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**Discomfort sharing the general practice waiting room with mentally ill patients:  
a cross-sectional study.**

Running title: Attitudes to mentally ill patients

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## **Abstract**

### *Background*

Most mental illness is managed in general practice rather than specialist psychiatric settings. Management of mental illness in general practice is advocated as being less stigmatising than psychiatric settings. Thus, other patients' discomfort with sharing the waiting room with the mentally ill may be problematic.

### *Objectives*

To examine prevalence and associations of discomfort of general practice waiting room patients with fellow patients with mental illness and the implications for practices of these attitudes. We sought attitudes reflecting social distance, a core element of stigmatisation.

### *Methods*

A cross-sectional waiting room questionnaire-based study in 15 Australian general practices. Outcome measures were discomfort sharing a waiting room with patients with mental illness, likelihood of changing GP practice if that practice provided specialised care for patients with mental illness, and the perception that general practice is a setting where patients with mental illness should be treated.

### *Results*

Of 1134 participants (response rate 78.5%), 29.7% and 12.2%, respectively, reported they would be uncomfortable sharing a waiting room with a patient with schizophrenia or severe depression/anxiety. Only 29.9% and 48.8%, respectively, felt that general practice was an appropriate location for treatment of schizophrenia or

severe depression/anxiety. Ten percent would change their current practice if it provided specialised care for mentally ill patients.

### *Conclusions*

This desire of general practice patients for social distance from fellow patients with mental illness may have implications for both general practitioners with a particular interest in mental disorders and for the care-seeking and access to care of patients with mental illness.

### **Key words:**

Mental Disorders, Social Stigma, Family Practice, Depressive Disorder, Schizophrenia.

## Introduction

Most management of mental illness, in Australia as elsewhere, occurs in general practice or other primary care.<sup>1 2</sup> There is acknowledgement of ‘the critical role that general practice plays in the treatment of common mental disorders’.<sup>3</sup> Of unselected Australian general practice consultations, 12.4% address a psychological problem.<sup>4</sup> Within general practice there are also some general practices and general practitioners (GPs) who maintain a special interest in the management of mental illness and an enhanced workload of patients with psychiatric morbidity.<sup>5</sup>

Stigmatisation of mental illness is both highly prevalent and problematic.<sup>6-9</sup> Other patients’ attitudes towards the mentally ill that may be seen as stigmatising may be an especial problem for practices and GPs with a special interest in mental illness. These practices’ waiting rooms will reflect a patient demographic with a bias towards mental health patients.

In this study we explored attitudes of patients attending Australian general practices towards fellow general practice waiting room patients with potentially stigmatising medical conditions. We related these attitudes to previous waiting-room experiences. We also explored possible implications for practices of these attitudes. The primary aim of the study was to examine prevalence and associations of attitudes towards opiate-addicted patients and this has been reported previously.<sup>10</sup> The second aim was to similarly examine prevalence and associations of attitudes of general practice patients towards fellow patients with mental illness that may reflect stigmatisation and the implications of this for practices. Stigma is a complex construct and this study was concerned with one of its core components, social distance.<sup>7</sup> Social distance itself is a multifaceted concept,<sup>11</sup> but essentially ‘involves the desire to avoid contact with a particular group of people’.<sup>7</sup>

## Methods

This was a cross-sectional questionnaire-based waiting room study. The outcomes for the analyses presented in this paper were (a) the prevalence of discomfort with sharing a waiting room with patients with mental illness, (b) the prevalence of a history of disturbing or unsettling waiting room experiences related to the mental illness of other patients in the GP waiting room, (c) the expressed likelihood of changing GP practice if that practice provided specialised care for patients with mental illness, and (d) the prevalence of the perception that general practice is a setting where patients with mental illness should be treated (elicited by an item asking whether a neighbour with the condition should be treated in any of a number of settings including general practice).

