How to design education on mental disorders for general practitioners in South Africa

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Abstract

Objective:
This study looks at how the WHO programme Mental Disorders in Primary Care should be adapted for GPs in the South African context in order to positively impact the recognition and management of mental disorders.

Design:
Participatory action research was used to adapt the WHO programme. There were 3 phases to the study. Firstly a co-operative inquiry group of 10 GPs adapted the WHO materials. Secondly the findings of the inquiry were incorporated into the design of a web-based distance education programme. Thirdly the web-based programme was evaluated by means of an action inquiry with the 21 registered GPs.

Setting:
South African general practitioners working in both public and private practice.

Results:
The findings of the study are presented as a model of the primary care consultation with a specific focus on the recognition and management of mental disorders. The approach includes the use of one hypothesis for 'mental problems' and assessment in the 'lobby' of general practice. Six governing variables for this approach are described: cues, communication skills, continuity of care, confidence, course tools and community resources.

Conclusion:
This study presents a practical model of the primary care consultation, which focuses on an approach to the recognition and management of mental disorders. This model has been used to adapt the WHO programme for the South African context. The model may be of use to general practitioners, educational designers, teachers of family medicine / primary care as well as district managers who wish to enhance the quality of care for patients with mental disorders.

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Introduction

Mental disorders represent 10% of the global burden of disease and depression alone is the fourth leading cause.[1] Globally 24% of primary care patients have a diagnosable mental disorder and this can range from 53.5% in Santiago to 9.7% in Shanghai.[2] One study in a Soweto primary care facility found a prevalence of 14.4%.[3] However, despite being common and resulting in significant disability, less than 50% are recognised by primary care providers.[1] Of

those recognised less than half receive any medication and of those who do, benzodiazepines are most frequently prescribed. The majority of mental disorders however are managed in primary care and not in specialist psychiatric services.[3]

In response to this situation the World Health Organisation (WHO) developed an educational programme and set of management guidelines that were based on the Tenth Revision of the International Classification of Diseases (ICD-10).[4,5] This educational programme focused on the six most common conditions: depression, anxiety disorders, alcohol use disorders, sleep problems, unexplained somatic complaints and chronic tiredness. For each of these six conditions a set of desktop tools were provided that included diagnostic checklists, flowcharts and questionnaires, explanatory handycards and patient information leaflets.

In the UK the ICD-10 Guidelines were introduced to general practitioners (GPs) through a study day, but had no impact on the overall detection of mental disorders, the accuracy of diagnosis or prescription of antidepressants.[6] This UK study however was unable to tell us how the educational intervention should be modified to have a greater impact. It has been noted that empirical educational research frequently leads to negative findings and controlled trials are unable to describe what a program did do, what it ought to do, and how it could be modified to educate more successfully.[7] This study therefore takes a different approach to evaluating the WHO educational programme and looks at how the programme should be modified for GPs in the South African context by exploring in detail the nature of the relationship between the GPs and the educational process. New insights and knowledge generated are presented in the form of a model that may be of interest to other designers of educational interventions.

Methods

Participatory action research was chosen as the most appropriate methodology to understand the experience of the GPs and at the same time to adapt the programme. The value of this approach was also confirmed in the UK where action research was adopted as a way to develop and research a national mental health training programme for general practice after the programme failed to develop effective training initiatives using more traditional approaches.[8]

The methodology had three phases. In the first phase the original WHO materials were adapted by means of a co-operative inquiry group. In the second phase the findings of the inquiry were incorporated into the design of a web-based distance education programme. In the third phase the web-based programme was evaluated by means of an action inquiry. Each of these phases is outlined below.

The co-operative inquiry group was advertised and GPs with a known interest in mental health were also invited. Ten GPs from the Western Cape committed themselves to the group and although they shared a common interest in the topic these GPs came from a variety of practices, including private practices in suburban and inner city areas as well as public practices in community health centres on the Cape Flats and surrounding townships. First languages, used by patients and doctors, included English, Afrikaans and Xhosa. The GPs used the WHO materials in their diverse practices over a 6 month period and completed 4 action-reflection cycles. The co-operative inquiry group explored how the WHO materials should be adapted to be more practical and useful to GPs in the South African context.

