Prevalence of psychological distress in general practitioner adult attendees

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One in three Irish GP practice adult attendees were found to have varying degrees of psychological distress. That 89 per cent were not receiving treatment for their mental health problems also highlights the need for improved primary care mental health services.

With as many as one in every four GP service users experiencing psychological distress and depression predicted to become the second most common health illness by 2020 (WHO, 1999), it is more important than ever to profile the prevalence of mental health presentations to primary care services. Psychological distress has been described as an emotional condition consisting of negative perspectives of the self, others and the environment (Barlow & Durand, 2005). Although, for the most part, those who will experience psychological distress will not require any mental health services, it is still important to have supports available to them to prevent any further deterioration that may at a later date require more intensive service provision.

The WHO (2003) recommends the provision of most mental health services via primary care, especially in low-resourced countries. However, it is recommended that once reasonably well-resourced countries have developed robust primary care services they should then develop mainstream mental health services that liaise effectively with these primary care services (Thornicroft & Tansella, 2003). Ireland appears to neither have developed robust primary care services, secondary care mental health services nor adequate links between same (Mental Health Commission, 2006).

Now being rolled out, the Irish government's primary care strategy (Department of Health & Children, 2001) does not specifically address primary care mental health service provision. While it advocates a consultation-liaison model, neither does the Irish government's (2006) mental health policy provide for such service provision. Submissions for the latter highlighted the need for ready access to a comprehensive range of psychological therapies. More local to the catchment population of this present study, GPs had indicated that they wanted input from psychologists over and above that from other disciplines (e.g. nurses, social workers and physiotherapists; Byrne, 2007).

In the UK long waiting lists of between six months and one year for psychological therapies (Wooster, 2008) indicate that there is a strong clinical need for psychological therapy services and that the current NHS service provision is inadequate. Yet with regard to such services, the NHS is informally recognised as being more advanced than the Irish health services (e.g. Irish College of Psychiatrists, 2003). Although the Irish Mental Health Commission (MHC) has reported some improvements in mental health service provision in many service provision domains, successive annual reports indicate that primary care mental health resources are far from adequate (e.g. MHC, 2006).

Awareness of the psychological distress experienced among GP attendees will allow for planning on how best to support all levels of mental distress (e.g. support groups) and how to prevent people who present with mental health problems from deteriorating using early detection, reducing costs to the health services in the long term.

The aims of this study were to profile the prevalence of psychological distress in GP surgery adult attendees in a rural area. A

secondary aim was to profile both the percentage of service users receiving treatment as well as GPs' views of the findings of the study.

Method

An introductory letter (and a copy of the research proposal) was sent to all GPs (N= 16) in a defined local health office (or service) area (58,000 people). They were informed that they would be contacted by phone in the following days to ascertain if they were agreeable to participating. On subsequent contact, 10 surgeries agreed to participate in this study.

Respondents used a Likert scoring system (0–3) for each of the 12 items of the General Health Questionnaire (GHQ; Goldberg & Williams, 1988) that outputs three bands of psychological distress. Scores ranging from 0 to 15 are considered normal, those ranging from 16 to 20 indicate psychological distress, while scores in excess of 21 indicate severe problems and psychological distress (Goldberg & Williams, 1988). Respondents were also asked to indicate their gender, marital status and age group, and what mental health services they were attending.

Questionnaires, along with return post boxes, were delivered to participating surgeries. Following discussions with several GPs, it was decided that surgery receptionists would distribute the questionnaire to each service user over 18 years who presented in the surgery over a specified two-day period. Receptionists were given a debriefing protocol (a copy of which is available from the second author) to use with service users. The total number of service users who attended each surgery over the two days of data collection was also recorded.

Results

The 10 participant practices employed between one and five GPs, totalling 31 GPs in all. The service user response rate varied widely from 17 to 80 per cent across the participating practices, with an overall response rate of 43 per cent (N = 273). Fifteen per cent of participants did not provide details of their age. While 26 per cent of respondents did not disclose their gender, 22.7 per cent were male and 51.3 per cent were female. Likewise, while 24.5 per cent did not disclose their marital status, 25 per cent were single and 50.5 per cent were married (Table 1).

The GHQ-12 data indicated that 16.8 per cent of participants reported signs of psychological distress. An additional 16.2 per cent reported severe problems and psychological distress. Hence, a total of 33 per cent of participants reported some form of psychological distress with 67 per cent registering with no signs of psychological distress (Table 2).

Independent sample t-tests revealed that

Table 1: Age profile of participants

Age	18–29	30–39	40–49	50–64	65+	Missing data	Total
Percent	15.4	16.5	17.6	21.6	13.9	15.0	100
Number	42	45	48	59	38	41	273

Table 2: GHQ scores (%)

GHQ Score	0–15 (Normal)	16–20 (Psychological distress)	21+ (Psychological distress & severe problems)
Male (N = 62)	67.7	11.3	21.0
Female (N = 140)	65.0	20.0	15.0
Participants (N = 273)	67.0	16.8	16.2

Table 3: GHQ scores categorised by marital status (%)

GHQ Score	0–15 (Normal)	16–20 (Psychological distress)	21+ (Psychological distress & severe problems)
Single (*N* = 68)	66.0	15.0	19.0
Married (*N* = 138)	64.5	20.3	15.2

Table 4: GHQ score divided into age categories (%)

	GHQ Score		
Age	*0-15*	*16-20*	*21+*
18-29	14.9	13.0	20.9
30-39	17.1	13.0	18.6
40-49	16.6	15.2	23.3
50-64	19.9	30.4	20.9
65+	16.0	13.0	4.7

Table 5: GPs' responses to research findings

Response	Number of GPs who gave this response
1. Agreed with the findings.	6
2. There is a need for psychological therapy services and counselling in primary care.	6
3. GPs are not equipped to deal with some psychological problems and don't have access to appropriate treatment.	7

there were no statistically significant differences between scores on the variables of gender (t = .275, p = .21) and marital status (t = .196, p = .39).

