



Original article

Training General Practitioners to Detect Probable Mental Disorders in Young People During Health Risk Screening



Anne-Emmanuelle Ambresin, M.D.^{a,b,1}, Christiaan P. Otjes, M.D.^{a,*,1},
 George C. Patton, M.B.B.S., M.R.C.Psych., M.D.^{c,d,e}, Susan M. Sawyer, M.B.B.S., M.D.^{c,d,e},
 Sharmala Thuraisingam, M.Biostat.^a, Dallas R. English, M.S., Ph.D.^f,
 Dagmar M. Haller, M.D., Ph.D.^{a,f,g}, and Lena A. Sanci, M.B.B.S., Ph.D.^a

^a Department of General Practice, University of Melbourne, Melbourne, Australia

^b Multidisciplinary Unit for Adolescent Health, Lausanne University Hospital, Lausanne, Switzerland

^c Centre for Adolescent Health, Royal Children's Hospital, Melbourne, Australia

^d Department of Paediatrics, University of Melbourne, Melbourne, Australia

^e Murdoch Children's Research Institute, Melbourne, Australia

^f School of Population Health, University of Melbourne, Melbourne, Australia

^g Primary Care Unit, Department of Community Health and Medicine, Faculty of Medicine, University of Geneva, Geneva, Switzerland

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ABSTRACT

Purpose: The purpose of the study is to investigate whether a training intervention increases general practitioners' (GPs) detection sensitivity for probable mental disorders in young people.

Methods: Forty general practices were randomized to an intervention (29 GPs) or comparison arm (49 GPs). Intervention GPs participated in 9 hours of interactive training on youth-friendly care, psychosocial health risk screening, and responding to risk-taking behavior with motivational interviewing approaches, followed by practice visits assisting with integration of screening processes and tools. Youth aged 14–24 years attending GPs underwent a computer-assisted telephone interview about their consultation and psychosocial health risks. Having a “probable mental disorder” was defined as either scoring high on Kessler's scale of psychological distress (K10) or self-perceived mental illness. Other definitions tested were high K10; self-perceived mental illness; and high K10 and self-perceived mental illness. Psychosocial health risk screening rates, detection sensitivity, and other accuracy parameters (specificity, positive predictive value, and negative predictive value) were estimated.

Results: GPs' detection sensitivity improved after the intervention if having probable mental disorder was defined as high K10 score and self-perceived mental illness (odds ratio: 2.81; 95% confidence interval: 1.23–6.42). There was no significant difference in sensitivity of GPs' detection for our preferred definition, high K10 or self-perceived mental illness (.37 in both; odds ratio: .93; 95% confidence interval: .47–1.83), and detection accuracy was comparable (specificity: .84 vs. .87, positive predictive values: .54 vs. .60, and negative predictive values: .72 vs. .72).

Conclusions: Improving recognition of mental disorder among young people attending primary care is likely to require a multifaceted approach targeting young people and GPs.

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IMPLICATIONS AND CONTRIBUTION

This study demonstrates the effectiveness of a complex intervention in improving general practitioners' detection of probable mental disorders in psychologically distressed young people self-perceiving a mental illness. These findings suggest that detection of mental disorders in youth could be improved utilizing a multifaceted intervention targeting both youth and general practitioners.

Conflicts of Interest: The authors have no conflicts of interest to disclose.

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* Address correspondence to: Christiaan P. Otjes, M.D., Department of General Practice, University of Melbourne, 200 Berkeley Street, Carlton 3053 VIC, Australia.

E-mail address: chrisotjes@gmail.com (C.P. Otjes).

¹ Both authors contributed equally to this work.

Over the past two decades there has been growing emphasis on effective identification of psychosocial risks in young people attending primary care [1] partly due to shifts in causes of adolescent morbidity and mortality from infectious and somatic diseases to psychosocial and lifestyle problems [2]. The high prevalence (30%–40%) of emotional distress [3] is of particular concern because of its effects on education, relationships, and quality of life and its association with other health-compromising behaviors such as smoking and increased risk of suicide [4,5].

Globally, primary care clinicians provide most health care for common mental disorders [6]. In Australia, general practitioners (GPs) are the gateway to specialist mental health services. Yet, only 20%–60% of young people with mental disorder are identified in primary care [3,7–9], with higher rates of underdiagnosis and undertreatment of depression compared with adults [10], which contributes to significant unmet need [11]. Psychosocial assessment is a recommendation within policy and clinical practice guidelines that could be important in reducing the treatment gap were it regularly practiced [12].

