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Research papers

How ready are practice nurses to participate in the identification and management of depressed patients in primary care?

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ABSTRACT

Background Practice nurses (PNs) see increasing numbers of patients with mental health problems, but previous studies have highlighted gaps in relevant competencies in primary care staff.
Aim To determine PNs' knowledge, attitudes, training and current practice with respect to depressed patients.
Method Postal survey of PNs in one-in-two sample of Scottish general practices.
Results From 428 practices, 442 of 786 PNs (56.2%) responded. While they reported seeing significant numbers of depressed patients, 82% felt they lacked adequate knowledge and training. Specific gaps in knowledge were found. Only one in four had attended post-qualification mental health training. PNs rated mental health training as a lower priority than areas of physical illness in which they had already received more training.
Conclusions PNs are not, and do not feel, fully prepared to work with depressed patients, but may not be motivated to acquire the necessary further skills. Appropriate training courses should be developed and evaluated.

Keywords: depression, primary care nurses, training

Introduction

Between 30% and 40% of attenders in primary care have significant psychological symptoms, and around 10% have significant depressive illness, a condition that frequently goes undiagnosed.[1–3] The identification and management of depression is a task for the extended primary care team, and 70% of the general public surveyed during the 'Defeat Depression Campaign' considered it appropriate to approach any health professional if they were depressed.[4,5]

By 1999 there were about 20 000 practice nurses (PNs) working in the UK, and there has been a ten-fold increase over five years in the proportions of PNs who spend significant amounts of time seeing patients with mental health problems.[6,7] Almost all PNs have only general nurse training and very few have post-qualification training in mental health.[6–9]

However, in contrast to efforts to educate general practitioners (GPs) in the UK about depression, no similar concerted attempts with PNs have been reported.[5,10,11] This is unfortunate, since there is growing evidence that involving appropriately trained nurses in the management of depression in primary care can prove significantly effective.[12–17] It is not surprising, therefore, that PNs have been reported to be relatively poor at detecting mental illness, or that they perceive themselves to be inadequately prepared for these tasks.[6,7,18,19]

The *National Service Framework for Mental Health Services* states that 'Any service user who contacts their primary care team with a mental health problem should have their needs identified and assessed', but the *Mental Health Policy Implementation Guide* highlights gaps in mental health competencies in primary care staff.[20,21] The *Framework for Mental Health Services in Scotland* recognises the need to address these deficiencies, and the Scottish 'Health Plan' contains a specific commitment to enhance the training of primary care nurses.[22,23] To inform that process, a study of PNs working in Scottish general practice was undertaken to determine their current workload and practice with depressed patients; their attitudes to and knowledge of depression and its treatment; their perceptions of their own knowledge and preparedness for working with depressed patients; and their views on further training.

Methods

Sample

The subjects of the study comprised the PNs working in a one-in-two random sample of all Scottish general practices, stratified by health board and number of partners, and selected using a computerised randomisation procedure. Each nurse was mailed a questionnaire with a covering letter and a pre-paid envelope for return. Non-responders were sent up to two postal reminders and received one telephone reminder.

Instrument

The questionnaire contained seven sections:

1 personal details
2 practice details
3 caseload
4 depression:
   - how often patients ask about depression,
   - whether nurses feel able to deal with depression
   - actions taken after identifying depression
   - views on the nature of depression and its management.

Questions in the fourth area were derived from the 'Defeat Depression Campaign' and from the Royal College of Psychiatrists' 'Changing Minds Campaign' aimed at reducing the stigma of mental illness.[24,25]

5 delivery of interventions for depression
6 training: details of previous mental health training, willingness to attend future training, prioritisation of training needs
7 the Depression Attitude Questionnaire (DAQ) which is a 20-item scale measuring attitudes to depression, yielding scores in four principal components; attitudes to treatment; professional unease; beliefs about the malleability of depression; beliefs about the identification of depression.[26] DAQ scores are reflected in practice, including diagnostic ability, preferences for treatment and ease in managing patients.[27,28]

Statistics

Simple descriptive statistics were applied, with statistical significance defined by P values < 0.05 and 95% confidence intervals (CIs), using parametric and non-parametric tests, as appropriate.

