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Mental Disorders in General Practice

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A thesis submitted in partial fulfillment of the requirements for the degree of Doctor in Philosophy
The University of Auckland

November 2004
The University of Auckland

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VOLUME ONE
Abstract

Background:
There is a high rate of mental disorders among general practice attendees that is associated with substantial morbidity, disability and global burden. As a consequence GPs play a pivotal role in ensuring that patients with mental disorders are recognised and optimally treated. While there is little doubt of the role GPs play in managing mental illness in general practice the literature suggests a proportion of patients will go unrecognised or else be inadequately diagnosed and in some instances inadequately treated by their GP. The known problems of under diagnosis of mental disorders has been seen until recently to be a problem of GP knowledge and skill, which has led to the close scrutiny of GP performance in this field. In response to this close scrutiny has been the development of a wide range of physician education programs aimed to improving the clinical performance of GPs. However, more recently it has been acknowledged that reasons for low recognition and inadequate treatment of mental disorders in general practice is not only the GPs lack of skill and knowledge, but instead involves a complex interplay of GP, patient and systemic factors unique to GPs, their patients and the general practice setting. Therefore there is a growing interest in research to not only explore ways to improve the clinical performance of GPs, but to also gain a better understanding of the range of issues that GPs are confronted with when managing mental disorders in general practice.

Aim: There were two aims of this research: 1) examine GP attitudes, reported confidence and behaviour pertaining to the detection, diagnosis and management of mental illness in general practice (Study One); and 2) describe the epidemiology of depression in general practice and investigate symptom attribution styles as it relates to depression (Study Two).

Methodology: In Study One 800 randomly selected rural and urban GPs in the North Island were invited to complete the Attitudes, Reported Confidence and Behaviour Questionnaire Revised (ARCBQ-R). The ARCBQ-R had been previously piloted and reliability and validity issues addressed and published elsewhere. In Study Two, 15 general practices were randomly selected from a database of Auckland General Practices, of which 35 consecutive general care attendees were recruited from each of the 15 general practices. Consenting patients completed a self report questionnaire on mood and health and a computerised version of the Composite International Diagnostic Interview (CIDI) questionnaire (depression module only).
Results:

Study One: Four hundred and sixteen (52%) GPs completed the ARCBQ-R. GPs are confronted with a wide range of mental disorders in their day-to-day practice, with a predominance of depression and anxiety. GPs were most confident in detecting, diagnosing and treating depression and were most confident in prescribing antidepressants, particularly SSRIs for depression and anxiety. GP confidence in detection, diagnosis and treatment of mental illness was influenced by a number of GP factors such as: interest in mental health, previous mental health training, gender and exposure to mental disorders in their practice. Systemic and patients factors were also reported to influence the way in which GPs recognise and manage mental disorders in their practice. Only a small proportion of GPs reported to use solely DSM-IV or ICD-10 classifications when making a diagnosis, and the majority relied on informal ways to diagnose mental disorders in their patients, which raises questions about the appropriateness of formal diagnostic classifications in general practice. Training needs for this group of GPs involved both treatment and diagnostic issues pertaining to more complex disorders. GPs believed that shared care of mental disorders is the most effective way to provide optimal care for patients. However a number of issues pertaining to availability and assessibility of secondary mental health services along with structural issues such as cost, time and extended consultations in general practice must be addressed before this model of care can work to its full potential.

Study Two: A total of 475 general practice attendees agreed to take part in this study. Approximately 20% of general practice attendees met DSM-IV criteria for major depression in the last 12 months and 12% for major depression with a recency of ‘1 month to less than 2 weeks’. Just under 5% of the sample met DSM-IV criteria for dysthymia, of which 80% had comorbid major depression. A greater proportion of participants who were divorced or separated, unemployed or looking for work, younger in age, of Maori ethnicity and had a history of mental illness met criteria for DSM-IV major depression. Compared to non-depressed participants, depressed participants in this study reported significantly more missed work or social activity in the last year due to emotional problems. With the aid of two screening questions for depression, GPs in this study accurately identified 75% of depressed general practice attendees. The most common attribution style amongst general practice attendees was a normalising attribution style. Patient attribution styles was not found to influence the level of
depression detection by GPs, instead past and current illness profiles influenced GP detection rates of depression.