All 10 group meetings were audiotaped and the process of planning, group reflection and knowledge construction was recorded. Key group discussions were also recorded on newsprint and each facilitator kept detailed personal notes of both process and content contributions within the group. Important discussions and decisions were subsequently documented in a written summary of each meeting that was distributed to each member.

Individual members kept observation notes and narrative accounts of what happened in their practices. In between group meetings people communicated their writing electronically using a group list server that maintained an electronic archive. At the end of the 6 months each person wrote a document describing his or her own personal inquiry and these were shared on the list server. The principal researcher then drew up a tentative 'reflective summary', which was used as the basis for constructing the final group consensus.

A number of criteria were considered as key to the quality of the inquiry: alignment with purpose, ownership of the inquiry process, development of reflectivity, democratic and collaborative group dynamics, commitment to practical action, documentation of the inquiry, transferability of the findings and construction of practical knowledge.

Following this the findings of the co-operative inquiry group were incorporated into the instructional design of a web-based distance education programme that was advertised to all South African GPs.

Finally the 16-week distance education programme was further adapted by means of an action inquiry with the nineteen GPs who participated in the first course. At the end of each of the eight 2-week modules the GPs submitted a detailed reflective journal of their experience and learning. Altogether 92 journals were posted on the Internet and analysed using

qualitative methodology. The journal text was coded, categorised and developed into themes. Six quality criteria were considered in this process: the reflectivity of the researcher, respondent validation by means of reflective summaries posted to the course participants, peer review of the analysis by an independent research consultant, documentation and thick description, fair dealing between participants and transferability of the findings.

The methodology of the co-operative inquiry group, the instructional design process and the methodology of the action inquiry are fully described elsewhere.[9-11]

Results

The findings of the study are presented as a model of the consultation (Fig 1). This model is discussed below in relation to the original WHO materials and is illustrated by quotations from the co-operative inquiry group and web-based reflective journals.

GPs reported that the WHO's six most common conditions were themselves so inter-related that it made more sense to initially consider them as one hypothesis of 'mental problem'. The testing of this one hypothesis was reportedly more efficient in the consultation than initially considering six separate conditions.

"My biggest problem with these diagnostic labels – there is so much overlap of symptoms between depression, anxiety, sleep disorders, fatigue, somatic symptoms and, yes, stress to make it difficult at the beginning to decide which of these sections to use. That probably explains why I have tended to use the somatic complaints section more, as it allows me to address patients offers before defining them into disease entities." SM

This one hypothesis could easily be considered alongside other physical hypotheses in a way that enabled the GP to confidently include psychological and physical hypotheses at the same time. This concept therefore was seen as a practical way of improving initial recognition in the consultation and not as a diagnostic category in itself. A number of questions to test the hypothesis were developed from the WHO materials and modified for the local context. Table I gives an example of questions developed for a Xhosa speaking community.

If the patient tested positively to this hypothesis they were seen to have entered the 'lobby' of general practice. The GPs reported that the WHO materials did not include an open assessment and management area where GPs could make sense of patient's mental problems without forcing them into a diagnostic category. Some patients were sub-threshold for diagnostic categories and for some the ICD-10 categories did not help manage the patient. For example 'adjustment disorder' or 'anxiety, not otherwise specified' while useful for research purposes did not help the GP and patient reach a practical management plan. These patients were reportedly better assessed and managed in a holistic way by considering clinical, individual and contextual issues (Table 2). The "messy entrance hall" or lobby was visualised as having a number of siderooms that represented specific diagnostic categories such as major depressive episode, panic disorder and so on. These siderooms should ideally be linked to spe-