Results

Respondents

Within 428 practices, 786 PNs were identified and sent questionnaires. Thirty-six (4.6%) declined to participate, and 317 (40.3%) did not respond. Completed questionnaires were received from 442 PNs, a response rate of 56.2% of eligible nurses from 72.2% of eligible practices. Almost all respondents were women (99.5%). The mean (standard deviation (SD)) age was 45.0 (7.5) years, and the mean (SD) time since qualifying was 23.9 (8.1) years. Almost all (98.4%) were registered nurses (registered general nurse or state registered nurse) and 15 (3.5%) held the additional qualification of registered mental nurse. PNs had worked within their current practice for a median (interquartile range (IQR)) of 7.0 (3–11) years, and worked for a median of 25 (20–34) hours a week. There was a median of 2 (1–3) PNs per practice.

Mental health placement

Three-hundred-and-seventy (84.9%) PNs had at least one mental health placement during general training, of whom 216 (58.4%) regarded it as a 'good experience'. Those who had experienced mental health placements had a lower mean (SD) age (43.9 (7.1) versus 50.8 (7.2) years, $P < 0.001$, 95% CI = –8.8 to –5.0) and had qualified more recently (22.8 (7.6) versus 30.0 years ago (7.5), $P < 0.001$, 95% CI = –9.2 to –5.1).

Current practice and training

When repeat visits were excluded, PNs had seen a median (IQR) of 5 (3–10) patients in the previous two weeks whom they considered to be depressed. Estimates were converted to proportions of patients seen in the same period, yielding a median (IQR) of 6.0% (2.7–11.1%). Those trained more recently (less than the mean) believed a higher proportion of their patients to be depressed (6.7 (2.8–12.5) versus 5 (2.5–10.0), $P = 0.03$, 95% CI = 0 to 2.5). Overall, 409 (94.2%) PNs said that patients do ask them about aspects of depression (see Table 1). However, only 76 (17.6%) felt able to deal effectively with people with depression. This was not associated with age, years since qualification or mental health placements. However, a greater proportion of those whose placement was a good experience felt able to deal with these patients (49 (23.3%) versus 13 (9.2%), $P = 0.001$, odds ratio (OR) = 3.0, 95% CI = 1.5 to 5.7). Of those who did not feel able to deal effectively with depressed patients, over 90% said they lacked adequate knowledge and training.

The most common action taken when PNs suspect a patient has a new episode of depression is to refer to a GP (see Table 2), although 163 (48.4%) would sometimes counsel such patients. Those who did counsel identified more patients as depressed (7.7% (IQR = 3.7–12.5) versus 5.0% (2.5–10.0), $P < 0.01$, 95% CI = –3.2 to –0.06). More of those whose mental health placement had been a good experience would refer patients to mental health professionals (78 (43.8%) versus 35 (30.2%), $P < 0.05$, OR = 1.1, 95% CI = 1.1 to 2.9) and a smaller proportion of them would do nothing (32 (12.6%) versus 35 (30.2%), $P < 0.01$, OR = 0.35, 95% CI = 0.2 to 0.7). Those who felt able to deal effectively with depressed patients were more likely to refer patients (35 (55.6%) versus 96 (33.3%), $P < 0.01$, OR = 2.5, 95% CI = 2.5 to 4.3); more likely to counsel (48 (80%) versus 110 (40.9%), $P < 0.001$, OR = 5.8, 95% CI = 2.9 to 11.4); and more likely to ask patients to come back to them (55 (88.7%) versus 193 (68.7%), $P < 0.01$,) OR = 3.6 95% CI = 1.6 to 8.2).

