will be needed if national policy objectives are to be met. We suggest that evaluation of current shared care programs should focus on the assessment of actual clinical skills and the impact of such skills on later health outcomes.

Acknowledgements

The project was funded through the States and Territories Pilot Projects Hospital Workforce Restructuring Program and cost $250 000 over a two-year period. It involved a collaboration between the St George and Canterbury Districts Mental Health Services and the respective Divisions of General Practice. It also received support from the Faculty of Medicine at the University of New South Wales via the Academic Department of General Practice and the Academic Department of Psychiatry, St George Hospital. The project was supervised by an executive steering committee comprising representatives of the Mental Health Service, the Divisions of General Practice and the Academic Departments of Psychiatry and General Practice.

References

Adeyemi JD & Jegede RO 1994, 'Integrating psychiatry into primary care: An experimental model', *Social Psychiatry and Psychiatric Epidemiology,* vol 29, pp 277–81.

Australian Health Ministers 1992, *National Mental Health Policy,* Australian Government Publishing Service, Canberra.

Bowman FM, Goldberg DP, Millar T, Gask L & McGrath G 1992, 'Improving the skills of established general practitioners: The long-term benefits of group teaching', *Medical Education*, vol 26, pp 63–8.

Carr VJ & Donovan P 1992, 'Psychiatry in general practice: A pilot scheme using the liaison-attachment model', *Medical Journal of Australia,* vol 156, pp 379–82.

Dowrick C 1992, 'Improving mental health through primary care', *British Journal of General Practice,* vol 42, pp 382–6.

Gask L, Goldberg D, Lesser AL & Millar T 1988, 'Improving the psychiatric skills of the general practice trainee: An evaluation of a group training course', *Medical Education*, vol 22, pp 132–8.

Goldberg D & Gater R 1996, 'Implications of the World Health Organization study of mental illness in general health care for training primary care staff', *British Journal of General Practice*, vol 46, pp 483–5.

Goldberg DP, Jenkins L, Millar T & Faragher EB 1993, 'The ability of trainee general practitioners to identify psychological distress among their patients', *Psychological Medicine,* vol 23, pp 185–93.

Harris MF, Silove D, Kehag E, Barratt A, Manicavasagar V, Pan J, Frith JF, Blaszczynski A & Pond CD 1996, 'Anxiety and depression in general practice patients: Prevalence and management', *Medical Journal of Australia*, vol 164, pp 526–9.

Jackson G, Gater R, Goldberg D, Tantam D, Loftus L & Taylor H 1993, 'A new community mental health team based in primary care: A description of the service and its effect on service use in the first year', *British Journal of Psychiatry,* vol 162, pp 375–84.

Joint Consultative Committee in Psychiatry of the Royal Australian College of General Practitioners and the Royal Australian and New Zealand College of Psychiatrists 1997, *Primary Care Psychiatry – The Last Frontier,* Draft Report for Discussion, National Mental Health Strategy Project, Sydney.

Joukamaa M, Lehtinen V & Karlsson H 1995, 'The ability of general practitioners to detect mental disorders in primary health care', *Acta Psychiatrica Scandinavica,* vol 91, pp 52–6.

Kendrick T, Burns T & Freeling P 1995, 'Randomised controlled trial of teaching general practitioners to carry out structured assessments of their long term mentally ill patients', *BMJ,* 311, pp 93–8.

Kerwick S, Jones R, Mann A & Goldberg D 1997, 'Mental health care training priorities in general practice', *British Journal of General Practice*, vol 47, pp 225–7.

Medical Workforce Working Group on Hospital Training and Career Development 1993, *General Practitioner Training in Hospitals,* a report prepared for the Australian Health Ministers' Advisory Council*,* School of Medical Education, University of New South Wales, Kensington.

Millar T & Goldberg DP 1991, 'Link between the ability to detect and manage emotional disorders: A study of general practitioner trainees', *British Journal of General Practice*, vol 41, pp 357–9.

National Health Strategy 1991, *The Australian Health Jigsaw: Integration of Health Care Delivery*, National Health Strategy, Issues Paper No 1, National Health Strategy, Melbourne.

National Health Strategy 1993, *Help Where Help is Needed: Continuity of Care for People with Chronic Mental Illness,* National Health Strategy, Issues Paper No 5, National Health Strategy, Melbourne.

Nazareth I, King M, Haines A, Tai SS & Hall G 1993, 'Care of schizophrenia in general practice', *BMJ,* 307, p 910.

Ormel J, van den Brink W, Koeter MWJ, Giel R, van der Meer K, van de Willige G & Wilmink FW 1990, 'Recognition, management and outcome of psychological disorders in primary care: A naturalistic follow-up study', *Psychological Medicine,* vol 20, pp 909–23.

Pallak MS, Cummings NA, Dorken H & Henke CJ 1993, 'Managed mental health, Medicaid and medical care offset', *New Directions for Mental Health Services,* vol 59, pp 27–40.

Phongsavan P, Ward JE, Oldenburg BF & Gordon JJ 1995, 'Mental health care practices and educational needs of general practitioners', *Medical Journal of Australia,* 162, pp 139–42.

Poynton A & Higgins P 1991, 'Role of general practitioners in care of long-term mentally ill patients', *British Journal of Psychiatry,* 159, pp 703–6.

Salokangas RKR, Poutanen O & Stengard E 1995, 'Screening for depression in primary care: Development and validation of the Depression Scale, a screening instrument for depression', *Acta Psychiatrica Scandinavica,* vol 92, pp 10–16.

Smith GR, Monson RA & Ray DC 1986, 'Psychiatric consultation in somatization disorder: A randomized controlled study', *New England Journal of Medicine,* 314, pp 1407–13.

Tippett VC 1994, 'Targeting opportunities for change: Mental health promotion in primary care', *Behaviour Change,* vol 11, pp 153–66.

Warner RW, Gater R, Jackson MG & Goldberg DP 1993, 'Effects of a community mental health service on the practice and attitudes of general practitioners', *British Journal of General Practice*, vol 43, pp 507–11.

Whiteford H 1992, 'Future directions for mental health services in Australia', *Australian Journal of Public Health,* vol 16, pp 350–3.