

Training general practitioners in mental health skills

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The need for family doctors worldwide to receive training in mental health skills has been well documented. As Goldberg & Gater (1996) recently commented on the implications for training of the findings of the World Health Organisation multicentre study (Üstün & Sartorius 1995):

Changes need to be made to the way in which both undergraduates and vocational trainees are taught about mental disorders, so that teaching emphasises the psychological syndromes that general practitioners are likely to meet in their everyday work. Training packages need to be developed for primary care staff in the detection and management of mental disorders.

In the UK about 40% of British General Practitioners (GPs) train formally in a psychiatric post as part of the two years of specialist attachment in their training (Pereira Gray, 1995) but the training needs of future GPs are quite different from those of psychiatrists. A few months working in a psychiatric unit, where the focus is on the management of acute and chronic psychotic illness, does not appear to provide GPs in training with the knowledge and skills that they perceive that they will need for working in primary care (Williams, 1998). Similar comments could undoubtedly be made about the content of many undergraduate psychiatric curricula which continue to focus on the 'major' mental disorders, and fail to integrate mental health training with general hospital and general practice training where students may see, but fail to recognise, any other patients with quite different types of mental disorder from those that they have learned about with their psychiatric attachment. Surveys of the perceived

training needs of experienced general practitioners in the UK also support the need for GP education that focuses on skill acquisition (Turton *et al.*, 1995; Kerwick *et al.*, 1997). Which skills are required?

In early work carried out in Manchester twenty years ago, Marks and colleagues showed that about 46% of the probable cases of emotional disorder being seen in primary care were missed by general practitioners (Marks *et al.*, 1978). They found that both personality factors, and the behaviour of the doctor in the consultation, were important determinants of whether a patient's emotional distress was recognised. Ten key interviewing skills were described:

Early in the interview. Making good eye contact, clarifying the presenting complaint, using directive questions for physical complaints, beginning with open-ended questions and moving to closed questions later (the 'open to closed cone').

Throughout the interview. Making supportive or empathic comments, picking up verbal and non-verbal cues, not reading the notes during the taking of the history, dealing sensitively but effectively with overtalkativeness (being able to 'control' the interview) and asking fewer questions about past history. Given the greater likelihood of being able to change interviewing skills than effect change in personality attributes, work began to focus on the development of improved interviewing skills by means of videofeedback training (Goldberg *et al.*, 1980).

This team then went on to examine interactive effects between the doctor and patient. Davenport *et al.* (1987) demonstrated that doctors who were good identifiers of emotional distress (doctors with a high 'Identification Index' or 'high II' for short) influenced the rate at which cues indicative of emotional distress were emitted by the patient. Doctors who were poor identifiers (or 'low II'), somehow suppressed the rate at which cues were emitted. Further work (Goldberg *et al.*, 1993) delineated a set of behaviours which lead to increased cue emission and

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which are practised more frequently by able identifiers, and other behaviours which decrease cue emission and are less frequently practised by this group. There was also evidence that 'patient-led' interviews lead to greater cue emission than 'doctor-led' interviews. However, the findings were complicated by the fact that there were other behaviours which were only associated with increased cue emission when practised by *able* identifiers and not by poor identifiers. This suggested that the usefulness of the behaviour depended on the strategy that the doctor was following in displaying the behaviour. It is no use learning skills in isolation without considering the pattern of the interview and the rationale behind their use.

The training packages that were informed by this research have therefore focused not only on teaching basic communication skills (Gask *et al.*, 1987; 1988) but also on the development of simple and transferable assessment and management strategies for commonly occurring problems in primary care practice, as originally described by Lesser (1985). This has led to production of packages to teach specific skills for management of patients with somatic presentation of emotional distress (Goldberg *et al.*, 1989), depression (Gask *et al.*, 1998), alcohol problems (Lewis & Gask, 1994), anxiety (Morriss *et al.*, 1999a) and those who are at risk of suicide or deliberate self-harm (Morriss *et al.*, in press). These have proved more acceptable to many doctors than interventions designed primarily to improve their interviewing skills. We find that GPs often perceive their skills, despite much evidence to the contrary, as quite satisfactory. Training packages produced so far go some way to meeting the perceived needs of both the GPs in training who attend our courses (Ratcliffe *et al.*, in press) and experienced GP in the broader community (Kerwick *et al.*, 1997). However, we recognise a need for development of further training packages covering such diverse topics as managing psychiatric emergencies, dealing with potentially violent patients, managing psychosexual problems and talking to parents and children during the consultation.

In evaluating the effectiveness of any educational intervention in primary care it is essential to ask three key questions. Does the intervention bring about a change in clinician behaviour? Does this change, if it occurs, subsequently result in improved clinical, social or economic outcome? Does the intervention improve the morale or confidence of the GP?

