2001

Psychological problems in New Zealand primary health care: a report on the pilot phase of the Mental Health and General Practice Investigation (MaGPIe)

John Bushnell  
*University of Wollongong, bushnell@uow.edu.au*

Deborah McLeod  
*University of Otago*

A D. Dowell  
*University of Otago*

C Salmond  
*University of Otago*

S Ramage  
*University of Otago*

*See next page for additional authors*

Publication Details

Psychological problems in New Zealand primary health care: a report on the pilot phase of the Mental Health and General Practice Investigation (MaGPie)

Abstract

Aim. To carry out a pilot study in two regions in order to investigate prevalence of psychological problems in primary care in New Zealand. Method. General Practitioners (GPs) within two geographic regions were randomly selected. All adult attenders at their practice on selected days were administered a short questionnaire, the GHQ-12, which assesses the presence of psychological symptoms. The GP recorded the reasons for each consultation, and was interviewed at the end of each day about selected patients, to determine their opinion about the type of psychological problems experienced. Results. Three-quarters of selected GPs (76%) agreed to participate. 96% of patients attending their GP agreed to complete the GHQ. Scores from 385 completed GHQ screening questionnaires suggested that 23.4% of GP patients had significant psychological symptoms. When GPs were asked about the main reason for consultation, they identified only 5.7% of current consultations as being for psychological reasons. In contrast, the GPs thought that 20.6% of patients described having some symptoms which were either mildly, moderately or completely psychological in the current consultation, and recognised that 17.4% of their patients had a mild, moderate or severe case of psychological disorder over the past twelve months. Conclusion. GPs identified one in five of their patients as having symptoms which were mildly, moderately or completely psychological, although psychological factors were the main reason for consultation in only one patient in twenty. Previous reports of very low rates of psychological problems among GP attenders in New Zealand have been thought to indicate major differences in access to health care or prevalence of common mental disorders within primary care services in this country. However, the apparently low rates of conspicuous mental disorder in New Zealand general practices may be better explained as an artifact of the type of questions asked.

Keywords
primary, problems, general, mental, phase, pilot, report, practice, care, health, zealand, psychological, investigation, magpie

Disciplines
Medicine and Health Sciences | Social and Behavioral Sciences

Publication Details

Authors
John Bushnell, Deborah McLeod, A D. Dowell, C Salmond, S Ramage, S Collings, University of Otago, Marjan Kljakovic, and L McBain

This journal article is available at Research Online: http://ro.uow.edu.au/smhpapers/1996
usually non-contact, involving twisting or landing awkwardly from a leap with sudden deceleration. When injured, the athlete fell to the ground unable to continue playing. A substantial early swelling usually developed indicating haemarthrosis.

When patients were initially asked to express in general terms what they sensed at the time of injury, about one in two (48.6%) sensed something dramatic had happened to their knee. More specific questioning about commonly known sensations associated with ACL tears produced a higher rate of more dramatic symptoms. Thus, about three in four (77.1%) sensed a ‘disruption’, and many felt ‘dislocation’, ‘bones moving’, ‘pop’ or ‘snap’.

We recommend that doctors dealing with acutely injured athletes have a high index of suspicion of ACL tear when given the characteristic history. Doctors should be aware that a complete tear of the ACL can be present at initial presentation, even if the physical examination is apparently negative or equivocal. The answers to specific questions about sensations indicating knee disruption at the time of injury are often helpful for diagnosis and should be sought. If in doubt, doctors should warn patients away from high-risk sports and refer early to more experienced doctors for definitive diagnosis and treatment.

Psychological problems in New Zealand primary health care: a report on the pilot phase of the Mental Health and General Practice Investigation (MaGPie)

The MaGPie Research Group, Wellington School of Medicine, University of Otago, Wellington.

Abstract

Aim. To carry out a pilot study in two regions in order to investigate prevalence of psychological problems in primary care in New Zealand.

