An examination and evaluation of mental health teaching and learning in "multi-level learner" general practices

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Abstract

Background: This study was designed to identify the appropriateness of the rural multi-level general practice learning environment for mental health education.

Methods: Individual semi-structured interviews were conducted with a purposive sample of 56 practice personnel at five practices in Victoria and South Australia. Interviews were transcribed verbatim and input into N-Vivo qualitative analysis software. Data were analysed against a template derived from open coding merged with basic themes derived from a literature review.

Results: Practice personnel in this study found the multi-level learning environment particularly well suited to mental health teaching but highlighted that learners sometimes had difficulty attaining the most suitable learning level. The study indicated that medical learners need further education about mental health, with exposure to mental health patients and scenarios emphasised as the most valuable ways to learn. An underutilisation of local mental health professionals as teachers was highlighted.

Conclusion: The general practice multi-level learner environment can provide positive outcomes for learning about mental health because it offers diverse opportunities for educators to effectively facilitate group learning.

Keywords*:* multi-level learning, mental health, teaching and learning, general practice, rural.

Introduction

For those who suffer from mental illness, the general practitioner (GP) is "first port of call" (Blashki, Jolly, Piterman, & Gunn, 2003). Mental health training is required if GPs are to effectively meet the needs of their patients with mental disorders (Blashki et

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al., 2003), particularly in rural areas where there is a dearth of psychiatrists and mental health workers (Gamm, Stone, & Pittman, 2010) and increasing numbers of mental health patients (Ellis, Philip, & Ellis, 2010).

The limited attention that mental health education receives in general practice (Blashki et al., 2003; Johnson & Stone, 2010) could be addressed if perceptions are modified early in professional development. The presenter of a 2010 General Practice Education and Training conference workshop, "Mental Health Unplugged" (Johnson & Stone, 2010), asked, "What scope is there for integration of all these different [mental health] programs at registrar level and beyond?"; however, mental health education needs to be aimed at medical students and all subsequent levels of training, as learning and attitudes of interns and medical students towards mental health are relevant to their future work even if they don't return to general practice (Thistlethwaite, Kidd, & Hudson, 2007). It is against this background that multi-level learner general practices can promote learning of mental health issues and begin to alter attitudes.

Sheer force of numbers makes general practices future education sites (Thistlethwaite et al., 2007). With 2012 graduates set to increase by 81% over 2005 (Joyce, Stoelwinder, McNeil, & Piterman, 2007), more general practices will take learners at varying stages of their professional development (Anderson & Thomson, 2009; Dick et al., 2007). Vertical integration (a term used in some literature to refer to multi-level learning) is defined as "the coordinated, purposeful, planned system of linkages and activities in the delivery of education and training throughout the continuum of the learner's stages of medical education" (GPET, 2004, p. 1). Vertical integration, or multi-level learning, in teaching and learning has the potential to reduce GPs' teaching loads through sharing teaching and learning roles across all learner stages. Other benefits include improved learning experiences and acquisation of teaching skills (Dick et al., 2007).

Despite GPs' significant role in mental health care (Parslow, Lewis, & Marsh, 2011), there is little research investigating mental health education within multi-level learner general practices. This study aims to identify the appropriateness of the rural multi-level general practice learning (MLL) environment for mental health education and factors that affect the nature and extent of teaching and learning. The project objectives were: to gain insight into whether and to what degree mental health is taught within multi-level learner practices; to ascertain the extent to which the mental health teaching delivered in these practices has relevance to the individual curriculum requirements of each learner; to learn who in these practices is delivering mental health teaching and identify any appropriate teachers who are not being utilised; and to consider what teaching methods are being used in mental health delivery and whether they meet the needs and expectations of the learners. The study identifies benefits and challenges associated with teaching and learning about mental health in an MLL environment where medical students and junior doctors at varying stages of their medical training are together within a general practice setting.

Methods

A qualitative research design was chosen, consistent with the exploratory nature of the study (Patton, 1990). A steering committee, comprising six staff from the regional general practice training organisation, GP practice leaders, a mental health specialist and a university researcher (to assist with research oversight), oversaw the project. The GP practice leaders and mental health specialist also worked at some of the sampled practices.

