



Small groups for supporting GPs' professional development in mental health disease



An evaluation

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BACKGROUND

Small groups provide opportunities for education, information sharing, development of clinical skills and peer support. They have been promoted in general practice in Australia, especially for mental health disease, and often by divisions of general practice.

METHODS

Minutes from a series of small groups supervised by psychiatrists were analysed to observe the content and themes over 5 years. Additionally, focus groups of general practitioner participants were asked to comment on what they found most valuable.

RESULTS

Forty-two GPs attended small groups (mean size 2–3) over 3 years, about half for 10–49 sessions. The most discussed diseases were depression (most frequently at 157 times), psychosis (137), personality disorders (79), drug and alcohol abuse (73), anxiety disorders (68) and suicide (42). Discussion of doctor-patient interpersonal and doctor self care issues increased from under 2% of all statements in 1995 to nearly 10% in 2000. Participating GPs found the small groups empowering, confidence increasing, and useful for addressing psychological and interpersonal issues at work.

DISCUSSION

Participating GPs found small groups useful and provided helpful recommendations based on their experiences.

Most (59%) Australian adults would contact a general practitioner first if they developed depression.¹ It is therefore important that GPs have access to ongoing education and support in mental health. This improves their attitudes toward patients with depression and increases self confidence in the management of common mental health disorders.^{2,3} Small group learning is now seen as a powerful method of quality improvement.⁴ Three main types of group experiences are available to GPs: peer support groups such as Balint groups,⁵ that deal with competitiveness, mistakes, anger, difficult patients, death, fear of malpractice, and family-work tensions;⁶ educational groups, that provide knowledge using either workshop or case conference formats;⁷ and interpersonal skills development groups for general or specific interviewing techniques.^{8,9}

The Southeastern and Eastern Sydney Divisions of General Practice (ESDGP) started a shared care mental health program in 1995 commencing with skills development groups. Supervision was provided by nine psychiatrists from St Vincent's and Prince of Wales Mental

Health Services and private practices. Topics for discussion were left to each group, and the process minuted. There were eight groups overall which ran continuously over the period. No psychiatrist received payment for attending groups, but participating GPs were paid by the ESDGP for 4 years, intended both as compensation for time and an incentive to participate. Conditions of payment included sending in minutes from each group. When the project funding lapsed in 2001, some GPs (n=3) left the groups.

Two similar groups were established in 1999 in Adelaide (South Australia) for GPs all over Adelaide following provision of a counselling skills course in association with the local mental health service. In these groups, the topics for discussion were also left to the discretion of the group members, however minutes were not recorded.

We sought to report the experience of a series of skill development groups (SDGs) provided for GPs over a 5 year period.

Method

We used two sources of data. First, the minutes compiled from notes taken by

Table 1. Summary of reflections made by focus group participants

Sydney

(Skills development groups)

Size of the group and frequency of meeting

Ideal size was 3–5 GPs, small enough for individuals to feel comfortable and have adequate opportunity to voice concerns and present patients for discussion

Fortnightly meetings worked best. GPs can 'sit on' a difficult case or issue for 2 weeks until the next meeting, but also appreciated access to a psychiatrist (particularly their group supervisor) for more urgent discussion

Composition of the groups: 'diversity promotes discussion'

A mix of doctors from practices with differing interests and expertise was preferable. GPs were able to learn from experiences of others and enlarge their referral networks. Consistent leadership was useful, but at the same time there was a need to evaluate goals so as not to become stale

Format of meetings

The most useful case presentations used a structured format including reason for presentation (eg. help with diagnosis, help with management, debriefing after a difficult consultation, and debriefing after an unfortunate or unexpected outcome), a brief history and questions for the group

Other useful strategies included: role playing of difficult interactions (where the doctors played their 'difficult patient' and invited another group member to interview them), feedback from seminars and conferences the participant doctors had attended, structured counselling techniques with cases presented to the group, and case conferencing with the case manager also in attendance

Records of meetings

Best if GPs take turns in completing minutes for the SDGs. They also recommended that summaries of all supervision groups (including the themes and interesting issues) could be shared with other SDGs at regular intervals. Some issues with confidentiality if minutes taken were later raised

Content of discussion

GPs generate issues for discussion in each group. Specific areas of discussion thought to be important included:

