

Editorial

Traditional mental health training's effect on primary care physicians in Saudi Arabia

Abdullah Dukhail Al-Khathami MBBS ABFM KFFCM MSc Med Edu (Cardiff, UK)
Consultant of Family, Community Medicine and Medical Education, Director of the Postgraduate Family Medicine Programme and Supervisor of the Primary and Community Mental Health programme, Eastern Province, Saudi Arabia

Abdallah M Mangoud
Retired Associate Professor, Department of Family and Community Medicine

Idris A Rahim
Professor, Department of Psychiatry

Mahdi S AbuMadini
Professor and Chairman, Department of Psychiatry
Dammam University, Dammam, Eastern Province, Saudi Arabia

Introduction

The joint WHO and Wonca Report published in 2008 considers the prevalence of mental health problems presenting to primary health care (PHC) to be as high as 60%.¹ In most cases patients present with depression, anxiety or somatoform disorders.² These conditions often present with physical rather than psychological complaints³ and are usually associated with a significant degree of disability.⁴ Despite the high prevalence of mental health (MH) problems, these frequently pass unrecognised in PHC settings^{2,5} – the identification of MH problems by PHC physicians is low.⁶ Recognition of such patients is vitally important in order to reduce not only the suffering of individuals but also the futile consumption of public resources.¹

Experience shows that brief training programmes in the traditional mode of training, i.e. workshops of as little as three to five days, without a clinical component, can substantially upgrade PHC physicians' knowledge and attitudes towards these disorders.⁷ However, their practical clinical performance has not been studied. We studied the change in PHC physicians' knowledge and attitudes, as well as the practical skills resulting from a short training course for the detection and management of common MH problems in the PHC setting.

Methodology

We carried out a cross-sectional intervention study of a randomly selected sample of 45 PHC physicians working in the Dammam Sector of the Eastern Province, Saudi Arabia. Our control group consisted of 146 PHC physicians who were not involved in the intervention training course.

The training course was run for four days without a clinical component attached. It was designed to focus on the recognition and management of the most common forms of MH problems presented in the PHC settings: depression, anxiety, somatoform, eating, and sleep disorders and the common problems of childhood and adolescent psychiatry. Various learning methods were used: audiovisual presentations, role play, real case presentation and group discussion. Workshops were run by teams of experienced psychiatrists and were conducted in small groups in order to facilitate individualised participation.

Assessment

Knowledge was assessed through multiple choice questions (MCQ) pre- and post-training. Multiple linear regression equations were used to elicit the

independent variables that could contribute to the explanation of variance in PHC physicians' knowledge of psychiatric disorders before and after the course.

The trainees' **attitudes** were assessed by a 26-item self-administered questionnaire. The questionnaire was based on 35 items which were used by Chinnayya *et al.*⁸ To evaluate the PHC physician's **practical skills**, the area of study was divided into four clusters. Thirty percent from each cluster were randomly selected to be the representative sample. In total, ten physicians were selected as the sample for practical skills evaluation. File audit was used to estimate the detection rate and patterns of management before and after the training intervention. Every candidate acted as his/her own control. Each PHC physician assessed on average 40 patients per working day.

Results

Knowledge

A significant improvement was found in participants' knowledge of mental health care (p -value <0.0001) after training. Only undergraduate psychiatric training had a positive contribution to the pre-test assessment (p -value = 0.0067), which explained 23% of the variance. Likewise, the variables affecting the post-test scores were the medical school attended ($p <0.0037$) and undergraduate psychiatric training ($p <0.0391$), jointly explaining 54% of the variance.

Attitudes

There was no statistically significant difference between the pre-intervention study group's and the control group's attitudes toward mental health issues (p -value = 0.866). There were significantly higher scores reflecting positive attitudes in the post-test compared with the pre-test evaluations ($p <0.0001$). Six months after the intervention, the positive attitudes evident immediately post-test persisted within the study group ($p = 0.274$). Multiple regression analysis also revealed that the duration of the undergraduate psychiatric training course was the only independent variable that contributed to the variance in attitude scores. In this respect, those who had had more than four weeks' clinical rotation in psychiatry had significantly higher scores reflecting positive attitudes towards mental health issues ($p = 0.033$). The duration of the undergraduate psychiatric training explained 16.3% of the variation.

Practical skills

The total number of MH problems which were detected by all ten physicians during the six-month period preceding the course was only 20 cases (3.3 cases per 10 000 patents). This detection rate has not been affected by the training course, for the total number of detected cases during the six-month period following the course was little different (21 cases). Most of the diagnosed patients were referred to psychiatric clinics. In the pre-course period, no patient had a follow-up appointment within the PHC setting, but after the course two patients had follow-up visits with their PHC physicians.