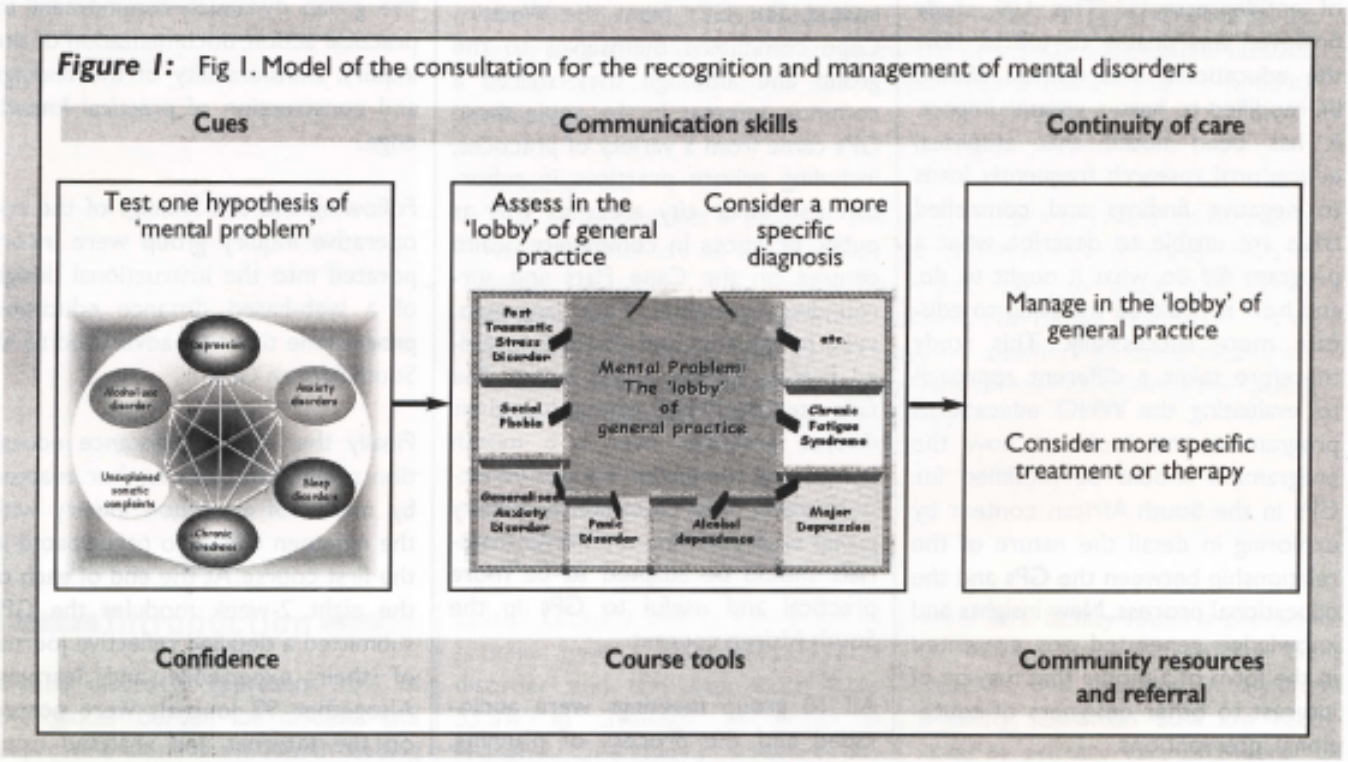

Figure 1: Fig 1. Model of the consultation for the recognition and management of mental disorders

Table 1: Questions to test the hypothesis 'mental problem' in a Xhosa community

1. Are you thinking too much?
2. How are you sleeping at the moment?
3. Do you feel exhausted or tired even when you are not working hard?
4. Do you feel sad or like crying for no reason?
5. As a person there are things that you enjoy doing – do you find that you no longer enjoy these things?
6. Do you sometimes have the feeling as though you are going to hear bad news?
7. Have you ever experienced traumatic events that made you feel extremely threatened or endangered? Or witnessed someone else in this situation?
8. (a) Have you ever felt you should cut down on your drinking?
   (b) Have people annoyed you by criticising your drinking?
   (c) Have you ever felt bad or guilty about your drinking?
   (d) Have you ever had an eye-opener first thing in the morning to steady your nerves or to get rid of a hangover?

If positive to any one further assessment may be required:

If positive to 2,3,4,5 then consider depression

If positive to 1,2,6 consider anxiety disorders

If positive to 8 consider alcohol use disorders

If positive to 7 consider post traumatic stress disorder

Table 1: Assessment in the lobby of general practice

Clinical

Consider whether other medical conditions could be causing the symptoms

Consider whether the symptoms could be a side-effect of medications

Consider possible lifestyle factors

Consider whether the person has a more specific mental disorder

Individual

Ideas "What do you think might be causing the problem?"

Fears "What was the worst thing you were thinking it might be?"

Expectations "What were you hoping we might be able to do for this?"