- transference and boundary issues (eg. setting appropriate doctor-patient relationship boundaries, accepting gifts from patients, dealing with intrusive parents, and deciding when to stop consulting (eg. doing 'too much' for a patient)
- dilemmas in running a practice (eg. handling disagreements with colleagues' prescribing, approaching harassed or impaired colleagues, managing time, concerns about patients lodging complaints over GP management or wanting to change GPs mid-treatment)
- concerns about clinical decision making (eg. missing depression or psychosis, dealing with multiproblem families)
- end of life issues (eg. when to stop active treatment, when to refer to a hospital)

Adelaide

(Case management, then Balint style group)

Ideal size is definitely small (4 GPs currently attend groups). All GPs agreed that self disclosure would be limited within larger groups

Once a month is appropriate for this group, as they would find it difficult to meet more often due to workload. Also have phone access to group leader (ASW), although rarely do

All group members are women, married GPs. They considered that, although having more variation (eg. male GPs) within the group would have its advantages, homogeneity allows for a sense of safety to disclose. Having a group leader with GP experience (10 years) was considered beneficial

Each week a GP was elected to present a case for the following week. However, the group did not take minutes and there was flexibility to change the topic of discussion after a 'sentinel event' (eg. patient suicide)

In regard to the strategies suggested by the Sydney group: this group has never incorporated role playing, occasionally group members provide feedback from useful conferences, counselling techniques are not presented, and there is no case conferencing

No records of the group meetings are taken. Because these are 'Balint' style meetings in which there is an emphasis on emotional expression and personal information is disclosed, minutes of the meetings was not deemed appropriate

The content of discussion changed as the groups switched from case management to the Balint approach, away from case discussions (which could become mired in the difficulties posed by particular patient) toward understanding (why the patient was seen as a problem, and why the GP was 'stuck'). This led to better discussion and outcomes. This group also discussed:

- transference and counter transference, boundaries (eg. accepting gifts) and terminating therapy issues
- dilemmas in running a practice
- clinical decision making has also been a common problem raised within the groups. Obviously this was addressed more in the earlier groups which used a case management approach, but less so within 'Balint' groups
- end of life issues were not discussed often. Although end of life in relation to suicide was frequently discussed

an attending GP on a standard form, which had the following fields: date, names of attendees, a summary of discussion, and the question: 'Did you discuss particular cases/patients?' Although the quality of these minutes varied considerably, and the consistency of their return from groups fell off after funding stopped, they were adequate for coding, which was conducted blind to the supervising psychiatrist and checked by two other authors. The minutes were coded into the following: diagnoses, treatments, and general problems (managing patients with complex and multiple problems; health care systems issues; and doctor self care, transference and potential boundary issues). Coding enabled a tally to be generated. We allowed double counting for comorbidity (eg. depression and somatisation were each counted).

Second, we conducted focus groups (one female and four male GPs in Sydney in late 2003, and four female GPs from Adelaide in late 2004). We sought to discover the topics raised, what methods were most helpful, and how best to evaluate outcomes for future meetings.

Results

Overall, 42 GPs (26 female and 16 male) participated in the small groups (from a total of approximately 420 GPs registered with the division). Each group consisted of a few GPs (average number of GPs per meeting was 2.8, range 1–8) who met regularly with a psychiatrist for 1 hour each fortnight. By the end of 2000, there were seven groups remaining, consisting of 26 GPs. Three GPs had left after payment was ceased, two because they had 'no further need', and the balance because they moved, retired, or became pregnant. Seven GPs had attended 50 sessions or more, 10 attended 30–49, 10 10–29, and 15 had attended <10 sessions.

Analysis of the minutes

Between 1995 and 2000 there were 375 minutes from the Sydney groups returned. The focus decreased from 55% case specific discussions in 1995 to 45% in 2000, with a

corresponding increase in discussion of more general or personal topics.

Out of 711 diagnoses coded, depression was the most frequent at 157 times, followed by psychosis (137), personality disorders (79), drug and alcohol abuse (73), anxiety disorders (68) and suicide (42). Out of 977 general issues, patient management was the most common (841, 86%), health system issues (90, 11%), and doctor-patient interpersonal issues or doctors' self care issues (46, 6%).

