Australian GPs' preferences for education about depression and related disorders

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OBJECTIVE
To investigate Australian general practitioners' experiences of accessing education about depression and their preferences for future education on depression and related disorders.
METHOD
Six hundred and eight anonymous surveys were distributed to GPs through 52 rural and urban divisions of general practice; 420 were returned.
RESULTS
Educational formats involving direct contact with people having mental health expertise were highly valued. Distance education and web based technologies were least used. In the previous year, women and older GPs had spent more time on education about depression. Most intended to undertake more such education in the future and said that education in psychosocial strategies would be very useful. General practitioners' attitudes to further education about depression were influenced by their gender, practice location, and their previous mental health training.
DISCUSSION
More face-to-face training may be desirable to take advantage of GPs' willingness to spend more time on education about depression and related disorders.

Australian general practitioners are interested in developing skills in counselling and diagnosis.[1] Such training may produce changes in GP behaviour,[2,3] although this is contested.[4] Depression is under recognised and under treated in general practice.[5,6] Therefore, mental health education should be made available to GPs so they have the opportunity to acquire the knowledge and skills to care for patients with mental health problems.[7,8] Although many GPs undertake further education and training in mental health skills, little information is available about their preferred content and format.

Method

In 2001, the Australian Divisions of General Practice (ADGP) – which endorsed the project – wrote to all divisions of general practice asking for their participation. The 52 divisions that agreed to participate were requested to forward questionnaire packages (10 for rural, 15 for urban divisins) to a representative sample of their GPs, attempting to balance gender, age, and interest in mental health issues. A total of 420 GPs completed and returned the surveys, a return rate of 69% (*Table 1*). Each GP who returned the questionnaire was paid $40 and his/her division, $10.

The items in the questionnaire were constructed through consultation with a reference group of GPs coordinated by the ADGP. Principal components analysis was undertaken in the sections asking about preferred methods, content, and disincentives to, mental health education. The factors derived by this were analysed against demographic variables by multivariate analyses of variance.

Results

Respondents committed a wide range of time for education on depression/anxiety in the past 12 months (*Table 2*); women GPs and those 45 years of age or older significantly more. Urban and rural GPs did not differ significantly in the amount of time they had spent on education. Most intended to spend more time on such education in the next 12 months, with no differences for GP gender, age, or rurality. Respondents most commonly obtained information about depression and anxiety from academic journals and newspapers (*Table 3*). Face-to-face training was commonly used and perceived to be very useful for the future.

Principal components analysis of the educational methods suggested three factors were important: 'electronic/distance', 'face-to-face', and 'paper' (*Table 4*). General practitioners who had completed previous mental health training rated face-to-face formats as more useful than those who had not ($p<0.01$). Urban

Table 1. Participant demographics

		(n-420)	
		Study sample	National workforce[10]
Sex	Men	46.9%	65.6%
	Women	53.1%	34.4%
Age	<35 years	15.7%	14.8%
	35–54 years	71.3%	59.6%
	55 years	13.0%	24.6%
Average hours worked		39.7	42.1
Qualifications			
–	FRACGP	37.1%	
–	Completed/completing postgraduate mental health	8.3%	
Training			
–	Completed mental health training in past 5 years	43.6%	

Table 2. Time committed to education on depression or anxiety

	n (%)	
	Completed in past 12 months	Anticipate completing next 12 months
No education	30 (7)	4 (1)
5 hours or less	139 (33)	86 (21)
6–15 hours	118 (28)	174 (42)
16 hours or more	130 (31)	150 (36)

Table 3. Preferred educational format

	Used in the past 12 months		n (%) Perceived usefulness in the next 12 months			
	Yes	No	Not at all useful/ a little useful		Quite useful/ very useful	
Academic journals/publications	84%	16%	146	(36)	259	(64)
Medical newspapers (eg. Aus Doc)	83%	17%	207	(52)	194	(48)
Face-to-face training package	50%	50%	59	(16)	308	(84)
Case review with other health professionals	39%	61%	90	(25)	274	(75)
Case review with psychiatrist	39%	61%	83	(23)	282	(77)
Video/audio/CD-rom materials	36%	64%	182	(52)	170	(48)
Professional supervision/peer support	30%	70%	125	(36)	227	(64)
Internet based information program	14%	86%	194	(59)	136	(41)
Attachment to mental health service/clinic	13%	87%	157	(47)	18	(53)
Telemental health/telepsychiatry	13%	87%	225	(67)	110	(33)
Distance education	10%	90%	207	(62)	129	(38)
Internet based interactive support from mental health professionals	4%	96%	191	(59)	131	(41)

GPs with mental health training were more likely to consider electronic formats less useful than urban GPs without such training. However, rural male GPs with mental health training considered this format to be more useful than those without mental health training, whereas the difference seen for urban female GPs held for the rural female GPs ($p<0.01$).

In the urban setting, both male and female GPs with mental health training considered paper based methods to be less useful than those without mental health training. Similarly, in the rural setting, women GPs with mental health training saw paper based education methods as less useful than women without mental health training, but for rural male GPs the reverse held where those with mental health training saw this method as more useful than those without mental health training ($p=0.02$). That is, male GPs in rural areas who had already participated in some mental health training were more inclined to value paper based and electronic educational methods, unlike their urban counterparts and women GPs in general.