Context

Consider key areas for psychosocial problems

Consider a genogram to explore the family "Who else is at home with you?"

cific therapies. The GP should consider whether the patient belonged better in one of these rooms, but could also decide to keep the patient in the lobby. A new section, for use in the lobby, entitled 'mental problems' was added to the educational programme with its own diagnostic checklist, flowchart and management handycard. Sleep problems, chronic tiredness and unexplained somatic complaints, from the original WHO materials, were incorporated into this new section 'mental problems' as these were not in themselves specific diagnoses.

"In the package, the most relevant section dealing with these somatic complaints was the 'Unexplained Somatic Complaints' and I found this section very useful in explaining my patients somatic 'offers'. It occurred to me, however, that these were not strictly speaking 'unexplained' yet, and so this was not the right section to use in these patients. We therefore needed to consider a first diagnostic category in the package that would deal with undifferentiated symptoms and somatic complaints. Something like a "lobby" in a house of mental disorder management, where patients would be managed before moving them to specific rooms if diagnostic criteria satisfied their allocation into one of the six rooms." SM

From the experience of GPs with the course materials six factors were identified that could influence the process of recognition and management as well as the use of the educational programme in the practice environment. These were referred to as the six C's: Cues, Communication skills, Continuity of care, Confidence, Course tools, Community resources and referral.

GPs reported that the WHO materials needed to be linked to the presentation of cues from the patients and not used as screening materials for all primary care patients. Diagnostic criteria were of little use if

the GP did not know when to use them with specific patients. Many GPs did not have well developed psychological 'illness scripts' and as a result failed to pick up cues and test for mental problems.

"Patients with mental disorders will in most instances not complain of a problem in the mind but will present with a physical complaint as an 'entry ticket'...I was pleased to notice that I had been able to pick up mental problems using simple cues that I had ignored in the past. It is a sadness that I realise that through the years in practice I may have been missing so many mental illness." J1AM

"Once I began picking up on cues and allowing the patient to talk, it was as if a tap had been opened. Suddenly a lot of patients were confiding in me and allowing themselves to express their emotions." J2VB

The GPs reported that the WHO programme, while referring to communication skills, did not actively address the issue and this was found to be a critical factor.

"From the outset it was obvious that I sorely lacked the communication skills which encourage patients to discuss their psychological problems." J7VB

GPs also reported that continuity of care in the health system was as important as communication skills in the consultation. In some settings, especially with a high workload and short consultation time, the process of recognition, assessment and management needed to spread out between several consultations.

"I cannot spend half-an-hour with a patient - although often I do – due to enormous workload. So, once I have established that the patient is suffering from a mental disorder, I like to hand out the leaflet and questionnaire and ask the patient to return a couple of days later." J0FY

The confidence of the GP in his or her ability to explore and manage mental disorders was reported as another important factor. Consciously developing a practical approach in the consultation, rather than simply increasing GP's knowledge of specific conditions boosted confidence.

"I feel gradually more confident now that I don't have to run away from many of the psychiatric conditions I may encounter in the practice." J4AM

The provision of simple desk-top tools to support each step in this model of the consultation appeared to enable the GPs to change and integrate a new approach into their practice. GPs asked for Posttraumatic Stress Disorder to be added as one of the anxiety disorders in the South African context.

"It is not simple to recognise mental health problems, however by using these structured questions it makes it easier to arrive at a diagnosis with some certainty. The mini-mental state examination is not well suited for the busy practices we find ourselves in...Also keeping the DSM-IV criteria within easy reach is not possible. In most instances this is what makes most GPs to be uncomfortable in dealing with mental disorders." J2AM

The awareness of and accessibility of other community based resources and referral opportunities was reported as another important factor.

"We won't diagnose psychological problems adequately until we have resources to deal with them. I realise that I don't diagnose alcohol abuse, as I have no faith that I can do anything for sufferers. However I diagnose depression well, when I have time to deal with it or a psychologist to whom the patient can go. So it will take a change in the system rather than just a few guidelines." BS

In addition to this model of the consultation and its governing variables a number of other factors were identified that impinged on the success of the educational programme. The most important of these factors were the beliefs and assumptions of the GPs regarding mental disorders. GPs had a number of fears and concerns regarding these patients. For example they were concerned about being manipulated or fooled by patients, being overwhelmed by psychosocial issues, and missing physical problems. Mental patients were seen as requiring extra time that was not available and were seen as 'difficult' or 'heart sink' patients. Many GPs had the belief that mental disorders are uncommon and severe and that they must clearly differentiate between either physical or psychological explanations for their patient's symptoms. The ability of GPs to engage with the programme and to change their practice depended to some extent on the degree to which the course enabled the articulation and reflection of these beliefs and assumptions.