Sampling and ethics

We used purposive sampling (Patton, 1990) to select five rural practices in eastern and southern Victoria and southern South Australia from a total of 116 practices available to host medical learners in the area covered by the regional training provider for the Australian General Practice Training program, Southern General Practice Training. The practices selected hosted multi-level learners at the time of the study and had an existing relationship with the regional training provider. With the assistance of the steering committee, the five rural practices were selected as representative of the range of MLL practices in these areas in terms of number of medical learners and GPs and their experience and qualification profiles, and patient load and demographics. Participants were informed that one of the authors had an educator role with Southern General Practice Training and that this author would not participate in data collection.

The sampled practices had between 3 and 14 GPs, supported by 3 to 6 nurses and 2 to 15 administrative staff. One practice hosted visiting specialists on a regular basis and had a dental suite; another employed two allied health practitioners. Four practices were the only practices in their town and immediate region; one practice was one of two located in its town. The rural populations served by the practices varied from approximately 3,500 in a small town with a rural hinterland to a regional city of 26,000 people.

Once practices were selected, all general practice staff that were, or could be, involved in the teaching and/or learning of mental health were invited to participate in the study.

Approximately 50% of GPs, 75% of medical learners, four of the five practice managers and around 20% of nursing and other staff participated. A similar proportion of staff and learners in each practice participated. Analysis of the data revealed that saturation was reached (Huberman & Miles, 1994; G. W. Ryan & Bernard, 2000), that is, themes reoccurred and no new themes emerged from the last few interviews conducted with each group.

Participants were asked to complete a semi-structured interview and a 5-minute survey to gather demographic data as well as interest and confidence in diagnosing and treating patients with various mental health issues. Copies of the data collection instruments are included in the appendix.

Ethics approval was obtained from Deakin University Human Ethics Advisory Group.

Questionnaire and interview guide

The questionnaire and interview guide questions were informed by a review of multi-level learning and mental health education literature, the most significant of which is cited in the Introduction, and analysis of the curricula of medical learners situated within the sampled practices. The questionnaire and interview guide were validated by expert medical educator and mental health practitioner project steering committee members. There were minor refinements to the interview guide following pilot interviews.

Transcription and analysis

The survey data were entered into an Excel spreadsheet and basic descriptive statistics were calculated. Interviews were audio recorded, transcribed verbatim and loaded into N-Vivo 9 qualitative data management software.

Data were analysed against a template derived from open coding merged with basic themes derived from a literature review (Huberman & Miles, 1994; Patton, 1990; G. W. Ryan & Bernard, 2000). The approach to data analysis was consistent with the mainstream qualitative tradition that organises raw data, for example, collected from interviews and observations, into narrative description with major themes and case study examples (Patton, 1990). Using an approach that was deductive but allowed for an inductive element, chunks of text within the transcripts were coded against themes derived from the literature (Huberman & Miles, 1994; G. W. Ryan & Bernard, 2000; Yin, 2003), with the addition of themes that emerged from the transcripts, consistent with the thematic analysis approach (Pope, Ziebland, & Mays, 2006) and grounded theory strategy (Corbin & Strauss, 2008; Glaser & Strauss, 1967). Data analysis included comparison of themes emerging both between individual practices and between categories of interviewees. Coding was reviewed by another coder and discussed, until all codes were agreed. The recurrence of themes in the data indicated that saturation had been reached (Huberman & Miles, 1994; G. W. Ryan & Bernard, 2000; Yin, 2003). Member checking, that is, taking summaries of key themes back to key participants in the study (Creswell & Plano Clark, 2007), was undertaken with the three interview participants who were also members of the steering committee.

The themes are presented below as headings and subheadings in the "results" section and discussed in the "discussion" in relation to the relevant literature, as per the mainstream qualitative tradition (Patton, 1990).

Results

Our purposive sample of 56 participants comprised nine GP supervisors (GPS), seven "other" GPs (OGP), nine registrars (R), five interns (I), seven medical students (MS), two mental health specialists (MHS), eight nurses (N), four practice managers (PM) and five administration staff (A). There were 21 men (M) and 35 women (W). The median age range was 46–55 years (range 18–65 years). Interviews lasted 15–45 minutes. Data from all groups informed the results, although not all participant categories interviewed are quoted in this paper.