When GHQ scores were divided between single (N = 68) and married (N = 138) participants, it was found that 60.9 per cent of individuals who displayed psychological distress were married, while 21.7 per cent of this same group were single. Additionally, 46.5 per cent of those who had GHQ scores of 21 and above were married and 30.2 per cent were single. Of those who scored less than 15 on the GHQ, 49.2 per cent were married and 24.3 per cent were single.

Table 4 illustrates how psychological distress was most prevalent in the 50–64 years age group. The group that reported severe problems and psychological distress most often was the 40–49 years age group. Additionally the group that registered most frequently into the 0-15 GHQ score group was the 50–64 years.

Eighty nine per cent of the overall sample of participants indicated that they were not receiving any form of treatment for their mental health concerns. Those attending a GP for treatment accounted for only 6.6 per cent of the sample. Respective figures for attendance at community mental health teams (CMHTs) and private professionals were 1.8 per cent and 2.2 per cent. Of the participants registering with psychological distress (i.e. 16.8 per cent, N = 46), 89 per cent were not receiving any treatment, 4.3 per cent were attending a GP and 6.5 per cent were attending a private professional. Of the participants registering with severe problems and

psychological distress (16.2 per cent, *N*= 44), 72 per cent of attendees were not receiving any treatment, 13.6 per cent were attending a GP, 6.8 per cent were attending a CMHT and 6.8 per cent were attending a private professional.

All of the GP surgeries (*N*= 16) that were originally asked to participate in this study were asked to provide their opinion on the study's findings. GPs were not asked for their names or surgeries to encourage honest and open evaluation of the findings. Nine GPs provided feedback (Table 5).

Discussion

This study found that one in every three GP adult attendees in a defined geographical area had some degree of psychological distress. This figure contrasts with a world average of one in every four (WHO, 1999). In the context of poor primary care mental health services in Ireland, this higher prevalence figure of one in three indicates that there is a marked need for the provision of psychological therapy services in primary care settings.

In relation to the marital status findings and in line with previous studies (e.g. Hoeyman et al., 2002), unmarried participants reported greater psychological distress than their married counterparts. As the majority of the sample were middle-aged or above (21.6 per cent), it is possible that some of those who responded as 'single' may have been divorced. Divorcees have greater psychological distress than previously unmarried and currently married counterparts (Hope et al., 1999). Additionally, this study found that those in the 40-49 year age bracket had the greatest number of high GHQ scores. This finding contrasts with those of other studies (e.g. Jorm et al., 2005) that indicate that psychological distress declines with increasing age. This difference in findings may be due to service user exposure to risk factors that were not profiled in the current study.

In terms of access to psychology, this study indicated that service users had markedly limited involvement with (public) psychological therapy services of any type. Only 6.6 per cent of the participants were attending their GP for mental health concerns, 1.8 per cent were attending a CMHT member while a further 2.2 per cent were attending a private professional. This contrasts with a UK study that found that participants with high GHQ scores mostly attended GPs, above all other health professionals, to address their mental health concern (Oliver et al., 2005).

There are various approaches to enhancing primary care mental health service provision capacity (Bower & Gilbody, 2005). While our mental health policy Vision for Change advocates a consultation-liaison model between secondary-primary care services (Department of Health & Children, 2006), at best implementation is patchy. Despite good exemplars elsewhere of populating primary care services with mental health practitioners (e.g. the UK Government's Improving Access to Psychological Therapy initiative; Clark et al., 2008), the roll out of our primary care strategy (Department of Health & Children, 2001) has markedly neglected mental health service provision.

The option of training (existing) primary care staff (e.g. via dissemination of information and guidelines, intensive practice-based education seminars) has been partially adopted (e.g. the Mental Health in Primary Care project 2007). However, such projects are specific to GPs, who care for more than 90 per cent of mental health problems. Their feedback on this study's findings reinforces the perception that their high throughput model predisposes to considerable strain in trying to adequately manage psychological problems in primary care. This is not surprising considering that they have limited postgraduate training in mental health or psychological therapies (Copty & Whitford, 2005). Hence, the finding that many GPs would like more training in the identification and management of mental health presentations, and to share the burden of care with other (secondary care) mental health professionals (Ni Shiothchain & Byrne, 2009b).

The small sample size (*N* = 273) and response rates for both GPs (63 per cent) and practice attendees (43 per cent) limit the generalisability of this study's findings.

The GPs who participated may be those who had an established interest in recognising and managing mental health difficulties in a psychological manner (Copty & Whitford, 2005). Likewise, the participant service users may have had a similar interest. Hence, this study's sample may have been skewed towards finding higher estimates of psychological distress. The variability in the service user response rate ranging from 17 to 80 per cent possibly reflects differences in receptionist attitude and enthusiasm for the study, suggesting that the debriefing protocol was poorly implemented.

Conclusion

This study has implications for Irish primary care mental health services. That one in three participants registered as having psychological distress yet few had accessed psychological therapy services highlights the need to enhance primary care mental health service provision capacity. To adequately address this issue, further research is needed to explore the nature of primary care mental health presentations and to examine creative practices for managing the high prevalence disorders in primary care (e.g. White, 2008).

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