PNs reported little contact with mental health specialists, most particularly psychiatrists (8.7%) and psychologists (9%), with only a few more having

Table 1 Reported frequencies that patients ask practice nurses about aspects of depression

	Frequently *n* (%)	Sometimes *n* (%)	Never *n* (%)
Depressive symptoms/illness	84 (19.5)	306 (71.0)	41 (9.5)
Medication for depression	53 (12.7)	297 (71.4)	66 (15.9)
Counselling/psychotherapy for depression	28 (6.7)	270 (64.9)	118 (28.4)

Table 2 Actions taken when practice nurses suspect a patient has a new episode of depression

	Always *n* (%)	Frequently *n* (%)	Sometimes *n* (%)	Never *n* (%)
Contact GP to arrange assessment	282 (65.9)	81 (18.9)	53 (12.4)	4 (2.8)
Refer directly to a mental health professional	10 (2.8)	27 (7.5)	98 (27.4)	223 (62.3)
Nothing – leave it to other health professionals	13 (4.3)	10 (3.3)	24 (7.9)	258 (84.6)
Give counselling or other treatment	8 (2.4)	22 (6.5)	133 (39.5)	174 (51.6)
Advise patient to return to see me again	1 (8.0)	42 (12.0)	185 (52.7)	96 (27.4)

contact with community psychiatric nurses (11%). Although 241 (57%) were involved in administering depot antipsychotic medication, involvement in other mental health interventions was infrequent.

Since becoming PNs, only 109 (25%) had attended any mental health courses or study days. More of those who had attended a training event felt able to deal effectively with depressed patients (35 (33%) versus 39 (12.2%), $P < 0.001$, OR = 3.6, 95% CI = 2.1 to 6.0). Three-hundred and fifty-five (83.5%) said they would attend a mental health course given time and funding, and this was more frequent in younger PNs (198 (91.7% versus 146 (75.3%), $P < 0.001$, OR = 3.6, 95% CI = 2.0 to 6.5), and those with positive mental health placements (194 (93.3%) versus 105 (75.5%), $P < 0.001$, OR = 4.5, 95% CI = 2.3 to 8.7). However, only 199 (47.5%) believed mental health training to be a priority for PNs, and only 124 (30.1%) thought their GPs would consider it a priority. Those who already felt able to deal effectively with depressed patients were *more* likely to consider it a priority (47 (63.5%) versus 147 (43.9%), $P < 0.01$ OR = 2.2, 95% CI = 1.3 to 3.7).

Respondents rated the five clinical areas of mental health, hypertension, diabetes, asthma, and cervical screening in terms of priority for PN training. Mental health received the lowest median rating, and only 62 (15.1%) rated it as the highest priority, with 172 (41.8%) rating it as the lowest. Three-hundred and seventy-nine (85.7%) had already attended courses in at least one of the clinical areas other than mental health.

Attitudes to depression and its treatment

Respondents were asked to indicate their level of agreement with 12 statements about depression derived from the 'Defeat Depression' and 'Changing Minds' campaigns, and responses to (11 of the 12) items were also categorised as indicating a 'negative' opinion (see Table 3). Two-hundred and seventy-three (61.8%) PNs did not respond negatively to any item. Those whose placements had been a good experience were less likely to score any negative items (70 (32.4%) versus 66 (46.2%), $P < 0.05$, OR = 1.8, 95% CI = 1.2 to 2.8).

Table 4 shows the four component scores on the DAQ. Responses to the 20 individual items are available from the authors. Younger PNs (age below the mean) had lower mean (SD) scores on 'attitudes towards treatment' (45.2 (8.7) versus 47.1 (8.3), $P < 0.05$, 95% CI = –3.5 to –0.2) and on 'inevitability of depression' (25.5 (13.3) versus 28.3 (14.4), $P < 0.05$, 95% CI = –5.5 to –1.7). Those who qualified more