### *Study questionnaire:*

These outcomes were elicited by items within a questionnaire constructed for the study. For the questionnaire items regarding discomfort sharing the waiting room and the perception of where patients should be treated, respondents were asked separately regarding ‘schizophrenia’ and ‘severe depression or severe anxiety’. The rationale was that previous work has suggested differences in stigmatising attitudes to these conditions.<sup>8 9 11</sup> For the questionnaire item regarding changing practices, the term ‘mentally ill patients’ was used, as GPs’ special interest is more likely to be mental illness generally rather than condition-specific. Similarly, for the questionnaire item regarding past experience of disturbing waiting room experience, the term ‘mental illness’ was used. This item elicited respondents’ impressions or assumptions of the



cause of the behaviour of their fellow waiting room attendees, but it was reasoned that they would be unlikely be aware of the specific mental disorder diagnosis.

Comparable questionnaire items elicited attitudes, intentions and experiences related to fellow patients in general practice waiting rooms with a number of other potentially stigmatising medical conditions: faecal incontinence, urinary incontinence, Attention Deficit Hyperactivity Disorder and alcohol abuse. Questionnaire items also elicited the same information regarding patients with diabetes. It was intended that items regarding these other conditions would normalise the questions related to opiate addiction and mental illness.

In order to contextualise expressed likelihood of changing GP practice, participants were asked for their likely response to other scenarios: the practice increasing its fees (by \$A10 or \$A20 per consultation), and consistently being kept waiting (for 15 or 30 minutes).

Participant demographics and whether the respondent had a personal or family history of mental illness were also elicited. Practice demographic variables were provided by practice managers of the participating general practices.

The Socioeconomic Indexes for Areas (SEIFA) Index of Relative Socioeconomic Disadvantage<sup>12</sup> was employed to define socioeconomic status. The Australian Standard Geographical Classification – Remoteness Area (AGSC-RA)<sup>13</sup> was employed to define the rurality/urbanicity of residency. Both SEIFA scores and AGCS-RA classifications were derived from respondents' postcodes.

#### *Setting:*

The study was conducted in practices of the Network of Research General Practices (NRGP).<sup>14</sup> The NRGP includes major city and inner regional practices across the

Hunter Valley, New England, Central Coast and Mid-north Coast regions of New South Wales, Australia. All practices in the Network were invited to participate.

*Procedures:*

During three randomly selected half-day sessions over a two-week period (between August and December, 2009), patients 18 years of age or older were invited by practice receptionists to participate in the study as they presented for appointments. Respondents were provided with an information pack containing an information statement, a questionnaire and a reply-paid envelope. The questionnaire was anonymous and either returned to a box in the waiting room or mailed to the researchers by reply-paid post.

*Statistical analyses:*

Associations were calculated using Chi-square and t-tests. Dichotomous outcomes were modelled using a logistic regression model within a Generalised Estimating Equations framework to adjust for clustering of patients within practices. Models with one predictor were compared with final models consisting of the variables of interest and other variables aligned with the outcome. All analyses were performed using SAS V9.2 (SAS Institute Inc., Cary, NC, USA.) or SPSS for Windows, version 17 (SPSS Inc, Chicago, Ill, USA).

**Results**

Fifteen of the 16 Network member practices participated. We received 1138 responses (response rate of 78.5%).

The average age of respondents was 52.7 (SD19.8) years (Median age: 53.5) and 69.7% were female. There were similar proportions of participants from major cities

(49.6%) and inner regional areas (50.4%). Respondents attending their usual practice comprised 95.2% of the sample.

#### *General practice as an appropriate location for treatment of mental illness*

When asked where a neighbour with potentially stigmatising medical conditions should be treated, only 29.9% (95% CIs 27.2 to 32.7) and 48.8% (95% CIs 45.8 to 51.8) felt that schizophrenia and severe depression /anxiety, respectively, should be treated in general practice (see Table 1 for locations thought appropriate).

