

**Identification of psychosocial risks in primary care**  
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**Background:** As the first port of call for those who are unwell, and as the gateway to New Zealand's secondary health care system General Practitioners (GP's) and Practice Nurses (PN's) are faced with a vast range of illnesses and psychosocial issues to identify, assess and manage. It is generally expected that these primary care practitioners will detect and respond appropriately to almost any health related problem their patients present with.

There is a growing focus on preventative care in primary practice. This requires GP's and PN's to screen for biomedical, lifestyle and mental health factors so they can be addressed thus reducing the adverse impact on a patient's health (Goodyear-Smith, Arroll, Sullivan, Elley, Docherty, Jones, 2004; Goodyear-Smith, Arroll, Coupe, Buetow, 2005). As well as these factors, primary care practitioners are expected to identify and treat chronic and acute medical illness, monitor and prescribe medication in a timely manner, encourage patients to engage in illness prevention behaviour such as immunization, and follow up to ensure patients comply with treatment recommendations.

This large burden of responsibility sits within a challenging health climate. Difficulties in recruiting and retaining health professionals, a reduction of GP's income and an increased requirement for documentation are contributing to GP burnout (Dowell, Coster, Maffey, 2002). One of the key stressors for GP's is patients bringing multiple problems to appointments which presents the challenge of both listening properly and keeping to time, while providing effective care (Dowell et al, 2002). In the current economic climate more and more people are delaying their regular appointments in order to reduce the costs of medical care (Dew, Dowell, McLeod, Collings, & Bushnell, 2005; Southern Cross Medical Care Society, 2009) increasing the prevalence of this patients presenting with multiple problems. Given this situation primary care practitioners may benefit from quick and effective tools that help to determine what the priorities are for these patients.

### ***Psychosocial Risks***

While medical illness and risk are often prioritized in general practice (Crawford, Ryan & Shipton, 2007; Dew, Dowell, McLeod, Collings, & Bushnell, 2005) there are a large number of psychosocial factors that cause significant harm to individuals health that also need to be addressed. These include alcohol and drug use (Ministry of Health, 2009), family violence and child abuse (Ministry of Social Development, 2007), mental illness (Rodenburg et al, 2009) and suicide and self harm (Ministry of Health, 2008). Smoking, alcohol and drug misuse, anxiety and depression all meet the World Health Organisation criteria for areas that need screening in primary care.

Research looking at GP assessment of psychosocial risk suggests in many cases these problems are being missed. One New Zealand study which examined GP's assessment and management of psychosocial risks associated with chronic back pain found that time constraints and prioritizing physical complaints often prevented psychosocial issues from being covered (Crawford et al, 2007). Further barriers found in this study were concerns over how the patient may react to enquiries of this nature, and clinician dislike of the guidelines for assessment.

The rates of intimate partner violence and child abuse are high within New Zealand (Ministry of Social Development, 2007). A large New Zealand study which looked at case notes of 143,643 patients across 447,890 consultations, found that domestic violence was only mentioned in 0.075% of notes (Miller, Thow, Hall & Martin, 2005). This figure is vastly different from the 33% to 38% incidence rate that Fanslow & Robinson (2005) found in a survey of

2855 women based in Auckland and North Waikato. These authors also reported women who had experience moderate to severe intimate partner violence were significantly more likely to have visited a health care professional in the previous four weeks. For 75% of these women, that health care professional was their GP. This suggests that GP's are either not recognizing or discussing domestic violence with their patients, or they are not noting their concerns. Miller and colleagues concluded that while patients often do not disclose domestic violence, GP's also generally do not ask about it. They state that some of the barriers to addressing domestic violence in general practice include fear of offending the patients, a sense of powerlessness if the patient discloses they are the victim of violence but do not want to make the changes required to prevent it, and time constraints.

It is thought that regular screening of all patients is likely to be more successful than opportunistic screening of some in identifying psychosocial risk factors (Goodyear-Smith et al, 2004). These authors conducted research administering a purpose designed screening measure in New Zealand general practice waiting rooms that asked patients to identify if they were experiencing a range of psychosocial difficulties, and to then indicate if they wanted assistance with these problems at this time. Results were positive, with almost 100% completion rate by patients. Further GP's did not report becoming overburdened with new problems to address. The authors suggest that the use of a general measure such as theirs has the potential to highlight high risk areas that can then be screened for more carefully by primary care practitioners.