Discussion

The importance of this research lies in the use of the pre- and post-tests as indicators of the positive effects as well as an assessment of any long-term effects of the training programme in the field of mental health care. This approach would allow us to measure the immediate and the long-term effects of the programme on the PHC physicians' achievement. There was consistent positive change in PHC physicians' attitudes immediately and at six months after the training course. These improvements will hopefully positively influence MH services in the PHC setting.

MH training courses for PHC physicians have been documented as being cost effective, and as contributing to improving knowledge as well as attitudes toward mental health. Given the current status of the healthcare system of the Eastern Province of Saudi Arabia, PHC physicians should play a more active role in the provision of MH care.

The duration of undergraduate psychiatric training was significantly positively associated with the PHC physicians' knowledge and attitudes toward mental illnesses.

A high prevalence of mental illness in PHC settings has been documented in this region. Unfortunately, our programme has not achieved any improvement in the practical skills of illness recognition. Trainees are seldom able to diagnose MH problems. This means that most mentally ill patients don't receive a real benefit from their visits to PHC settings. This is deplorable in view of the fact that most of these minor psychiatric morbidity cases, if identified, can be appropriately managed by PHC physicians.

We speculate from experience that a number of factors may be forming a barrier to more effective delivery of mental health services in the PHC setting.

Many health providers may be wary of becoming involved in mentally ill patients' care, preferring to adopt a minimalist, distant role and deal only with physical complaints. As most of the patients do present with physical symptoms, 'somatically oriented' physicians are more likely to miss the concomitant psychological features. The stigma of mental illness might influence the physicians' readiness to 'label' their patients. Finally, the lack of psychotropic medications available to the study PHC settings may have had a major role to play.

The PHC physicians' undergraduate course, with very little time dedicated to psychiatric training, appears to have made a significant contribution to the difficulties encountered in recognising and treating mental health problems in PHC settings in Saudi Arabia. A broader curriculum incorporating adequate psychiatric training during the undergraduate period and ongoing postgraduate medical education, with more emphasis on clinical training in mental health, preferably within the PHC setting, should be considered in order to improve the provision of MH services in the PHC setting in Saudi Arabia.

Study limitations

The main limitation of this study was the difficulty of ensuring that a sufficient number of trainees attend the course. This was due to the shortage of PHC physicians and a lack of replacements for them.

Conclusion

Attention should be given to improving undergraduate psychiatric training in order to achieve better quality MH provision at the PHC level. There is a need for an advanced, preferably long-term, postgraduate MH training programme that focuses on the management of MH problems in PHC settings. Other initiatives should be considered in order to improve PHC physicians' skills, such as the establishment of a referral clinic with specialists who have an interest in primary MH care. This would hopefully build a good communication pathway

between PHC physicians and specialists through consultation and training, intended to promote and enhance the provision of primary MH care.

ACKNOWLEDGEMENTS

The authors' great appreciation is owed to Dr Gabriel Ivbijaro for his invaluable advice and ongoing support. Also, I wish to express my thanks and appreciation to Dr Eleni Palazidou for her help in reviewing and restructuring the manuscript.

REFERENCES

- 1 WHO/Wonca Joint Report. *Integrating Mental Health into Primary Care: a global perspective*. 2008. www.who.int/mental_health/policy/en/
- 2 Ormel J, Maarten W, Koeter J, Brink W and Willige G. Recognition, management, and course of anxiety and depression in general practice. *Archives of General Psychiatry* 1991;48:700-6.
- 3 Rasmussen N and Avant R. Somatization disorder in family practice. *American Family Physician* 1998;40:206-14.
- 4 Gureje O, Simon G, Ustun T and Goldberg D. Somatization in cross-cultural perspective: a WHO study in primary care. *American Journal of Psychiatry* 1997;154:989-95.
- 5 Joukamaa M, Lehtinen V and Karlsson H. The ability of general practitioners to detect mental disorders in primary health care. *Acta Psychiatrica Scandinavica* 1995;91:52-6.
- 6 Higgins E. A review of unrecognized mental illness in primary care. Prevalence, natural history, and efforts to change the course. *Archives of Family Medicine* 1994;3:908-17.
- 7 Qureshi N, Al-Ghamdy Y, Al-Haddad N, Abdelgadir M and Tawfik M. Integration of mental health care into primary care. Preliminary observations of continuing implementation phase. *Saudi Medical Journal* 2001;22:899-906.
- 8 Chinnayya H, Chandrashekar C, Moily S *et al*. Training primary care health workers in mental health care: evaluation of attitudes towards mental illness before and after training. *International Journal of Social Psychiatry* 1990;36:300-7.

ADDRESS FOR CORRESPONDENCE

Dr Abdullah Dukhail Al-Khathami, Fax: 00966-3-8949234; email: mabna@yahoo.com

Accepted October 2010