Some studies have examined whether training, targeted on the identification of mental disorders, enhances GPs' capacity to identify mental disorders in youth [7,8,13]. A feasibility study of brief training for GPs focusing on systematically screening for mental health issues and intervening if depression was identified, resulted in increased screening, and improved depression identification [13]. Training GPs in clinical skills with youth has also improved knowledge, skills, and self-perceived competency in working with young people [14].

The present article derives from a larger study [15] which aimed to assess the impact of a three-part intervention for GPs, including screening for a broad range of psychosocial health risks and counseling for identified risky behaviors, on young people's engagement in risky behaviors (tobacco, alcohol and illicit drug use, road and driving risks, and sexual health risk taking).

This article examines whether this intervention also improved GPs' sensitivity in detecting young people's probable mental disorder. We hypothesized that increased screening and discussion of a broad range of psychosocial health risks would lead to increased identification of mental disorders (increased detection sensitivity). Secondary aims, including screening rates for various psychosocial health risks, and other psychometric properties of detection accuracy (specificity, positive predictive values [PPVs], and negative predictive values [NPVs]), were also computed. This is the first study investigating whether GPs improve in their detection sensitivity of probable mental disorders after a training intervention aiming to improve discussion of psychosocial health risks in general between GPs and young people.

Methods

Ethics approval was obtained from the University of Melbourne Human Research Ethics Committee.

Study design

Data derived from a cluster randomized controlled trial (2007–2011), informed by CONSORT (Consolidated standards of reporting trials) guidelines [16], of screening young people for psychosocial health risks and responding to risky behaviors with motivational interviewing in the general practice setting (the

prevention access and risk taking in young people trial [15]). The detailed protocol and main results about impact on clinicians' screening for risky behavior at baseline postintervention (T0), and young people's engagement in risky behaviors 3 and 12 months postconsultation have been published elsewhere [15]. As the intervention affected practice systems, a cluster design was chosen where the practice was the unit of randomization. Practices were stratified by postcode level advantage-disadvantage (Socio-Economic Indexes for Areas [17]) and practice type (private billing, bulk billing, and community health centers), forming six strata. Block randomization with fixed block sizes of two was used within strata. The allocation sequence was generated in Stata [17] by an independent statistician and remained concealed from researchers until completion of the 12-month follow-up. The computer-assisted telephone interview (CATI) and the in-practice recruiting research assistants (RAs) were blind to the study arm status of the practices, and young people were not informed of the practice arm in any researcher communication. Because of the nature of the intervention, clinicians (GPs and practice nurses) were not blind to study status. Data for this study derive from measures administered to youth (exit interview) and GPs (encounter form) in both trial arms at T0, after consultation, which was also after intervention.

Participants

General practices were recruited through a variety of methods including advertisements in General Practice Divisions and the Royal Australian College of General Practitioners' newsletters, direct mail outs, the Medicare Australia database, and the Victorian practice-based Research Network, encompassing urban and regional centers. All youth aged 14–24 years attending participating clinicians were eligible for inclusion unless clinicians judged them as too physically or mentally unwell to participate (e.g., vomiting, febrile, weak, cognitively impaired, or psychotic) or unable to give informed consent. Minors aged 14–17 years were eligible without parental consent if judged a mature minor by clinicians.

Intervention

In brief, the intervention was delivered at the practice level and included three components: (1) clinician training in youth-friendly care (6 hours) and motivational interviewing approaches for management of risk-taking behaviors (3 hours) [18], (2) provision of a nonstandardized screening tool to assist in assessment and discussion of psychosocial health risks, and (3) two practice visits to feedback to clinicians the psychosocial health risks their young patients were experiencing; assist with developing office procedures to implement screening; train reception staff in youth-friendly care; and update practice specialist referral lists with youth-specific alternatives. Management of mental disorders was not a specific focus of the training but written resources for referral and management of common disorders accompanied the workshops. The psychosocial health risk screening tool was developed from the HEADSS mnemonic (Home; Education, eating, exercise; Activities and peers; Drugs, cigarettes and alcohol; Suicide, depression and other psychiatric symptoms; and Safety) [19], after finding that a similar HEADSS-based tool stimulated psychosocial health risk discussions by hospital-based clinicians [20]. The comparison arm clinicians received a 3-hour didactic seminar on best practice in adolescent health care, including psychosocial assessments.

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