### ***Mental Health Issues***

Current population lifetime levels of mental health concerns in New Zealand are somewhere between 20% and 40% (O'Brien, Moir & Thom, 2009). These authors suggest that GP's are often the first health professional those with mental health concerns will seek out to request help, and are well equipped to respond to patients with mild to moderate symptoms. However, considerable research with people attending general practice settings has found that only one third of those who are experiencing significant psychological distress present with this concern to their GP (McKelvey, Davies, Pfaff, Acres & Edwards, 1998; Davis, Galyer, Halliday, Fitzgerald & Ryan, 2008; Lillis, Mellsop & Emery, 2008). One London based study interviewed patients with clinically significant GHQ-30 scores who had not reported their emotional distress to their GP's (Cape & McCullough, 1999). They found three categories of reasons that patients were not reporting their distress to GP's which included: primarily realistic reasons such as they were coping with the distress, or they had more important medical issues to be addressed; reasons related to psychological embarrassment such as such as feeling the problem was trivial and not wanting to waste the doctors time; and third there were reasons relating to the doctors behaviour. Interestingly across all three groups, 48% of the respondents indicated they believed that their GP's did not have enough time to address their emotional problems, indicating patients are aware of the time pressure reported elsewhere by GP's.

Research exploring GP's explanations also appears to have common themes. The most common reasons cited by GP's were a lack of time and multiple problems within an appointment, a lack of skills and training, concern over how the patient would respond to raising such issues, dissatisfaction with diagnostic criteria and prioritizing medical illness (Lillis et al, 2008; Dew et al, 2005; Goodyear-Smith et al, 2005). Interestingly, research by Davis and colleagues (2008) found that when screened in New Zealand clinic waiting rooms

with the General Health Questionnaire – 12, a significant number of patients who presented to their GP's with medical complaints were experiencing clinically significant psychological distress. Of the 31% whose psychological distress was picked up by their GP, they were usually patients moderately well known or well known by the practitioner. This suggests that those patients who visit their doctors less frequently, and present with a number of problems are likely to have their mental illness undetected unless they explicitly state that they are distressed.

### ***Suicide and Self-Harm***

Suicide and intentional self-harm are two serious psychosocial issues that are of concern in New Zealand. Currently over 500 people die by suicide every year in this country while over 5000 are hospitalized for two days or more due to intentional self-harm (Ministry of Health, 2008). As with other psychosocial issues the onus for health care professionals is on early detection and support and treatment for those presenting as high risk for suicide or self-harm (Didham, Dovey & Reith, 2006). Given the fact that many people experiencing mental health problems are cared for primarily by their GP, and that mental health problems is the largest risk factor for suicidal behaviour, it is essential that suicidality is identified, assessed and responded to within a primary care setting. Suicide risk is highest in young people from socially disadvantaged homes (Beautrais, Wells, McGee, Oakley & Brown, 2006). Unfortunately this group of people are also likely to visit their GP less often and save up a number of issues for one appointment reducing the likelihood that mental health issues, or suicidal ideation will be discussed unless they specifically raise it.

There is a growing body of literature which shows that a number of people who commit suicide have seen their GP in the period prior to their death. Draper, Snowdon & Wyder, (2008), Schulberg, Hyg, Bruce, Lee, Williams, & Dietrich (2004) and Didham, Dovey & Reith (2006) found that up to 75% of those who died from suicide had seen their GP in the three months prior to their deaths. Retrospective studies have shown that in many of these cases no risk assessment had been done (Milton et al, 1999) and that often no mental health notes have been recorded, and no mental health diagnosis or treatment has been given (Didham et al, 2006; Brown et al, 2001).

Research suggests that the rate of patients disclosing their suicidal ideation is similar or less than those disclosing psychological distress. McKelvey and colleagues (1998) found that only one third of those who have suicidal ideation will express this to their GP during a consultation, while many more disclosed such thoughts when asked in a waiting room screening measure. It appears that the key indicator for screening for suicide risk is current mental health problems (Milton et al, 1999; Brown et al, 2001) yet for the large percentage of people their psychological distress goes unacknowledged. Research by McKelvey and colleagues (1998) found that those presenting with medical complaints were just as likely to express suicidal ideation as those presenting with psychological complaints. This suggests that only screening for suicidal ideation in those with a diagnosed mental health problem is not adequate in identifying and responding to this risk.

The majority of the research in this area has focused on retrospective reviews of those who have lost a patient to suicide and there is little known about how those in primary care generally screen for psychosocial risk, mental health problems or suicide risk. This is particularly true amongst those who have not lost a patient to suicide (Didham et al, 2006).