Method. General Practitioners (GPs) within two geographic regions were randomly selected. All adult attenders at their practice on selected days were administered a short questionnaire, the GHQ-12, which assesses the presence of psychological symptoms. The GP recorded the reasons for each consultation, and was interviewed at the end of each day about selected patients, to determine their opinion about the type of psychological problems experienced.

Results. Three-quarters of selected GPs (76%) agreed to participate, 96% of patients attending their GP agreed to complete the GHQ. Scores from 385 completed GHQ screening questionnaires suggested that 23.4% of GP patients had significant psychological symptoms. When GPs were asked about the main reason for consultation, they identified only 5.7% of current consultations as being for psychological reasons. In contrast, the GPs thought that 20.6% of patients described having some symptoms which were either mildly, moderately or completely psychological in the current consultation, and recognised that 17.4% of their patients had a mild, moderate or severe case of psychological disorder over the past twelve months.

Conclusion. GPs identified one in five of their patients as having symptoms which were mildly, moderately or completely psychological, although psychological factors were the main reason for consultation in only one patient in twenty. Previous reports of very low rates of psychological problems among GP attenders in New Zealand have been thought to indicate major differences in access to health care or prevalence of common mental disorders within primary care services in this country. However, the apparently low rates of conspicuous mental disorder in New Zealand general practices may be better explained as an artifact of the type of questions asked.

Internationally, there is increasing pressure for primary health care to take on greater responsibility for managing mental illness. In New Zealand, in contrast to most other countries providing socialised health care, primary care is run as a private business with costs to patients. This may have an impact both on what sort of problems patients disclose to their GP, and the response of the GP to the patient who does disclose psychological difficulties.

Although a few studies have described the nature of consultations in New Zealand general practice, none have had a primary focus on mental health. These studies have reported low rates of consultation for psychological reasons (3.1%, 4.4% and 7.6% respectively). In contrast, extensive research into psychological problems in primary care in other countries has generally found between a quarter and a third of consultations are with patients who are experiencing significant psychological distress. The World Health Organisation (WHO) international study in fifteen different centres in fourteen countries found that 24% of general practice attenders had a current mental disorder reaching ICD-10 criteria and another 9% had a sub-threshold disorder (clinically significant symptoms, but not meeting full criteria for ICD-10). The lower rates of consultation for psychological reasons are not due to greater psychological health in this country. There is no less disorder in the New Zealand general population: prevalence rates of mental disorder in New Zealand are similar to European and North American countries in which many primary care studies have been undertaken.
The apparently low prevalence of mental health problems in primary care may reflect the emphasis of the New Zealand GP studies, which focused on asking for one main reason for attending one consultation. This may not allow for the complexity of reasons for seeking medical consultation, especially where those with physical illness also have psychological problems, where psychological distress is presented as somatic concerns, or where the GP has adopted a strategy of exploring the patients’ problems in smaller ‘bites’ over several consultations.

This pilot study aimed to randomly select GPs, and compare data from the General Health Questionnaire (GHQ) with the opinion of the GP about the psychological state of their patients.

Methods

Two settings were chosen for the study, both in the North Island of New Zealand. One was a largely rural area in Taranaki province. The other was Wainuiomata, a relatively deprived urban area located near Wellington city. The study sampled both individual GPs and their patients. Lists of GPs in each area were compiled, and selection of GPs made from these lists. Patients visiting their GP were recruited if they were aged eighteen years or over and were able to read, understand and complete the GHQ. A more detailed GP interview sought additional information about some patients. GHQ scores were used to allocate patients to three groups of severity of psychological symptoms. These groups were sampled for the GP interview with differing probabilities. All patients to three groups of severity of psychological symptoms. These groups were sampled for the GP interview with differing probabilities. All

Patients who were not identified by the GHQ sampling strategy but were identified by the GP were also included for GP interview.

The selection of measures in this pilot study were largely influenced by the WHO’s International Study on “Psychological Problems in General Health Care”.

Initial patient screening instrument. The GHQ-12 is a twelve item self report questionnaire widely used in primary care research. Each item is rated on a four-point scale, representing the severity of symptoms of psychological distress over the past few weeks.