#### *Disturbing or unsettling experiences and discomfort in the waiting room.*

Only 3.5% (95% CI 2.5 to 4.7) of respondents reported ever having had, in any GP waiting room, a disturbing or unsettling experience related to the mental illness of another patient. Despite this, 29.7% (95% CI 27.0 to 32.5) of respondents reported that they would be uncomfortable sharing a waiting room with someone with schizophrenia and 12.2% (95% CI 10.4 to 14.3) would be uncomfortable sharing with someone with severe depression or severe anxiety.

Having had a negative waiting room experience with another patient with mental illness was not significantly associated in regression analyses with discomfort sharing a waiting room with patients with severe depression/anxiety but was for schizophrenia (OR 2.20) (Tables 2 & 3) Significant associations of discomfort for severe depression/anxiety were male sex (OR 1.46) and increasing age (OR 1.02 for each year). For schizophrenia, increasing age was significantly associated with being less likely to report discomfort (OR 0.99 for each year), as was a personal or family history of mental illness (OR 0.73).

#### *Intention to change practice*

When asked whether they would change General Practice surgeries if a GP at their current practice commenced provision of specialised care for mentally ill patients, 10.0% (95% CI 8.3 to 11.8) reported being moderately or highly likely to change surgeries. Respondents with a personal or family history of mental illness (OR 0.55) and younger respondents (OR 1.02 for each year older) were significantly less likely to change surgeries if a GP provided specialised mental illness care (see Table 4). The context for these findings is that 28.7% (95% CIs 26.0 to 31.5) and 26.6% (95% CIs 24.0 to 29.4), respectively, of respondents reported an intention to change practices if they were consistently kept waiting 30 minutes in the waiting room or if the practice increased its fees by \$A10 per consultation.

## **Discussion**

### *Main findings*

Our study found evidence of potentially stigmatising attitudes to patients with mental illness, as manifested by respondents' desire for social distance from other patients with mental disorders in GPs' waiting rooms. This finding is not entirely unexpected, given the prevalence of stigmatisation of mental illness in previous community samples.<sup>8</sup> But it is noteworthy given the considerable prevalence of mental illness in general practice waiting rooms.<sup>15</sup> That our study was conducted in GPs' waiting rooms is an important context, allowing us to explore implications of mental health stigmatising attitudes for health care delivery in general practice.

That only a minority of respondents (29.9% and 48.8%, respectively) felt that schizophrenia and severe depression/anxiety should be treated in general practice is a surprising finding, given that 12.4% of Australian general practice consultations include a psychological problem (depression in 4.2%, anxiety in 1.9%)<sup>4</sup> and that GPs

have been nominated by general population samples as the most appropriate place to seek help for psychological problems.<sup>16</sup> In a study from the United States,<sup>9</sup> when respondents were asked whether persons (in vignettes) with schizophrenia or major depression, respectively, should seek consultation with or treatment by “a general medical doctor”, 87% and 91% reported in favour. While not directly comparable (our questionnaire citing ‘general practice’ rather than ‘general medical doctor’ and ‘severe depression or severe anxiety’ rather than presenting a vignette depicting major depression), the differences are still striking. This is especially so as the United States study also showed considerable stigmatising attitudes towards schizophrenia and major depression.<sup>9</sup> The reasons for the difference in attitudes between the two studies and the two countries are not obvious.

Greater discomfort with patients with schizophrenia than with patients with severe anxiety/depression is consistent with previous evidence of desire for social distance being greater for schizophrenia compared with depression.<sup>8 9 11</sup>

Our study didn’t explore the complex aetiology of stigma<sup>6 7</sup>, but the significant association of waiting room discomfort with schizophrenia and previous unsettling waiting room experience with patients with mental illness (and the non-significant trend with severe depression/anxiety) suggest that the attitudes and anticipated behaviours reflecting desire for social distance found in our study may have some basis in personal experience as well as in community perceptions of mental illness.