Changes in clinician behaviour can be assessed under either controlled role-played conditions or in real

life consultations between GP and patient. In the former an actor plays a patient consulting a GP before and after training. A rater, who is blind as to whether the videotaped role-played consultation with the GP occurred before or after training, determines the presence or absence of specific clinician behaviours (Gask *et al.*, 1987; 1988; 1989; 1998; Bowman *et al.*, 1992; Kaaya *et al.*, 1992). This type of study is especially useful when patients present relatively rarely e.g. patients who are at significant suicide risk. However, these types of study do not show whether the taught skills are used in routine clinical practice. More confidence can be placed in the results of role-played before and after training studies when improvements in clinician skills are accompanied by improved attitudes of GPs to these patients' problems (e.g. Gask *et al.* 1998) and if the skills are maintained over time (Bowman *et al.*, 1992).

Studies of the use of clinical skills in routine general practice after training are difficult to perform and only practical for common mental health presentations such as somatised mental disorder (Blankenstein, 1998) or the evaluation of general interview skills (Goldberg *et al.*, 1980).

Nevertheless, over the last two decades, several studies have demonstrated significant improvements in GPs' communication skills and their ability to recognise and manage psychological distress following mental health skills training (Goldberg *et al.*, 1980; Bensing & Sluijs, 1985; Whewell *et al.*, 1987; Gask *et al.*, 1987; 1988; 1989; 1998; Bowman *et al.*, 1992; Kaaya *et al.*, 1992). The important components of such training appear to be opportunities for video or audiotaped feedback of participants actual performance, opportunities to role-play in order to learn specific microskills and modelling of behaviours to be learned using specially prepared teaching videotapes based around a clear model of the skills and strategies to be acquired (Gask, 1998).

It has been also recognised, from the mixed findings of studies designed to improve recognition through screening, that simply focusing training on recognition alone, without also addressing the management of emotional disorders in primary care, is unlikely to bring about any considerable health gain. As Ormel & Tiemens (1995) comment: ... *The negative results stress the intrinsically close relationship of recognition and management skills. Without the latter, the objective of better recognition remains difficult to achieve.*

It is likely that patients only benefit from the recognition of their mental disorder by the GP if the

patient believes that the GP has a full understanding of their problems. In patients with somatised mental disorder in primary care, improvement in psychiatric symptoms was associated with the patient's perceived satisfaction with the GP's understanding or explanation of their problems (Downes-Grainger *et al.*, 1998) rather than patient perceptions that the GP was disinterested or rejecting of their problems, or passively accepting the patient's view of their problems (Salman *et al.*, 1999).

However, thus far it has not been easy to find conclusive evidence that training GPs in management skills does produce clear evidence of health gain. Catalan *et al.* (1984) showed that a brief psychological intervention by the GP after training was as equally effective as anxiolytic medication. Evans *et al.* (1987) demonstrated that patients of trained doctors were significantly more satisfied and had lower levels of anxiety after consultations compared to patients of untrained doctors. Neither of these studies, however, details whether there was any change in doctor behaviour following training, nor do they describe fully what form the training took. Roter *et al.* (1995) have reported some promising positive results for patients, evident up to six months follow-up, in a randomised controlled study of training for doctors in handling emotional distress. In our own study of the impact on patients with somatised emotional distress of training experienced GPs in 'Reattribution' techniques (Goldberg *et al.*, 1989), we have found, using a before-after study design, promising economic benefits of training (Morriss *et al.*, 1998) with clinical and social benefit limited to patients who, at least in part, accepted that their problems were emotional in origin (Morriss *et al.*, 1999b). Follow-up was limited to 3 months and this work needs to be replicated in a randomised-controlled trial with a longer period of follow-up.

Other studies have, however been less promising. Putnan *et al.* (1988) found that residents were able to learn new skills from training in interviewing behaviours but that this had no effect on patient outcome. In Seattle, Lin *et al.* (1997) examined whether physician education had enduring effects on the treatment of depression and on depression outcomes. Results showed no lasting educational effect in any of the outcomes measured. Finally, in the best known study on the island of Gotland, Rutz *et al.* (1989a) reported that GPs identified more patients with depressive disorders and treated them more appropriately after provision of training. The

suicide rate dropped the year after educational programmes were introduced and there was a decrease in both the utilisation of psychiatric inpatient care and the sick leave of depressed patients (Rutz *et al.*, 1989b). However these all returned to baseline values after 3 years (Rutz *et al.*, 1992).

What can we learn from these studies? Although the Gotland study is not directly comparable with the other work in that it did not focus on skill acquisition, it demonstrates the importance of ensuring that training effects can be maintained, with, if necessary, the provision of 'booster' sessions. In all the other studies, the follow-up period was much shorter. Skills training may also be more successful in producing positive outcomes for patients when it is not too ambitious in content and focuses on a realistic set of relatively easily learned skills (as in the «Reattribution» package (Goldberg *et al.*, 1989). In general, studies of patient outcome after GP training have been too small, bearing in mind that effect sizes of training in patients are small. The unit of randomisation should be the GP rather than the patient because the GP or practice is the target of the training, which will further inflate the sample size approximately two fold (Dunn, 1994). Economic benefits of training may be easier to demonstrate when training is focused on patients who either consume a lot of health care such as somatising patients (Morriss *et al.*, 1998) or are absent from work through illness but can return to work such as patients with milder anxiety or depressive disorders (Mynors-Wallis *et al.*, 1997).