Encounter form. A record of all patient consultations was completed by the GP. The encounter form asked about the patient’s pattern of consultation, the reason for contact, current state of health, extent of physical and psychological components to the consultation, and the severity of physical, illness, and psychological disorder. The encounter form was adapted for New Zealand conditions from the ‘Physician Encounter Form’ used in the WHO study.

GP interview. GPs were interviewed about patients who were identified by the GHQ sampling strategy to obtain diagnosis of a mental disorder, onset of disorder, medication and other treatments, and the GP’s future plans for patient care.

GP characteristic questionnaire: GPs also completed a questionnaire about themselves, including: length of career; type of practice; specific experience or training in mental health; services offered to patients with psychological disorders; knowledge of and experience of local mental health services; and attitudes towards mental health.

Recruitment of general practitioners. A list of potentially eligible GPs within the two geographical regions was compiled from sources including the Royal New Zealand College of General Practitioners and a commercial agency handling GP publications. Selected GPs were sent a letter of introduction and invitation to take part in the study, followed where possible by a personal visit. Each GP was offered reimbursement for the opportunity costs of participating in the study, and participation earned re-accreditation points for continuing medical education and self-audit.

Recruitment of patients. On the days on which data collection occurred, the practice receptionist asked each eligible patient whether they would take part in the study by filling in a brief questionnaire on ‘stress and worry’ as they waited to see their GP. Consenting patients were then asked by a researcher to complete the GHQ-12, as well as a few additional questions. The GP completed an ‘encounter form’ immediately after the consultation. At the end of the day, the researcher met with the GP who completed the more detailed interview about the sub-sample of patients identified by the sampling strategy described above. A questionnaire describing the characteristics of the GP and practice was also completed.

Analysis: Descriptive statistics were derived using the EPI-INFO statistical package.

Results

In Taranaki, of fourteen GPs selected, nine agreed to participate. Refusals were almost all due to lack of time. In Wainuiomata, all seven GPs agreed to participate. This yielded a combined response rate of (16/21) 76%. Thirty-one of the GPs were male and three were female, and mean age was 45 years (SD 12, range 32–66). Half (eight or 50%) identified themselves as New Zealand European/Pakeha. The mean length of time practising as a GP was sixteen years (SD 12, range 2–37 years), and in their current practice was fifteen years (SD 7, range 0.5–27 years). On average, the Wainuiomata GPs had practiced for slightly longer (nineteen years vs thirteen years). Almost two-thirds were New Zealand graduates (ten or 63%). Only two GPs were not either a full or associate member of the Royal New Zealand College of General Practitioners.

Patient response rate, background and demographic variables. A total of 385 GHQ’s were completed. The overall patient response rate was 96% (385/402). In Taranaki, there were 57 (39%) men and 88 (61%) women with a mean age of 53.0 years (SD 18.0). In Wainuiomata, there were 110 (46%) men and 130 (54%) women with a mean age of 45 years (SD 17).

Results from the General Health Questionnaire-12. Although 409 encounter forms were completed, we report on 385 where there was also a completed GHQ. In Taranaki, the mean GHQ score was 2.3 (SD 3.0) and the median was 1 (range 0-12). In Wainuiomata, the mean GHQ score was 2.9 (SD 3.5) and the median was 1.5 (range 0-12). The frequency distribution for both areas is shown in Table 1.

The distribution of scores for the two areas did not differ significantly (Kruskal-Wallis $\chi^2=3.387$, df=1, $p=0.066$). Hence the groups are combined for further data analysis.

Frequency of Consultation. A large group of patients (151/385 or 39.2%) had consulted five or more times in the past twelve months, 121 patients (31.4%) had consulted three or four times, 76 (19.7%) patients had consulted one or two times and 35 (9.1%) had not consulted the GP in past twelve months.

