

## Attitudes of Israeli Primary Care Physicians Towards Mental Health Care

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**Abstract:** Rates of depression and anxiety are increasing all over the world in developed and developing countries as well and Israel is no exception to this trend. People suffering from depression and anxiety disorders tend not to turn for professional help to mental health clinics but to primary care. This cross-sectional study examines the attitudes and barriers of primary care physicians in the southern region of Israel toward providing care for depression and anxiety in their practices. In 2002 we sent a questionnaire concerning attitudes and barriers toward depression and anxiety to 99 primary care physicians from 14 primary care clinics with a response rate of 67.7% (67 physicians); 80.6% of the participants agreed with the statement that depression and anxiety are frequent problems in primary care and they should be treated in primary care clinics, but 37.3% reported to have little interest in treating mental disorders, 47.7% thought depression and anxiety should be treated in mental health clinics; 43.3% of the participants declared that they experienced a personal difficulty in taking care of patients with depression and anxiety, and 85% identified time constraint as a major barrier to care of depression and anxiety in primary care. This study suggests that in order to improve treatment of depression and anxiety in primary care, there is a need for a change of attitudes of the primary care providers.

Rates of depression and anxiety are increasing all over the world. According to WHO reports there is little difference in the prevalence of mental health impairments between developed and developing countries (1). Of the population in U.S.A., 5.1% reported mental health problems, mainly depression and anxiety (2). In Europe the general prevalence of depression was found to be about 5% (3). Depression is expected to be second to heart disease as a source of the global burden of disease by the year 2020 (4). Among patients attending primary care clinics the prevalence of mental health disorders is even higher. In Sweden 30.2% of patients visiting primary care reported depressive symptoms (5), while 16.4% reported anxiety symptoms in Denmark (6). Twenty-five to 50% of visitors in primary care clinics have some kind of mental health impairment (6). It is reasonable to assume that Israel is no exception to this trend.

Schwartzman et al. found that 5.9% of primary care patients in southern Israel suffered from major depression and 15.9% had depressive symptoms.

The direct medical costs of patients with major depression were three times higher than the general population and the costs of people with depressive symptoms were higher by 25% (7). We found no Israeli study on anxiety disorders, but we may assume that its prevalence is similar to other countries.

People suffering from mild depression and anxiety disorders tend not to turn for professional help to mental health clinics (8). An Australian study has found that 49% of persons with depressive disorder had consulted their GP for mental health problems in the last year compared with 12% who consulted a psychiatrist (9).

Primary care physicians are therefore the main health care providers patients are willing to approach for treatment of their mental health problems. Nevertheless, the literature reports under-diagnosis and under-treatment of mental health problems in primary care (10).

Clalit Health Services (CHS), Israel's largest Health Maintenance Organization, decided to embark on a long-term program for improving the care

of depression and anxiety in primary care. As a first step in the program our aim was to identify the attitudes and barriers in the way of primary care physicians treating depression and anxiety in their clinics. This is a cross-sectional study which examines the knowledge, attitudes and barriers of primary care physicians toward providing care for depression and anxiety in their practices.

## Methods

**The research tool:** On the basis of a literature search (11–15) we constructed a questionnaire with face validity. The main domains of the questionnaire are: (A) attitudes and knowledge and competence, (B) barriers toward depression and anxiety care, and (C) definition of measures to improve the care of these disorders in primary care practice.

Item response was on a scale of 4 (definitely agree) to 1 (completely disagree). Rating 4, 3 was considered affirmative and rating 2, 1 was considered negative.

**The sample:** In 2002 we sent the questionnaire to 99 primary care physicians (PCPs) from 14 primary care clinics in the southern district of CHS in the Beersheba region. All the clinics in the region, 14 altogether, were approached. All the clinics were urban.

**Analysis:** We used SPSS version 12.0.

1. Descriptive statistics were calculated.
2. Reliability was calculated by the internal consistency statistic Cronbach's alpha.
3. Pearson product moment correlation coefficients were used to determine correlations between demographic data and item responses.

Type 1 error was set at 0.05.

## Results

Sixty-seven out of 99 physicians returned the questionnaire, a response rate of 67.7%; 41 physicians out of these 67 responders (61.2%) were board certified family physicians (FPs), all others were general practitioners (GPs).

The average duration of working as a PCP was 17.8 years (STD 8.390), with median 18.5 years.

FPs were younger, with 15.11 working years (std 6.738, median 17) and GPs worked on average 28.88 years in primary care (std 5.842, median 31). The internal consistency of the attitude, knowledge and skills questionnaire was high; Cronbach's alpha for the whole questionnaire was 0.698.

## Attitudes

80.6% of the participants agreed that depression and anxiety are frequent problems in primary care, and 80.6% agreed with the statement that these problems should be treated in primary care. Nevertheless, 47.7% stated that the preferential locus for treatment of depression and anxiety are mental health clinics; 80.6% of the physicians agreed that there is under-diagnosis and under-treatment of depression and anxiety in primary care; 37.3% stated that they have no interest in treating depression and anxiety in their practice.

## Knowledge and Skills

70.1% of the physicians thought they have enough knowledge to diagnose depression and anxiety and 68.5% that they are competent to treat them; 89.5% see a connection between the occurrence of depression and anxiety to life events; 43.3% declared that they experienced a personal difficulty in taking care of patients with mental health problems.

## Barriers to Care

85% of the respondents identified time constraints as the highest ranking barrier; 59.7% indicated lack of knowledge in diagnosis and 59.7% lack of knowledge concerning treatment, as barriers. Absence of access to psychiatric care was stated by 62.7%, and 68.7% of the physicians indicated that shortage of specialists' support was a barrier to better care. The internal consistency of the barriers to the care portion of the questionnaire was 0.763.