The finding that personal or family history of mental illness was associated with less discomfort with patients with schizophrenia (and a non-significant trend in anxiety/depression) is consistent with previous literature regarding social distance/stigma and family or personal history of mental illness.<sup>17</sup>

In Australia, unlike some countries such as the UK, there is no registration of patients and individual patients may freely change practices or attend more than one practice. So an indication that 10% of respondents would be moderately or highly likely to change surgeries if a GP provided specialised care for mentally ill patients could be seen to be a disincentive to providing such care. It is possible that this may reflect a volatility in a 'non-registration' practice environment (rather than an effect of attitudes to mental illness). Evidence of this can be found in the stronger association with intention to change practice in the event of a consultation fee rise or increase in waiting time. But intention to change practice was only half as likely in those with a personal or family history of mental illness, suggesting a contribution of mental illness stigmatising attitudes to intention to change practice. The association with increasing age could also be argued as favouring a contribution of stigmatising attitudes. Older patients in general are less likely to change practice as they more highly value continuity of care,<sup>18</sup> but in this study increasing age was associated with increasing discomfort with patients with anxiety or depression as well as increased intention to change practice.

#### *Strengths and limitations of the study*

The excellent response rate of practices (94%) and patients (79%) was a strength. While the sample frame of general practices was a network of research general practices rather than a random sample, practices and GPs in the NRGP are in many aspects similar to unselected Australian practices and GPs (though no NRGP practices are located in capital cities and practices tend to be larger and located in areas of lower Socioeconomic status).<sup>14</sup> There is also evidence that higher response rates of research network practices compared to randomly sampled practices may result in equivalent biases in the two sampling strategies.<sup>19</sup>

A potential limitation of the findings is that we inferred stigmatising attitudes from participants' responses to simple questionnaire items rather than responses on a validated instrument. This meant that rather than exploring the complexity of social distance in these respondents we elicited responses to singular circumstances. The rationale is that we were interested in a very specific situation (and the implications for practice), and a strength of the study was that it elicited these attitudes and intentions in the setting in which they apply – the GP's waiting room. It may also be that discomfort with sharing a waiting room with someone with mental illness and an expressed intention to change practice if the practice provided specialised care for the mentally ill are of far more practical importance and interest to GPs and general practices than the performance of their waiting room patients on validated stigma scales.

While discomfort with the mentally ill and intention to change practice strongly suggest a desire for social distance our other outcome, an opinion that someone with mental illness should not be treated in general practice, may be based on other factors. It could reflect, for example, an opinion that best medical care for these patients would best be delivered in secondary rather than primary care. Thus it is a less robust outcome measure than discomfort and willingness to change practice.

Being a cross-sectional study with retrospective ascertainment of disturbing or unsettling experiences, there is potential for recall bias. A further limitation of the study was in assessing intention to change practice rather than actual change of practice. But to study disturbing experiences contemporaneously, and actual change of general practice surgery and its relationship to a change in GP care of mental illness, in a cohort study or RCT would be a difficult undertaking.

*Implications for practice and policy*

GPs and their practices may be concerned by the 10% of patients who expressed an intention to change their practice if a special interest in mental illness was undertaken there. This may have economic implications for the practice. But it may be that any such effect may be attenuated, in a non-registration system, by concurrently attracting patients with mental illness to the practice. It is also uncertain to what extent patients would be aware of a practice's or practitioner's special interest areas.

The level of potentially stigmatising attitudes to mental illness implicit in our findings is of concern. Not only the extent of these stigmatising attitudes, but also the fact that they are set in the context of general practice is relevant. General practice is the environment where most medical care for mental illness is sought: 'Like their international counterparts, Australians rely most on general practitioners for their mental health care'.<sup>1</sup> General practice attendance is also thought to be less stigmatising for mental illness patients than psychiatric services.<sup>20</sup>

Furthermore, there is abundant evidence that much mental illness in the community does not come to the attention of medical services or receive treatment.<sup>1 2 21</sup> These services can potentially treat much of this morbidity efficaciously. This gap in mental illness treatment has been identified as a policy priority.<sup>2 22</sup> Any bridging of the gap would have general practice at its centre.<sup>2 3</sup> Any stigmatisation of mental illness in general practice may be an impediment here, creating an environment discouraging patients from presenting their mental health symptoms (stigma has been associated with reduced willingness to seek help for mental illness<sup>23-25</sup>).