Training studies have only just started to examine whether there are benefits to the GP in terms of improved morale, improved confidence or growth in professional or personal development. The cost of training GPs might be worth paying if there were such benefits to GPs even if patients did not clinically benefit. There are some studies which show that GPs feel more confident about managing patients once they have learnt some specific management skills (Gask *et al.*, 1998; Morriss *et al.*, 1999b).

Lin *et al.* (1997) however rightly point out that training alone may be ineffective without paying more attention to both the organisation of services at the interface between primary and secondary care, and the value of systematic follow up to ensure that the GP's treatment benefited the patient. When physicians are trained to recognise and deal with patients more effectively, they also need to know what to do when they get out of their depth. There is a danger that GPs will be discouraged from using

their newly learnt skills if GPs fear that they may uncover problems which they cannot manage and local secondary care services will ignore. Too little attention has, so far, been paid to the need for longer-term support and supervision yet it may be simplistic to expect to be able to provide a 'shot' of training and leave primary care workers to carry on alone. American studies have shown the benefits of the involvement of psychologists and psychiatrists together with patient self-help in supplementing the GP's care of depressed patients (Katon *et al.*, 1996). However health care services in other countries probably cannot afford nor have access to such resources. An alternative is 'stepped care' in which patients are systematically followed up by the primary care team and given more intensive care by secondary care services if patients have made insufficient progress after a certain time period.

Recent reviews of the methods likely to be effective in continuing education for GPs (Davis *et al.*, 1995; Smith *et al.*, 1998) suggest that a range of strategies including academic detailing, targeting opinion leaders, systematic practice-based interventions and a combination of strategies or 'multifaceted interventions are more effective educational strategies than traditional methods such as lectures and conferences. Any strategy designed to bring about change must also pay attention to the environment and local context in which the intervention is to take place (Mays, 1994). What can those of us involved in developing training strategies for mental health skills in primary care learn from this work?

We do know already that only a limited number of doctors (in our experience about ten per cent of those approached) will be interested enough in mental health issues to attend a course outside their workplace. These numbers are of course greater if training is provided earlier and this has been the reasoning behind our attempts to specifically improve mental health skills training for medical students and for GP trainees (Creed, 1987; Ratcliffe *et al.*, in press) and to train GP teachers themselves how to teach communication skills to their trainees (Gask *et al.*, 1991; 1992).

However, considerably more experienced doctors can be reached (up to 35%) if training is provided in the workplace, for the entire primary care team. There are other important advantages of this type of training such as the members of the primary care team learning how to support each other and developing guidelines and/or policy on the management of certain types of patient across the whole primary

care team. However, we have found that training is often interrupted by routine service demands in the workplace, and as a result some GPs have difficulty in engaging fully with the training.

We have also found others workers such as nurses, where they work with doctors as part of a team, to be more readily enthusiastic about training and able to learn new skills (Morriss *et al.*, 1999a), although there is still doubt about how most effectively to employ such skills in managing mental health problems once they have been acquired (Mann *et al.*, 1998). When the training of nurses in the practice team is encouraged and supported by the GPs and other health professionals with mental health expertise e.g. community psychiatric nurses visiting primary care, the skills of practice nurses can be a useful resource to the primary care team. If such support is not available, practice nurses are discouraged from utilising these skills and it is likely that their skills decay over time.

Other doctors may be reached by offering a range of different strategies from videofeedback training at the highest level to those who are most committed (there is evidence that their skills can still be improved) through to academic detailing visits, reminders and patient-mediated interventions. These might be aimed at indirectly influencing what happens in the consultation by directly influencing patients locally via public information campaigns. The problem is that there is no evidence that these other interventions will be effective in developing *skills*. However, what they may do is serve as ways of getting doctors involved in mental health training, breach barriers and begin to support a primary care environment where there is an increased awareness of the need to develop such skills. Experience from the *Defeat Depression Campaign* which ran in the UK under the joint auspices of both the Royal Colleges of Psychiatry and of General Practice would suggest that local ownership of strategies, rather than campaigns which are perceived to be 'top down' and nationally or 'expert' led are more likely to be successful in breaking down such barriers.

This of course poses logistical problems. Such multifaceted, locally focused approaches are costly, time consuming and as yet have not been fully subjected to analysis in terms of clinical and economic benefits and costs. There is also a considerable skill shortage in terms of having the professionals available to organise and run such interventions. At a more basic level, there is still a considerable lack

of skilled facilitators available to teach communication skills effectively using proven videofeedback techniques at either an undergraduate or postgraduate level.

Clearly more research is required in order to demonstrate the benefits of training in mental health skills but lessons from the existing research suggest that a broader approach, addressing the day-to-day difficulties not just at the interface with the patient but at the organisational interface between primary care workers and specialist mental health professionals may be needed. It has perhaps been naïve to expect longer-term health gains from training without addressing issues of skill retention, supervision and support. Approaches to education may need to be more flexible, offering a range of co-ordinated strategies across a district. Finally, more attention needs to be paid to development of the skills at all levels necessary to facilitate such effective training.

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