<table>
<thead>
<tr>
<th>GHQ score</th>
<th>Frequency</th>
<th>Taranaki</th>
<th>Cumulative</th>
<th>Wainuiomata</th>
<th>Cumulative</th>
</tr>
</thead>
<tbody>
<tr>
<td>0</td>
<td>63</td>
<td>41.4</td>
<td>41.4</td>
<td>82</td>
<td>14.2</td>
</tr>
<tr>
<td>1</td>
<td>18</td>
<td>12.4</td>
<td>53.9</td>
<td>38</td>
<td>15.8</td>
</tr>
<tr>
<td>2</td>
<td>21</td>
<td>14.5</td>
<td>70.3</td>
<td>32</td>
<td>13.1</td>
</tr>
<tr>
<td>3</td>
<td>9</td>
<td>6.2</td>
<td>76.6</td>
<td>14</td>
<td>5.8</td>
</tr>
<tr>
<td>4</td>
<td>3</td>
<td>2.1</td>
<td>78.6</td>
<td>15</td>
<td>6.3</td>
</tr>
<tr>
<td>5</td>
<td>7</td>
<td>4.8</td>
<td>81.4</td>
<td>7</td>
<td>2.9</td>
</tr>
<tr>
<td>6</td>
<td>9</td>
<td>6.2</td>
<td>89.7</td>
<td>11</td>
<td>4.6</td>
</tr>
<tr>
<td>7</td>
<td>4</td>
<td>2.8</td>
<td>92.4</td>
<td>8</td>
<td>3.3</td>
</tr>
<tr>
<td>8</td>
<td>2</td>
<td>1.4</td>
<td>99.8</td>
<td>5</td>
<td>2.1</td>
</tr>
<tr>
<td>9</td>
<td>2</td>
<td>1.4</td>
<td>95.2</td>
<td>8</td>
<td>3.3</td>
</tr>
<tr>
<td>10</td>
<td>4</td>
<td>2.8</td>
<td>97.9</td>
<td>9</td>
<td>3.8</td>
</tr>
<tr>
<td>11</td>
<td>0</td>
<td>0.0</td>
<td>97.9</td>
<td>4</td>
<td>1.7</td>
</tr>
<tr>
<td>12</td>
<td>3</td>
<td>2.1</td>
<td>100.0</td>
<td>7</td>
<td>2.9</td>
</tr>
</tbody>
</table>

Table 1. Frequency distribution of scores on the GHQ-12.
Main reason for consultation. Only in 22 cases (5.7%) did the GP feel that the main reason for consultation was psychological. In 169 (43.9%) cases, the main reason for the consultation was a physical acute illness. In 70 (18.2%) cases, the main reason was pain, and in 55 (14.3%) cases it was for a physical chronic condition. Other reasons were: administration/paperwork (5.2%), preventive health care (5.7%) and pregnancy/family planning (5.7%). Patient’s worry or concern was also recorded by the GP as an additional main reason for consultation in fourteen (3.6%) cases.

Extent of psychological symptoms present. Table 2 shows that GPs thought the presenting problems were completely physical in 53% of patients. About a fifth (20.7%) had current symptoms that were thought to be mildly, moderately or completely psychological, although presenting symptoms were thought to be completely psychological in only 3.6% of consultations. Looking back at each patient over the past year, the GP felt that just over 40.8% of patients had been mildly, moderately or severely physically ill during the past twelve months, whereas 17.4% were scored as a mild, moderate or severe case of psychological disorder during the past twelve months.

Relationship between the GHQ-12 and the GP’s opinion. A ‘probable case’ on the GHQ-12 was defined as a score of five or above. On the encounter form completed after each consultation, it was defined by the presence of mild, moderate or severe psychological disorder over the past twelve months. Overall, the GP and GHQ-12 agreed in 77.6% of cases, but of 67 patients identified by the GP as having ‘significant psychological distress’ only 36 (46%), and of the 90 GHQ identified ‘probable cases’, 36 (40%) were thought by the GP to have ‘significant psychological distress’. There were six missing cases on the encounter form, where the GP had not known the patient for a sufficient length of time.