Discussion of drug treatments were recorded almost three times as often (203 times) as counselling, psychotherapy and alternative treatments combined (70). Most commonly, drugs were reported for depression (94 times), for psychosis (49), and anxiety disorders (37).

Over time there was a trend toward greater discussion of doctor-patient interpersonal and doctor self care issues, with entries rising from under 2% in 1995 to nearly 10% of the all discussion statements in 2000.

Focus groups

The GPs were asked a series of questions about what they had learned from their experience. The comments and suggestions made by GPs in the focus group were added to the overall input from the minutes to form an impression of how best to run the SDGs (*Table 1*). This list was then shown to the Adelaide group, who added their comments (*Table 1*). The group had changed their focus from case discussion to a greater emphasis on insight and reflection and their comments reflected the change in emphasis.

Discussion

There are several deficiencies of this study: the quality of the minutes (collected for a different purpose) was inconsistent, and the sample of GPs was a small proportion of those who could have participated. Yet the results of the focus groups were similar between both Adelaide and Sydney.

That depression was the most discussed topic is in line with it being the fourth most

commonly managed problem in Australian general practice.¹⁰ There was more attention to medication than psychological treatment, but this changed, perhaps as GPs became more confident in their management of psychological interventions.

The GPs seemed to appreciate the increase in confidence given by the contact with the supervising psychiatrist. The change toward more emotional content may have reflected past work that shows group members became less inhibited with time.⁶ However this may have been related to external phenomena. The high female-male ratio of GPs who participated is worthy of comment. Although the numbers are small, this may reflect a real difference in attitude directly, or may reflect more experience in mental health.^{11,12}

How the benefits could be translated into a national service is difficult to suggest. No such mechanism yet exists in Australia. New modes of GPs working with psychiatrists are currently being examined by the Department of Health and Ageing, and the introduction of a new item number (291) is ideally placed to provide psychiatric consultation on a one-off basis for GPs who frequently see patients with mental health problems. As this mode of working evolves, opportunities may develop through divisions of general practice to coordinate both SDGs and one-off consultations through local networks.

Implications of this study for general practice

- GPs require continuing professional development in mental health problems in primary care.
- There are a number of models for support and supervision, but little evaluation.
- The group all used one model: small group sessions managed by a psychiatrist.
- The most common diagnoses raised by GPs were depression, psychosis and personality disorders.
- GPs enjoyed the supervised groups and were able to provide thoughtful and helpful feedback based on their experiences.

Conflict of interest: none declared.

Acknowledgment

The study was funded by the NHMRC (222708) and an infrastructure grant from the NSW Centre for Mental Health.

References

1. Wirthlin Worldwide Australasia. National mental health benchmark. Sydney: The Royal Australian College of General Practitioners, 2001.
2. Richards JC, Ryan P, McCabe MP, et al. Barriers to the effective management of depression in general practice. *Aust NZ J Psychiatry* 2004;38:795–803.
3. McCormick J, Thomas J. Better outcomes: a case study. *Aust Fam Physician* 2004;33:943–5.
4. Wilson I, Howell C. Small group peer support for GPs treating mental health problems. *Aust Fam Physician* 2004;33:362–4.
5. Balint M. *The doctor, his patient and the illness*. London: 1957.
6. Eubank DF, Zeckhausen W, Sobelson GA. Converting the stress of medical practice to personal and professional growth: 5 years of experience with a psychodynamic support and supervision group. *J Am Board Fam Pract* 1991;4:151–7.
7. McCue JD, Sachs CL. A stress management workshop improves residents' coping skills. *Arch Intern Med* 1991;151:2273–7.
8. The American Academy on Physician and Patient. Available at: www.physicianpatient.org/course_design.html.
9. Platt FW. Findings from Miles Workshops on physician-patient communication. 9th International Balint Federation Congress. Charleston, South Carolina. November 9–13, 1994.
10. Leeder S. Survey reveals GPs' vital role. *Australian Doctor* 2001;27.
11. Wilson H. Self care for GPs: the role of supervision. *NZ Fam Physician* 2000;27:51–7.
12. Davenport TA, Hickie IB, Naismith SL, et al. Variability and predictors of mental disorder rates and medical practitioner responses across Australian general practices. *Med J Aust* 2001;175:S37–41.

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