A further consideration is that general practice has been advocated as the setting where the co-morbidity of mental and physical disorders should be managed.<sup>3</sup> Stigmatisation of mental illness and a perception among patients that general practice is not an appropriate setting for the care of serious mental illness will have



implications for the management of co-morbidity. Addressing this issue will be complex, but is likely to involve education and a challenging of stigmatising attitudes at both community (improving mental health literacy and encouraging help-seeking behaviour<sup>1</sup>) and at individual practice levels.

It is disappointing therefore to note that in the United States in the decade 1996-2006, despite the fact that ‘clinicians, advocates, and policy makers have presented mental illnesses as medical diseases in efforts to overcome low service use, poor adherence rates, and stigma’,<sup>9</sup> stigmatisation (desire for social distance) of schizophrenia and depression has not decreased.<sup>9</sup> This suggests that efforts at the practice level – making general practices more ‘mental health friendly’ and the implementation of practice-based strategies for de-stigmatisation – may be a suitable focus. Our findings suggest GP waiting rooms as a suitable setting for display of public education materials (posters and leaflets) in support of public education campaigns around the issue of mental health stigma.<sup>9</sup> Patients in waiting rooms, we have demonstrated, may have stigmatising attitudes and, furthermore, education delivered here will be contextually relevant.

#### *Implications for future research.*

As we have discussed above, in ‘*Strengths and limitations of the study*’, in this questionnaire-based study we have not been able to explore the complexity of social distance inherent in the responses of study participants to our questionnaire items. This is a suitable subject for qualitative enquiry.

#### *Conclusion*

This study demonstrated considerable desire on the part of general practice attendees for social distance from fellow patients with mental illness, particularly patients with

schizophrenia. This may have implications for both GPs with a particular interest in mental disorders and for the care-seeking of patients with mental illness.

**Table 1. Where respondents' neighbours with Mental illness conditions should be treated: opinions of respondents \***

Condition	General Practice	Hospital clinic	Stand alone clinic	Community Pharmacy
<b>Schizophrenia</b> (% of respondents) (n = 1047)	29.9	33.0	53.5	2.2
<b>Severe Anxiety or depression</b> (% of respondents) (n = 1064)	48.8	28.7	43.0	2.3

\*respondents could nominate more than one location

**Table 2:** Predictors of patients with depression or anxiety causing discomfort to other patients in the Waiting Room

Variable	Class	Univariate Model			Final Model		
		OR	95% CI	P-value	OR	95% CI	P-value
Gender	Female	1			1		.
	Male	1.59	(1.32, 1.92)	<.0001	1.46	(1.17, 1.82)	0.0009
Geographic area	Major City	1			1		.
	Inner Regional	1.17	(0.85, 1.61)	0.3301	1.37	(0.89, 2.11)	0.1525
–Frequency of practice attendance	Weekly or more	1			1		.
	Monthly	1.32	(0.78, 2.23)	0.3057	1.34	(0.78, 2.28)	0.2905
	Several times pa	1.35	(0.74, 2.46)	0.3226	1.59	(0.82, 3.08)	0.1677
	Yearly or less	1.69	(0.86, 3.32)	0.1310	2.01	(0.89, 4.5)	0.0915
Negative Waiting Room experience with Mental Illness	Yes	1.47	(0.6, 3.58)	0.3951	2.29	(0.92, 5.71)	0.0752
Personal or family history of Mental Illness	Yes	0.6	(0.4, 0.91)	0.0171	0.64	(0.36, 1.13)	0.1207
Age		1.02	(1.01, 1.02)	0.0001	1.02	(1.01, 1.03)	0.0001
Practice attendance (years)		1	(0.99, 1.02)	0.7742			