Table 3 Practice nurses' views about depression and its treatment

	Agree *n* (%)	Neutral *n* (%)	Disagree *n* (%)
People with severe depression should be offered antidepressants	346 (79.7)	68 (15.7)	20 (4.6)*
Antidepressants should be continued for at least four months after recovery	277 (64.0)	148 (34.2)	8 (1.8)*
The main treatment for severe depression should be counselling	103 (23.8)*	159 (36.7)	171 (39.5)
People with severe depression are unpredictable	224 (51.7)*	121 (27.9)	88 (20.3)
Counselling is very or fairly effective in depression	292 (67.1)	121 (27.8)	22 (5.1)
People with severe depression are a danger to others	58 (13.4)*	86 (19.8)	290 (66.8)
People with severe depression need to pull themselves together	5 (1.1)*	17 (3.9)	413 (94.9)
Tranquillisers are very or fairly effective in depression	25 (5.8)*	173 (40.0)	234 (54.2)
Antidepressants are very or fairly effective in depression	345 (79.7)	63 (14.5)	25 (5.8)*
People with severe depression tend not to improve with treatment	26 (6.0)*	85 (19.7)	321 (74.3)
Antidepressants are drugs of addiction	62 (14.4)*	88 (20.4)	282 (65.3)
People with severe depression are hard to talk to	169 (38.2)*	77 (17.7)	188 (43.3)

*Indicates a view considered by the authors to be 'negative' or 'erroneous'

Table 4 Depression Attitude Questionnaire component scores

	Practice nurses	GPs		Psychiatrists
	Mean (SD)	Mean[a]	Mean[b]	Mean[b]
Attitudes towards treatment (high score = biochemical basis of severe depression, antidepressants useful, psychotherapy unsuccessful)	50.0 (8.5)	47.5	52.1	52.3
Professional unease (low score = comfortable managing depression, such work is not heavy-going, such work is rewarding, psychotherapy should be left to a specialist)	60.5 (16.1)	43.0	51.0	32.0
Inevitability of depression (high score = pessimism towards depression, depression is caused by deprivation in early life and not amenable to change, is a natural part of being old, patients are better off with psychiatrists than GPs)	26.8 (13.8)	24.5	29.9	30.1
Identification of depression (high score = difficulty distinguishing depression from unhappiness, depression comes from people's misfortunes, little help beyond GP)	39.2 (15.1)	40.6	45.5	33.4

[a]Dowrick *et al* (2000)[28]
[b]Kerr *et al* (1995)[27]

recently had lower 'inevitability of depression' scores (25.5 (13.7) versus 28.4 (13.9), $P < 0.05$, 95% CI = –5.6 to –0.2). Those who had been on a mental health placement had lower 'inevitability of depression' scores (26.2 (13.8) versus 30.4 (13.5), $P < 0.05$, 95% CI = –7.8 to –0.5). Those whose placement had been a good experience had lower 'professional unease' scores (56.7 (16.1) versus 64.7 (13.8), $P < 0.001$, 95% CI = –11.3 to –4.8). Those who felt able to deal effectively with depression had lower 'professional unease' scores (48.6 (17.2) versus 63.0 (14.6), $P < 0.001$, 95% CI = –18.2 to –10.7), lower 'inevitability of depression' scores (23.4 (15.3) versus 27.4 (13.2), $P < 0.05$, 95% CI = –7.4 to –0.6) and lower 'identification of depression' scores (32.7 (17.1) versus 40.8 (14.3), $P < 0.001$, 95% CI = –11.7 to –4.3). Those who had already attended a mental health course had lower 'professional unease' scores (55.4 (17.0) versus 62.1 (15.3), $P < 0.001$ 95% CI = –10.1 to –3.2). Those who were willing to attend future mental health courses had lower 'professional unease' scores (58.8 (15.5) versus 68.4 (17.0), $P < 0.001$, 95% CI = –13.7 to –5.5). Those who considered mental health training to be a priority had lower 'professional unease' scores (54.5 (15.6) versus 65.3 (15.0), $P < 0.001$, 95% CI = –13.5 to –7.6).

Discussion

Response rate and generalisability

Our response rate of 56.2% is in the lower range of acceptability, but should enable reasonably confident extrapolation. Our methodology avoided the majority of factors associated with lower response rates to postal questionnaires, as recently reviewed by Edwards.[29] Previous surveys of UK practice nurses' involvement in, or attitudes to, mental health issues have yielded similar or lower response rates, whereas a previous survey of Scottish practice nurses' attitudes to a non-mental health issue reported a response rate of 88%.[6,7,19,30] It is thus possible that PNs' discomfort over mental health issues has a detrimental effect on response rates. It is further possible that those who did respond might feel more skilled and comfortable in dealing with depression than do non-respondents, although we do not have evidence to that effect. As elsewhere in the UK, PNs within Scotland vary in their working arrangements and responsibilities and contractual arrangements with their host practices. However, we are not aware of any uniform and systemic differences between PNs or practices in

Scotland and the rest of the UK that would preclude generalisation of our findings.