Selection for detailed GP interview. The detailed interview of the GP was completed for patients identified either by the GHQ sampling strategy or through identification by the GP (168 patients in total). The cut-points one and four, when applied to the distribution of GHQ scores, allocated 23.4% (90) of the patients to the highest scoring group, 24.4% (94) to the medium group and 52.2% (201) to the low scoring group, and each group was sampled with differing probabilities as described above. There were 26 other patients (14.8%) not identified by the GHQ sampling strategy who were identified by the GP as having a significant psychological disorder.

Table 2. Extent to which presenting symptoms are physical and/or psychological* according to the GP.

<table>
<thead>
<tr>
<th>Extent</th>
<th>Physical Number</th>
<th>Psychological Number</th>
</tr>
</thead>
<tbody>
<tr>
<td>Not at all</td>
<td>24 6.2</td>
<td>253 65.7</td>
</tr>
<tr>
<td>Somewhat</td>
<td>27 7.0</td>
<td>45 11.7</td>
</tr>
<tr>
<td>Mildly</td>
<td>29 7.5</td>
<td>12 8.3</td>
</tr>
<tr>
<td>Moderately</td>
<td>84 21.8</td>
<td>34 8.8</td>
</tr>
<tr>
<td>Completely</td>
<td>205 53.2</td>
<td>14 3.6</td>
</tr>
<tr>
<td>Not applicable</td>
<td>16 4.2</td>
<td>7 1.8</td>
</tr>
</tbody>
</table>

*Physical/psychological categories are not exclusive.

Table 3. The relationship between GHQ probable ‘caseness’ and being identified by the GP as having significant psychological distress.

<table>
<thead>
<tr>
<th>GHQ probable “case†”</th>
<th>GP identified significant psychological distress</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>No</td>
</tr>
<tr>
<td>No</td>
<td>258 (68.1%)</td>
</tr>
<tr>
<td>Yes</td>
<td>54 (14.3%)</td>
</tr>
<tr>
<td>Total</td>
<td>312 (82.3%)</td>
</tr>
</tbody>
</table>

*Missing data on six cases
†A “probable case” on the GHQ-12 was defined by a person scoring 5 or above.

Diagnosis of psychological disorders. Psychological disorder most commonly diagnosed by GPs as ‘possible’ or ‘definite’ included mixed anxiety/depression (9.3%), depression (7.0%) anxiety disorder (2.1%) drug/alcohol disorder (2.1%) and personality disorder (2.1%).

Duration of illness and treatment. Over half of patients with a psychological disorder identified by the GP were rated as having a ‘chronic ongoing problem’ (44/78, 56.4%). Treatment in the last month for psychological disorder included anti-depressant medications (38.5%). In 38 (48.2%) cases, no drugs were prescribed. Discussion of problems (65.3%) and regular follow-up (35.9%) were the most common ‘other’ treatments received by patients over the past month.

Discussion

The results of this study cast some light on the paradoxical findings of previous GP research in New Zealand in relation to the prevalence of identified psychological problems. When GPs were asked about the main reason for consultation, they identified only 5.7% as being for psychological reasons. This is consistent with the WaiMedCa, PriMedCa and CoMedCa studies,1-3 but much lower than international studies such as the WHO study of Psychological Problems in General Health Care.4 At the same time, however, the GPs thought that 20.7% of their patients described current symptoms which were mildly, moderately or completely psychologically in the current consultation, and recognised that in the past twelve months, 17.4% of their patients had a mild, moderate or severe case of psychological disorder. Although about a fifth of GP attenders were identified by the GHQ and by the GP as having significant psychological distress, only 36 of the 121 patients identified by either method were identified by both methods, suggesting that there are important discrepancies between what is identified by the GP and by the GHQ. When GPs are asked to rate the presence and severity of both physical and psychological symptoms, and not just one or the other, the New Zealand data on psychological problems begin to more closely approximate the patterns of use of primary health care services seen in other countries. Since primary care services are the sole source of treatment for about three quarters of those obtaining help for mental health problems,7 further research is clearly warranted into factors influencing identification and treatment of mental disorders in primary care.
Saying is believing

Margie Comrie, Senior Lecturer, Department of Communication and Journalism, College of Business, Massey University, Palmerston North.