**Present Study:** Other than regular waiting room screening there has been little research which has looked at the detection of more general psychosocial and mental health problems in primary care. There also appears to be little literature discussing how mental health practitioners and primary care practitioners could collaborate to improve the identification and management of all psychosocial risks. To ascertain what, if anything, local mental health professionals can do to assist primary care providers we first seek to try and understand current practice within New Zealand, and current confidence and satisfaction with that practice. The aim of this project was to enhance understanding of current risk screening in general practice within the Waikato, an area which is representative of a large section of New Zealand.

We expected that while psychosocial and suicide risk would be considered a serious and real problem for primary care providers, with the multitude of other risks they manage daily it would not present as a top consideration in routine appointments. This project also aimed to explore whether demographic features such as years of practice, patient populations and the experience of losing a patient to suicide influence practice and confidence. Further the research aimed to uncover whether different practitioners or practice groups had specific approaches to identifying, assessing and managing psychosocial risk factors generally, and suicide risk in particular.

Surveys were posted to 487 General Practitioners and Practice Nurses within the Waikato region, with freepost return envelopes included. This number represents all practitioners we were able to identify and would constitute a very high proportion of the total eligible participants. Researchers were assisted by the local primary health care body to ascertain contact details for this population. Three weeks after the initial post out a second survey was posted as a reminder, and to prompt further responding. A link to complete the survey online was also included in the mailed out information, and was placed on the host organization website. Respondents were also invited to volunteer to participate in an interview with the researchers to gain a deeper understanding of their views and practices in this area. Forms indicating a willingness to be interviewed were separated from survey forms by an administrator not involved in the project so that survey responses remained anonymous.

**Results:** A survey was constructed by the research team with the aim of assessing primary care practitioners' day-to-day experience of risk identification, assessment and management. Risks covered included abuse and neglect, alcohol and drug abuse, and poverty in relation to adequate housing, heating, diet and being able to afford medical care. The survey aimed to explore respondent's views about current practice, what processes were useful, and what more may be required. It also asked respondents to rate their confidence in identifying and managing these risk factors within their practice. Demographic information collected included how many GP's in each respondent's clinic, number of patients currently enrolled in practice, whether the respondent practiced in a rural or urban area, workload, deprivation index of the main patient catchment area, and practitioner ethnicity, gender, years of practice and age. Consultation with local GP's was entered into for feedback on the appropriateness of the survey questions.

Of the 487 surveys sent out, 36 (7%) were returned. This low number of respondents has limited the meaningful analysis that can be completed in this study. However, some basic trends were found. There was a difference in

confidence reported in identifying nearly all psychosocial risks categories dependent on whether the primary care practice had specific measures or processes for identifying the risks. This was the case for all risks except alcohol abuse, where there was no difference between the two groups. However, it was not consistently the case that those working within practices which had measures or processes in place were more confident. In general, the group of practitioners who did not have access to measures or protocols reported more confidence in the identification of risk associated with the Inability to Afford Adequate Housing (*Adjusted z* = 3.13, *p* = .002), Inability to Afford Medical Care (*Adj z* = 2.37, *p* = .018), and Suicidal Risk (*Adj z* = 2.65, *p* = .008).

There was no statistical association between the level of confidence reported in any risk category and either the age of the practitioners, or the number of years that they have been in practice. However, confidence in identifying Risk of Neglect ( $r_s = .49$ ,  $p < .05$ ), and the risks that service users could not afford adequate heating ( $r_s = .58$ ,  $p < .05$ ) or housing ( $r_s = .44$ ,  $p < .05$ ) were associated with higher numbers of enrolled patients. Low ratings of confidence were associated with higher patient numbers.

We wondered whether those practices which possessed measures or processes for identifying psychosocial risks reported a higher frequency of risks being identified. The only risk area where there was a difference between the two groups was associated with sexual abuse (*Adj z* = -2.15, *p* = .031), with the group of practitioners who had protocols in place reporting that they had to deal with these risks more frequently.

We specifically prompted to see if respondents felt more confident in identifying Risk of Suicide within different patient age groups. However, this did not appear to be the case with participants rating themselves between very and somewhat confident in all groups. Participants reported feeling least confident when dealing with children (under 12 years).

While 40% of respondents indicated that the primary reason they would screen for suicide risk was if the patient presented with depression, 75% of respondents indicated they would be willing to use a brief screening measure.