Current practice

Our study confirmed that PNs see sizeable numbers of patients whom they consider to be depressed, and are asked about depression by their patients. However, they feel ill-equipped to deal with such patients, and have little interaction with mental health professionals. It would be very difficult for PNs to maintain and renew necessary knowledge and skills with this degree of professional isolation. Nonetheless, nearly half of our respondents indicated that they would counsel depressed patients. While they would not be alone in offering counselling in primary care when they are untrained to do so, this finding was disquieting especially when trained counsellors are effective in treating patients with mild to moderate depression in primary care settings.[31–33] Our finding that 15% of PNs sometimes 'do nothing' for depressed patients should be viewed cautiously, since they may know that someone else is treating the patient.

Knowledge and attitudes

Compared with the general public, PNs did not express particularly negative views about depression.[25] 'Negativity' was associated with PNs' rating of the quality of their previous training experiences. However, it is of concern that while almost all PNs were being asked questions about depression by their patients, nearly a quarter thought that the main treatment for severe depression should be counselling, only 65% refuted the view that antidepressants are addictive, and only 54% disagreed that tranquillisers are an effective treatment for depression. 'Negativity' was associated with the quality of PNs' experience of mental health placements. Future training initiatives should not only address the specific gaps highlighted here, but should also be structured to give PNs a positive experience.

In three out of four components of the DAQ, PNs differed little from GPs or, to a lesser extent, psychiatrists.[27,28] However, PNs' scores on 'professional unease' in the DAQ were very high, confirming their considerable discomfort in working with this patient group.

Training

Training had been unsatisfactory, was usually remote in time and only 25% had attended a mental health course since qualification, broadly confirming the review of Sorohan.[16] Negative training experiences were associated with greater professional unease about working with depressed patients. Positive training experiences were associated with lower professional unease, greater willingness to obtain further training, and a higher rating of its importance. That is to say, those nurses most in need of further training might well be least likely to seek it. Despite the high levels of professional unease, over two-thirds of PNs acknowledge not only that they are seeing increasing numbers of depressed patients, but also that the practice nurse could play a useful role in supporting such patients. Their low prioritisation of mental health as a training need compared with physical illnesses was, therefore, particularly disappointing. Although PNs' perceived priorities might partly reflect the differing priorities of the GPs with whom they work, our findings clearly indicate a relationship between motivation and the quality of previous related experience.[34] Consequently, there is a need not only to develop appropriate training interventions, but to find ways of providing incentives for PNs to attend. We found that PNs give higher priority to and more frequently obtain training in areas other than mental health where some form of professional recognition or accreditation is available, such as for asthma or diabetes. If PNs are to fulfil their potential to identify and support the management of depressed patients in primary care, nationally accredited courses should be developed and evaluated.

Implications

There is a manifest need to train PNs about the detection and management of depression, especially when training programmes in mental health improve nurses' knowledge and perceptions of competence and when previous studies have demonstrated that PNs' involvement with depressed patients in primary care settings is therapeutic.[14,15,35,36] Given the large number of nurses involved, innovative approaches will probably be required. While attitudes towards depression were generally positive, attitudes towards further mental health training were not, and motivational issues may well be the first barrier to tackle.

Conclusions

Clinical implications

- Practice nurses have gaps in their knowledge of depression and do not feel able to deal adequately with depressed patients.

- Training in this area is required.
- Courses should take account of highlighted gaps in knowledge and factors that may mediate motivation.

Limitations

- The response rate was in the lower range of acceptability.
- Reported attitudes and practices may not entirely reflect actual clinical behaviour.
- We have no information as to how supportive GPs would be to practice nurses receiving more mental health training.

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CONFLICTS OF INTEREST

None.

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