NZ Med J 2001; 114: 16-7

As a child, in the doctor’s waiting room I loved to pit my brains against the compilers of the Reader’s Digest “Test Your Word Power” section, and was always downhearted if I missed more than one. I imagine the idea was that having a grasp of words set you on the road of lifetime material success. I suspect it merely encouraged me to be pompous. But those inveterate trawlers of the dictionary in the magazine’s office did get one thing right - words are powerful.

Commanding the right vocabulary can carry the speaker a long way. My computer may be nothing more than a glorified typewriter to me. But I can hold my own in any company and ensure I’m not destined to be road kill on the information superhighway by liberally using the E prefix as in E-commerce, E-communication or E-teaching.

One of the most moving testimonials to the allure of words comes from Janet Frame. In The Envoy from Mirror City, newly arrived in London, she takes long bus journeys “to places with haunting names – Ponders End, High Wycombe, Mortlake, Shepherds Bush, each time arriving at a cluster of dreary looking buildings set in a waste of concrete.” Her autobiography, in part dedicated to showing she had never had schizophrenia, tells how when the word was applied to her, “It seemed to spell my doom”. How she would read case histories of those suffering from schizophrenia and use them to describe ‘hallucinations’ in her sessions with a young, handsome psychologist. The name ‘schizophrenia’, associated with artists and visionaries, exercised a powerful hold as she tried to match the named ‘symptoms’ with her own behaviour, treading a path leading to years of incarceration.

We name something and it takes on a life of its own – especially if the label packs an emotional punch. The media quickly circulate new expressions. ‘Road rage’ was all the rage a while back, giving a sort of legitimacy and freshness to common assault. It was first noticed overseas of course, but as we never like to be behind the times, it was not long before the media discovered we had our very own road ragers. Then there was ‘home invasion’. Breaking and entering houses followed by violence is unfortunately nothing new. But last year, following one brutal assault it got a name. Suddenly ‘home invasion’ - a new threat to our peace – had arrived. The concept focused a number of worries, fears and insecurities, setting off a push for a hasty law change.

Such phrases appear, gain currency and then fade away – presumably along with the phenomenon they describe. Whatever happened to ‘suburban neurosis’? It was rampant while I was growing up – women with real medical problems were diagnosed, instead, as suffering from suburban neurosis and fobbed off with valium tablets.

Now we have rocketing rates of ‘attention deficit disorder’. Severe cases are relatively rare, but it has a cluster of behaviours, most of which will be recognised by every parent in their child at some time. Stressed parents now have a name for what may often be little more than an uncomfortable clash between the energy levels of their children and the conflicting stimuli and restrictions of modern living. There is also apparently a chemical ‘cure’. Pressures on doctors from parents and drug companies increase and so does the number of children taking ritalin. Not only is there some dispute about the long-term effects of the drug, but it seems it is now being sold on the street, no doubt promoting another public panic.

Providing a name for something does, in a very real sense, bring it into creation. What is more, we have a habit of talking about an abstract notion as if it were tangible. For some time we have been in thrall to ‘the economy’. An alien dropping in on earth and listening to us talk would have to assume the economy is a living breathing entity, possibly a vengeful god that needs to be propitiated by appropriate sacrifices. This god also has a consort – ‘the market’, a sort of cosmic force that apparently cannot or should not be controlled.

Credulous and often mistaken borrowing of models and their language from business and economic theory has cast a pall over public life. In recent years, most of us have experienced the bewilderment and frustration of having the verbal rug whipped from under our feet. The language we use to describe our jobs and aspirations has been ‘re-engineered’ and whole concepts have disappeared. Worse, words that once meant one thing now mean another – generally, it seems, something rather more mean spirited than the original.

Correspondence. Associate Professor John Bushnell, Director, MaGPIe Research Group, Wellington School of Medicine, University of Otago, Box 7343 Wellington. Email: bushnell@wnmeds.ac.nz