Interviewees came from diverse practice settings and background experiences. Due to the low number of respondents it has again been difficult to identify general themes, however there were some issues that were consistently reported by those interviewed. These included the barriers presented by practitioners having a lack of time to identify and manage psychosocial and mental health issues in appointments, patients being unwilling to discuss such issues and a lack of timely psychological assistance available when problems were identified. Of the four people interviewed one GP reported an awareness of a domestic violence guideline which they did not closely follow. Other than that respondents did not know the location or content of any practice guidelines for the identification or management of the issues covered in the survey. All practitioners interviewed let the patient choose what to discuss, however if there were multiple problems they would try and prioritise what appeared most important, usually dealing with medical complaints first. Key recommendations to improve the situation were better access to timely and affordable (free) psychological and psychiatric assistance.

**Discussion:** Due to the particularly low number of response it has been difficult to gain strong meaningful data. However, the fact that response rates were so low is an interesting result in itself and may indicate a number of possibilities.

While we consulted with a local GP to check the suitability of the survey and the questions it asked, it is possible that poor survey design made it unclear what we were asking, and deterred people from responding. It could also be that a majority of the primary care practitioners who received this survey did not consider this a priority area in their practice and therefore selected not to respond. The literature suggests that many primary care practitioners do not feel adequately trained or resourced to respond to psychosocial and mental health problems (Dew et al, 2005) so there may have been some concern that responding to this survey would highlight this. Further both international and local research has found that psychosocial and mental health issues go largely undetected. It is likely therefore that the practitioners surveyed in this study are unaware of the prevalence of these problems in their patient population. It is therefore possible that the topics covered in this survey are not considered a top priority which may have impacted on the number of practitioners who responded.

It appears that in some cases having practice guidelines for recognizing and responding to certain risk factors increases practitioner confidence in identification and management of psychosocial risk. This increase confidence did not extend on to higher detection rates however, except for in the case of sexual abuse, so it is therefore difficult to determine if increased confidence impacts on improved practice or identification of different psychosocial and mental health problems. In three instances the effect was actually the opposite so that practitioners felt more confident identifying inability to afford adequate housing, inability to afford medical care and suicide risk when they did not have guidelines. One explanation of these data is that there are unlikely to be measures or protocols which are used in primary care settings to formally identify the former two risk categories, and there will be a plethora of advice on the latter, which may simply serve to confuse practitioners. Perhaps too much information is just as bad as too little.

While this research sought to have a specific focus on risk of suicide and self harm the survey responses did not indicate much that set these issues apart from the other psychosocial and mental health problems covered. Respondents generally indicated less confidence in identifying suicide risk in the very young (under 12 years).

Perhaps of most interest is the indication by the majority of respondents that they would be willing to use a brief screening measure to assist in the identification of the risks covered in this study. Given the current situation indicated in the literature that patients often do not disclose mental health or psychosocial concerns unless they are asked (Crawford et al, 2007; Miller et al, 2005; Goodyear-Smith et al, 2004; Davis et al, 2008) and that GP's often don't ask (Miller et al, 2005; Lillas et al, 2008, Dew et al, 2005, Milton et al, 1999; Didham et al, 2006) this is a promising result. Research by Davis et al, (2008) and Goodyear-Smith et al, (2004) suggests that when surveyed in waiting rooms patients are much more likely to disclose psychological distress, suicidal ideation and psychosocial complaints. If the use of such a measure became part of everyday practice perhaps we would quickly see a much higher rate of identification of psychosocial risks which may lead to earlier intervention and better outcomes.

One issue raised frequently in both the survey responses and the interviews was that even when mental health problems are identified there is little in the way of affordable or readily available services. To cover this issue in any more detail is outside the scope of this study, but is something that needs to be considered as initiatives to increase identification are trialed.

This research has potential to lead in to further research projects which should cover:

- a more in depth dialogue with primary care practitioners about current practice, considering current strengths and weaknesses of processes, and ways of working collaboratively with mental health professionals
- consultation with primary care practitioners and other experts working in this area regarding what measures may prove most effective
- a large scale study which tests the effectiveness of a chosen measure to increase identification psychosocial risks, and that also explores the consequences for practitioners of using such a measure