**Conclusion:** The current research findings report figures and trends consistent with overseas studies, not only demonstrating the high prevalence of mental illness, particularly that of depression present in general practice attendees, but the many issues that shape mental health care in general practice. Inline with Klinkman’s ‘Competing Demands Model’ GPs perform three important functions: 1) to identify mental disorders in the community; 2) directly provide mental health care to patients; and 3) a referral agent to secondary mental health services. Like Klinkman’s model, results derived from the two studies suggest GPs attitudes towards mental health will shape the level of involvement across these three functions. Results derived from ‘Study One’ and ‘Study Two’ extends on Klinkman’s model to incorporate ‘shared care’ as a potential model for managing more severe complex disorders. However, before such a model of ‘shared care’ can be implemented it is essential that accessibility and communication channels between primary and secondary sectors are improved, and structural funding arrangements including the appropriate remuneration for GPs time is addressed. In reality not all GPs will be interested in managing mental illness in their practice and therefore will not have the motivation to acquire and maintain a level of knowledge sufficient to work with patients with mental illness, whether it be in the capacity of ‘shared care’ or solely the responsibility of the GP. However, it is not unreasonable to expect GPs to have the necessary skills and ability to at least detect and diagnose mental illness in their patient population, and if necessary refer patients on to secondary mental health services. Prerequisite training in mental health, training in diagnostic classifications along with considerations around their appropriateness in general practice, a sound knowledge of patient risk factors for mental illnesses and established networks with secondary mental health services is necessary before GPs can successfully fulfill these roles.
Dedication

In loving memory of Aunty Aileen Stevenson, whose life was dedicated to the education of young people. Thank you Aunty Aileen for your good sense and encouragement.
Acknowledgements

The support and guidance from my primary supervisor Assoc Prof Bruce Arroll, is acknowledged with gratitude. Thank you for sharing with me your knowledge and wisdom and your many research interests in the field of mental illness in general practice. You have been instrumental in getting me through these years and I am forever grateful for your unfailing support and guidance.

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ARCBQ  Attitudes Reported Confidence & Behaviour Questionnaire
ARCBQ-R Attitudes Reported Confidence & Behaviour Questionnaire Revised
BDI  Beck Depression Inventory
CBDI Chinese Beck Depression Inventory
CES-D Centre for Epidemiologic Studies Depression Scale
CIDI The Composite International Diagnostic Instrument
CME Continuing Medical Education
DALYS Disability Adjusted Life Years
DAO Duly Authorise Officer
DEPS Centre for Epidemiological Studies Depression Scale
DIS Diagnostic Interview Schedule
DSM Diagnostic Statistical Manual of American Psychiatric Association
ECA Epidemiologic Catchment Area
Eta Effect size
FHSA Family Health Services Authorities
GDS Geriatric Depression Scale
GHQ General Health Questionnaire
GMS Geriatric Mental Status Examination
HDRS Hamilton Depression Rating Scale
ICD International Classification of Disease
MDD Major Depressive Disorder
MHQ Mood & Health Questionnaire
MOS Medical Outcomes Study Depression Measure
NCS National Comorbidity Survey
NDHB Northland District Health Board
NIMH National Institute of Mental Health
NZSMHW New Zealand Survey of Mental Health & Wellbeing
OCD Obsessive-Compulsive Disorder
PHQ Patient Health Questionnaire
PRIME-MD Primary Care Evaluation of Mental Disorders
PSE  Present State Examination
RCT  Randomised Control Trial
SADS  Schedule for Affective Disorders and Schizophrenia
SCAN  Schedule for Clinical Assessment in Neuropsychiatry
SCID  Structured Clinical Interview for DSM
SDDS-PC  The Symptom-Driven Diagnostic System for Primary Care
SIQ  Symptom Interpretation Questionnaire
SSRIs  Selective Serotonin Reuptake Inhibitors
TCAs  Tricyclic Antidepressants
WHO  World Health Organisation