"As a GP I am usually used to rush for making a diagnosis and to sort out the patients physical problem. Module 1 [weeks 3-4 in the course] was an eye opener to me to know that I, like many other GPs was missing many patients inner diagnosis." J7SS

"Most importantly it had a great impact in awareness in the extent of mental disorders in my practice. When I used to think of bipolar illness, major depression, schizophrenia, manic episodes etc. Now I also think of many other conditions like sleep disorders, generalised anxiety disorder, unexplained somatic complaints etc." J7SS

"Patients are not malingerers, they give definite 'cues' when they are experiencing psychosocial problems and they desperately need the doctor to recognise and act on them." J7VB

Another important factor that needed to be addressed was the diversity

of practice settings, languages and cultures within the South African context. Learners could adapt and modify the materials as part of the educational programme for their particular context.

Discussion

This study presents a model of the consultation that demonstrates a practical approach for GPs who want to recognise and manage mental disorders. The model can also be used as a framework to guide educators in the design of more effective interventions for both undergraduate and postgraduate students. A feature of action research is that this conceptual model was developed out of GP's practical experience with the WHO Educational Programme rather than from theory. In addition the findings of this research have already been implemented in the form of a web-based distance education programme for GPs. Some elements of this model are supported by other researchers who have also highlighted the importance of patient-centred interviewing and treatment, the therapeutic effect of the doctor-patient relationship, a biopsychosocial approach to clinical reasoning and care, synergistic attitudes and values, and the ability to diagnose and manage common mental disorders.[12]

This study did not attempt to evaluate the educational intervention by using pre-determined outcomes to measure changes in recognition and management, but rather focused on understanding how to design a practical and useful educational experience for the GPs. The alignment with purpose in the co-operative inquiry group was initially hampered by the need for participants to use the WHO materials in their practices rather than designing their own actions to explore questions regarding recognition and management of mental disorders. However this problem was overcome by the facilitators continually re-aligning the GPs at each group meeting. The participation of the web-based students in the inquiry process was more difficult than in the co-operative inquiry group due to the need for asynchronous interaction at a distance. However each student was required to produce a reflective journal at the end of every 2-weeks as both part of the educational and research agendas and this provided sufficient qualitative material to explore their experience.

This is the first time that the WHO programme has been evaluated in Southern Africa. This study is also unusual in being conducted by primary care practitioners as a recent review of the mental health literature in South Africa found no papers by primary care practitioners.[13] The findings are important in that they show how the WHO's universalistic and specialist-orientated perspective can be integrated with the more relativist and generalist-orientated perspective of the GP to create a practical and efficient approach to recognising and managing the common mental disorders.

In implementing this model as part of an educational intervention the educational principles used in the instructional design will also be important. In the design of the web-based distance education course it was recognised that learning that motivates adults:[14]

- Is perceived as relevant to self
- Makes use of the previous experience of the learners
- Is participatory and actively involves the learners
- Is focused on clinical problems
- Is designed so that they can take responsibility for their own learning
- Can be immediately applied in practice
- Involves cycles of action and reflection
- Is based on mutual trust and respect

Future research in the South African context should explore if this approach is also useful for clinical nurse practitioners and for undergraduate medical students. This model of the consultation may best be introduced at the undergraduate level by combining inputs from psychiatrists and family medicine / primary care.[12] Research into mental disorders is one of the top 10 priorities in the Essential National Health Research initiative and the need for further development and testing of models such as the one described here is highlighted in recent reviews of the literature.[13]

Conclusion

This study presents a practical model of the primary care consultation that focuses on an approach to the recognition and management of mental disorders. This model has been used to adapt the WHO programme for the South African context. This model may be of use to general practitioners, educational designers, teachers of family medicine / primary care as well as district managers who wish to enhance the quality of care for patients with mental disorders.

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