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- Beautrais, A. L., Wells, J. E., McGee, M. A., & Oakley Browne, M. A. (2006). Suicidal Behaviour in Te Rau Hinengaro: The New Zealand Mental Health Survey. *Australian and New Zealand Journal of Psychiatry*, 40, 896-904.
- Brown, G. K., Bruce, M. L., Pearson, J. L., & PROSPECT Study Group. (2001). High-Risk Management Guidelines for Elderly Suicidal Patients in Primary Care Settings. *International Journal of Geriatric Psychiatry*, 16, 593-601.
- Crawford, C., Ryan, K., Shipton, E. (2007). Exploring General Practitioner Identification and Management of Psychosocial Yellow Flags in Acute Low Back Pain. *The New Zealand Medical Journal*, 120 (1254), 2536-2548.
- Davis, J., Galyer, K., Halliday, T., Fitzgerald, J., & Ryan, J. (2008). Identify Psychological Distress in New Zealand Primary Care: The General Health Care Questionnaire – 12 (GHQ-12) as a Screening Instrument. *New Zealand Family Practice*, 35 (2), 86-90.
- Dew, K., Dowell, A., McLeod, D., Collings, S., & Bushnell, J. (2005). "The Glorious Twilight Zone of Uncertainty": Mental Health Consultations in General Practice in New Zealand. *Social Science and Medicine*, 61, 1189-1200.
- Didham, R., Dovey, S., & Reith, D. (2006). Characteristics of General Practitioner Consultations Prior to Suicide: A Nested Case-Control Study in New Zealand. *The New Zealand Medical Journal*, 119 (1247), 1-11.
- Dowell, A.C., Coster, G., Maffey, C. (2002). Morale in General Practice: Crisis and Solutions. *The New Zealand Medical Journal*, 115 (1158), 59-67.
- Goodyear-Smith, F., Arroll, B., Sullivan, S., Elley, R., Docherty, B., Jones, R. (2004). Lifestyle Screening: Development of an acceptable Multi-Item General Practice Tool. *The New Zealand Medical Journal*, 117, (1205), 1146-1152.
- Goodyear-Smith, F., Arroll, B., Coupe, N., Buetow, S. (2005). Ethnic Differences in the Mental Health and Lifestyle Issues: Results from a Multi-Item General Practice Screening. *The New Zealand Medical Journal*, 118 (1212), 1374-1384.
- Joiner, T. E., Pfaff, J. J., & Acres, J. G. (2002). The Brief Screening Tool For Suicidal Symptoms in Adolescents and Young Adults in General Health Settings: Reliability and Validity from the Australian National General Practice Youth Suicide Prevention Project. *Behaviour, Research and Therapy*, 40, 471-481.
- Lillis, S., Mellsop, G., & Emery, M. (2008). Diagnosing Mental Illness in General Practice. *New Zealand Family Practice*, 35 (2), 91-95.
- McKelvey, R.S., Davies, L.C., Pfaff, J. J., Acres, J., & Edwards, S. (1998). Psychological Distress and Suicidal Ideation Among 15-24 Year Olds Presenting to General Practice: A Pilot Study. *Australian and New Zealand Journal of Psychiatry*, 32, 344-348.

- Miller, D., Thow, N., Hall, J., Martin, I. (2005). Documentation of Family Violence in New Zealand General Practice. *The New Zealand Medical Journal*, 118 (1212).
- Milton, J., Ferguson, B., & Mills, T. (1999). Risk Assessment and Suicide Prevention in Primary Care. *Crisis*, 20 (4), 171-177.
- Ministry of Health. (2008). *New Zealand Suicide Prevention Action Plan 2008 2012: The Summary for Action*. Wellington: Ministry of Health.
- Ministry of Health. (2009). *Suicide Deaths and Intentional Self-Harm Hospitalisations: 2006*, Wellington: Ministry of Health
- O'Brien, A., Moir, F., & Thom, K. (2009). The Provision of Mental Health Care by Primary Health Organisations in the Northern Region: Barriers and Enablers. *Journal of Primary Health Care*, 1 (2), 120-125.
- Rodenburg, H., Dowell, T., & James, K. (2009). Primary Mental Health Care: Service Delivery and the Impact on the Workforce. *Journal of Primary Health Care*, 1 (2).
- Schulberg, H. C., Lee, P. W., Bruce, M. L., Raue, P. J., Lefever, J. L., Williams, J. W., Dietrich, A. L., & Nutting, P. A. (2005). Suicidal Ideation and Risk Levels Among Primary Care Patients with Uncomplicated Depression. *Annals of Family Medicine*, 3 (6), 523-528.
- Southern Cross Medical Society (2009). *Data Set for External Health Agencies*. Conducted by TNS Conserva.