### Interest in Issues Concerning Depression and Anxiety

80.6% of the physicians would like to improve their knowledge in diagnosis and treatment of depression and anxiety, 83.6% would like to improve their skills and 80.6% would like to receive personal counseling from psychiatrists (outreach visits) concerning their patients; 70.1% would like to improve their knowledge in issues such as pharmaceutical and psychological treatments for these disorders. There was no statistical difference between the two physicians' populations.

We did not find a statistical difference between the physicians according to their seniority in primary care, except the will to learn more about non-pharmaceutical interventions, in which the physicians with longer working experience were more interested ( $p=0.044$ ).

### Discussion

From the perspective of Israeli primary care physician in the southern region of Israel, the major barriers to treat depression and anxiety in primary care are lack of time (85%), difficulty to speak on mental health issues with the patients (43.3%) and lack of interest (37.3%). They also indicated a lack of specialist support (68.7%). They wished to improve their knowledge and skills in depression and anxiety care (70.1%).

The study limitations are the small sample size; the sample may not be representative for Israel. Nevertheless, we have examined an issue which should be examined in the Israeli context due to the unique position of mental health care in Israel. The reform in Israeli national health services, begun in 1995, did not included the mental health care which continued to be provided by the Ministry of Health, contrary to all other health services provided by the sick funds.

There are a few studies on this issue which examine the attitudes of primary care physicians to mental health care problems. The main perceived obstacles in the majority of these studies are lack of time to take care of depression and anxiety in primary care (14, 16), the lack of support of specialists (12, 16, 17), and deficiency in knowledge and skills (18).

Docherty found that lower levels of knowledge about treatments' effectiveness for depression were associated with poorer diagnosis and treatment of depression (19). Gerrity suggested that doctor's self efficacy for recognizing and managing depression was likely to influence the care the depressed patients received from their primary care physician (20). Richards found that lack of specialist support is a major barrier to better care of depression in primary care (12). Doron had investigated the attitude of Israeli physicians to outreach visits of psychiatrists and found that 96% of the physicians rated themselves as having good abilities in recognizing patients in distress (21).

An interesting finding of this study is the attitude of the Israeli physicians toward depression and anxiety; 38% declared no interest in treating anxiety and depression and 43% confess their personal difficulty to face mental health problems. These issues have yet to be fully investigated. There is a possibility that the ability of GPs to identify depression may not be an independent variable, but may rather reflect other beliefs, attitudes and skills (13). The discrepancy between the numbers of physicians who think that the primary care clinic is a preferential locus for treatment of depression and anxiety (80%) versus the percentage of physicians who thought they should be treated in mental health clinics (47%) indicates an ambivalence of the primary care physicians toward the treatment of mental health disorders.

The providers' attitudes and abilities are major factors in implementing any improvement program concerning anxiety and depression in primary care. Our findings point to serious attitude problems which should be further researched. Each improvement program concerning mental health care in primary care should address these issues in order to succeed.

This study shows that in order to improve treatment of depression and anxiety in primary care, there is a need to change the attitudes of the providers toward these problems. Also there is a need to adjust the infrastructure of care, to facilitate more time for encounters with patients with mental health problems in primary care and to develop mental health specialists' support for primary care providers.

Table 1. *Knowledge and attitudes concerning soft mental health problems*

Statement	Affirmative response	
	N	%
Depression and anxiety are frequent problems of patients in primary care clinic	54	80.6%
Primary care team (physician, nurse, social worker) should treat mild depression and anxiety	54	80.6%
There is under diagnosis and under treatment of depression and anxiety in community primary care	54	80.6%
I have enough knowledge to diagnose depression and anxiety	47	70.1%
I have sufficient tools and skills to treat depression and anxiety after diagnosis	46	68.5%
There is a connection between depression and anxiety and life events	60	89.5%
Depression and anxiety should be treated in psychiatric clinics	32	47.7%

Table 2. *Factors that interfere with the care of soft mental health problems in primary care practice*

Statement	Affirmative response	
	N	%
Lack of time	57	85%
Insufficient knowledge in diagnosis of depression and anxiety	40	59.7%
Insufficient knowledge in treating depression and anxiety	40	59.7%
Lack of means to treat depression and anxiety	42	62.7%
Shortage of specialists' support to treatment of soft mental health problems in your clinic	46	68.7%
Lack of personal interest to treat soft mental health problems	25	37.3%
Difficulty to speak on mental health issues with the patients	29	43.3%

Table 3. *Issues concerning soft mental health care for further enrichment*

Statement	Affirmative response	
	N	%
To learn more about diagnosis of depression and anxiety	54	80.6%
To learn more about etiology of depression and anxiety	17	25.3%
To improve medical treatment skills of depression and anxiety	56	83.6%
To improve non-medical treatment skills (CBT, supportive therapy) of depression and anxiety	48	70.1%
Consultation with psychiatrist concerning patients with soft mental health disorders	54	80.6%
Other issues	3	4.5%
No interest in further enrichment	2	3%

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## Commentary — Attitudes

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The role of primary caregivers in patients suffering from psychiatric syndromes is increasingly appreciated in western society. The de-isolation process occurring in psychiatry leads us to find similar solutions to those found in other fields of medicine. It should be noted that western medicine is undergoing a rapid process of specialization. Yet, most pa-

tients are treated in primary care. Treatment in primary care has several advantages:

1. Less stigmatic.
2. Leads to continuity of care.
3. The physician has a long-standing relationship with the patient and his family.