Variable	Class	Univariate Model			Final Model		
		OR	95% CI	P-value	OR	95% CI	P-value
SEIFA Index		1	(1, 1.01)	0.2289	1.00	(1, 1.01)	0.2551

**Table 3:** Predictors of patients with Schizophrenia causing discomfort to other patients waiting in the Waiting Room.

Variable	Class	Univariate Model			Final Model		
		OR	95% CI	P-value	OR	95% CI	P-value
Gender	Female	1			1		.
	Male	1.13	(0.84, 1.52)	0.4155	1.16	(0.86, 1.57)	0.3230
Geographic area	Major City	1			1		.
	Inner Regional	1.21	(1.06, 1.39)	0.0054	1.21	(0.94, 1.56)	0.1428
Frequency of practice attendance	Weekly or more	1			1		.
	Monthly	1.2	(0.82, 1.76)	0.3425	1.17	(0.79, 1.75)	0.4371
	Several times per year	1.16	(0.87, 1.55)	0.3220	1.15	(0.85, 1.56)	0.3629
	Yearly or less	1.18	(0.85, 1.63)	0.3246	1.06	(0.76, 1.47)	0.7517
Negative Waiting Room experience with Mental Illness	Yes	1.67	(1.08, 2.6)	0.0225	2.20	(1.18, 4.1)	0.0127
Personal or family history of Mental Illness	Yes	0.83	(0.64, 1.07)	0.1574	0.73	(0.54, 0.98)	0.0380
Age		0.99	(0.99, 1)	0.1312	0.99	(0.99, 1)	0.0475
Practice attendance (years)		0.99	(0.98, 1.01)	0.5445			

Variable	Class	Univariate Model			Final Model		
		OR	95% CI	P-value	OR	95% CI	P-value
SEIFA Index		1	(1, 1)	0.4345	1.00	(1, 1)	0.9830

**Table 4:** Predictors of respondents changing General Practice surgeries if a GP at the surgery provided specialised care for patients with mental illness.

Variable	Class	Univariate Model			Final Model		
		Odds Ratio	95% CI	P-value	Odds Ratio	95% CI	P-value
Gender	Female	1			1		.
	Male	1.62	(1.04, 2.52)	0.0318	1.27	(0.8, 2.01)	0.3161
Geographic area	Major city	1			1		.
	Inner regional	1	(0.64, 1.58)	0.9862	0.95	(0.57, 1.59)	0.8395
Frequency of practice attendance	Weekly or more	1			1		.
	Monthly	0.9	(0.49, 1.65)	0.7418	0.98	(0.47, 2.04)	0.9634
	Several times pa	0.63	(0.37, 1.07)	0.0858	0.71	(0.35, 1.43)	0.3401
	Yearly or less	0.72	(0.44, 1.19)	0.2051	0.69	(0.32, 1.51)	0.3579
Negative Waiting Room experience with Mental Illness	Yes	0.78	(0.22, 2.79)	0.7069	0.90	(0.21, 3.85)	0.8901
Would change practice if consistently wait >30min	Yes	1.92	(1.32, 2.81)	0.0007	1.67	(1.04, 2.69)	0.0332



Variable	Class	Univariate Model			Final Model		
		Odds Ratio	95% CI	P-value	Odds Ratio	95% CI	P-value
Would change practice if consult fee increased by \$10	Yes	2.64	(1.91, 3.66)	<.0001	2.17	(1.37, 3.44)	0.0009
Personal or family history of Mental Illness	Yes	0.5	(0.33, 0.76)	0.0010	0.55	(0.35, 0.88)	0.0131
Age		1.02	(1, 1.03)	0.0096	1.02	(1, 1.03)	0.0384
Practice attendance (years)		0.99	(0.98, 1.01)	0.3989	0.98	(0.95, 1.01)	0.1654
SEIFA Index		1	(1, 1)	0.7392	1.00	(1, 1.01)	0.6338

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