Respondents indicated preferences from a list of educational topics (*Table 5*). Principal components analysis of these suggested three important factors: 'diagnosis', 'treatment in focused psychological strategies', and 'patient education and compliance' (*Table 4*).

Women GPs had a greater preference for education in psychosocial treatments ($p=0.02$) and in strategies for patient education and compliance ($p<0.01$) than men, and those more than 54 years of age preferred diagnostic criteria topics ($p<0.01$).

The strongest disincentives to gaining further education about depression experienced by GPs were other educational

priorities, time pressures, and lack of access to face-to-face training (*Table 6*). Again, principal components analysis suggested three important factors: 'lack of access to training and nonelectronic resources', 'lack of electronic resources', and 'no need' (*Table 4*).

Rural GPs ($p<0.01$), those who had not undertaken mental health training, who were without postgraduate mental health qualifications ($p=0.01$), and those younger than 35 years of age ($p<0.01$) perceived the lack of access to face-to-face training and nonelectronic resources to be greater barriers to gaining mental health education than did urban GPs, those with mental health training, GPs with postgraduate mental health qualifications, and those more than 45 years of age.

Discussion

Our findings are generally consistent with those of previous studies,[9] although the GPs

Table 4. Principal components analysis of education questionnaire items

Section	Principal component factors	Percentage of variance explained
Format	Electronic/distance (eg. internet, telehealth)	24.3
	Face-to-face (eg. case reviews, professional supervision/peer support)	24.2
	Paper (eg. medical journals, medical newspapers)	12.6
Content	Diagnosis (eg. information on diagnostic criteria)	24.4
	Treatment in focussed psychological strategies (eg. problem solving, training in evidence based psychological therapies)	22.0
	Patient education and compliance (eg. strategies for educating patients)	18.9
Barriers	Lack of access to training and nonelectronic resources (eg. lack of access to useful materials)	23.7
	Lack of electronic resources (eg. computers)	22.6
	No need (eg. managed only a few patients with depression)	16.0

Table 5. Educational content: usefulness in future training programs

	Quite useful/very useful	
	n	(%)
Strategies for negotiating with patients who won't accept a depression/anxiety diagnosis	358	(86)
Sleep management strategies	358	(86)
Strategies/material for educating patients about depression/anxiety	344	(83)
Structured problem solving strategies	346	(83)
Medications that can cause or increase depression/anxiety	330	(79)
Training in evidence based psychological treatments (eg. CBT, IPT)	324	(78)
Interviewing strategies	320	(77)
Use of activity planning (behavioural activation) strategies	313	(75)
Patient barriers increasing difficulty of recognising depression/anxiety in general practice	303	(73)
Strategies for increasing patients' adherence to antidepressant medication	305	(73)
Medical diagnoses associated with a high risk of depression/anxiety	293	(70)
Suicide risk assessment (including examples of questions to ask)	286	(69)
Risk factors associated with depression/anxiety in general practice	266	(64)
Assessment tools/instruments	261	(62)
Controlled breathing training	256	(62)
Information on diagnostic criteria	223	(53)
Indications, side effects, and starting doses for common antidepressant medications	211	(51)

Table 6. Disincentives to gaining future education

	A fair amount/ a great deal	
	n	(%)
I don't have enough time for ongoing education	193	(47)
I have other educational priorities	175	(42)
I have poor access to small group, face-to-face training	163	(40)
I don't have access to education material from independent sources	94	(23)
I don't have access to useful educational materials	55	(13)
I don't feel I need more education/training	42	(10)
I don't have access to electronic resources (eg. internet)	38	(9)
I don't have access to equipment (eg. computers)	21	(5)
I don't feel the need as I manage few patients with depression and/or anxiety	16	(4)

placed greater emphasis on evidence based psychological treatments.[1] Our findings need to be understood within the limitations of the study. The survey instrument was developed for this study and has not been validated. What GPs say they intend to do may not translate into action. The study sample may not have been representative: the method was vulnerable to bias, there was a greater proportion of women GPs than the national workforce and a greater proportion were 35–54 years of age.[10] Consequently, the generalisability of the results to the wider GP population may be somewhat limited.

Nevertheless, a number of recommendations can be tentatively proposed. First, the high intention to undertake more education in depression and anxiety in the next 12 months suggests that the training requirements for level 1 of the General Practice Mental Health Standards Collaboration framework[11] can be met. Second, further educational programs in depression should particularly focus on skill development related to psychosocial interventions and management of patients, with some input on diagnostic criteria. Third, the experience of most GPs who have undertaken additional mental health training is that face-to-face instruction is more useful than other instructional formats. Some differences in responses were noted from rural GPs when compared to their urban counterparts, suggesting specific consideration needs to be given to the nature of the education programs developed for GPs in these settings.

Implications of this study for general practice

- Many GPs are aware of the need for further education in depression and related disorders.
- Training needs to focus on psychosocial approaches and patient management strategies.
- Preferences are generally for face-to-face training.

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