Contextual factors that affected mental health teaching and learning in the five practices are presented, followed by results that apply to teaching and learning in an MLL environment regardless of topic. Finally, results that related specifically to teaching and learning mental health in an MLL environment are presented.

Contextual factors that affect mental health teaching and learning in general practices

There were a number of contextual factors that affected mental health teaching and learning in general practices: the interest and activity in mental health care of GPs in the practice; the complexity of the topic; the attitudes of the learners and the practices; and the learners' curricula.

GPs' role in mental health care and teaching and learning

Whilst participant interest in mental health and experience dealing with specific mental health patients varied, all agreed that mental health care is a significant part of a GP's role. For many clinicians, mental health care was an essential part of their overall care for every patient:

> *Well, like it or not, a very significant proportion of our patients present with mental health problems. They may not always present in the form of a mental health problem, but anyone with the slightest degree of perceptive approach will recognise that it's a significant part of general practice and so you really can't avoid dealing with it in one way or another.* (MGPS 3)

Mental health teaching occurred in all practices, but the majority of learners stressed that more formal, structured mental health teaching was needed:

> *In the practice, we probably didn't cover mental health that much to be honest. … We didn't see a lot of mental health patients. … I don't think patients with those kinds of issues, most of them wouldn't be as inclined to speak to a student.* (WMS 53)

> *Mental health is not overly well taught or concentrated on a lot in the whole program. I think comparatively to how much of it you do and see, you kind of get a one-day history, a rundown of depression and anxiety and bipolar and that's about it. I often still feel that a lot of mental health learning is being done by myself.* (WR 30)

Complexity

Mental health teaching and learning is challenging due to the complexity of the topic:

> *People are all different, and I think often patients don't fall into one category of a mood disorder or an anxiety or, personality disorder—they're all intertwined, so I think people can feel quite confronted about trying to teach (mental health).* (WOGP 29)

> *We have a lot of overseas trained doctors, and I think the nuances of the English language, and just realising that a consultation isn't always actually about the presenting complaint, it's about the domestic violence, or the anxiety or something else that is going on … trying to teach learners that actually there's layers, upon layers, upon layers within a consultation can be challenging.* (WOGP 25)

Learner attitude

Attitudes of learners in respect to mental health are one of the biggest challenges for GP teachers:

> *Knowledge is relatively easy to teach. Skills can be taught … harder but can be done with enough focus on say observing, consulting on, modelling, role playing, video tape consultations, as well as just, you know, face-to-face tutes and trying to tell them what to do, although that's probably the least effective. The attitudes, however, can take a lot of shifting.* (MGPS 31)

Practice approach to mental health teaching and learning

The importance placed on mental health teaching and learning varied between practices:

> *I'm sure that mental health might be on the back burner for some clinics. It's not here. But that's simply because there is senior GP mentorship and leadership. Without that leadership and that focus then I would imagine it would be on something else.* (WMHS 1)

Each practice has its way of teaching mental health. Some conduct specific mental health teaching sessions:

> *In terms of the monthly themes, mental health comes around once in a 24-month cycle. So, for each learner, we focus on it for a month for that point.* (MGPS 31)

Others incorporate mental health care into most study cases:

> *What we work on largely is the apprenticeship model in terms of teaching, that's driven significantly by the presentations that the learners or the doctors have on a day-to-day basis and that generates questions and learning needs … mental health is a significant proportion of presentations.* (MGPS 23)

Exposure to mental health patients in the practice was the most effective way to learn for many:

> *One of our medical students had gone through most of their mental health tutes (at university) and really not seemed to have had a lot of exposure there. At that point, I actually subtly directed a patient towards him … that student really engaged well with that patient and suddenly found a whole lot of things that they hadn't been able to make sense of in a theoretical sense*. (MGPS 31)

Learners' curricula

GP teachers were not always aware of mental health curriculum requirements of learners' teaching institutions:

> *We try to (address the learners' curricula). We try to do it bit by bit, but it's a bit more integrated rather than point by point.* (MGPS 12)
>
> *I don't know what exactly their curriculum is (in regards to mental health).* (MOGP 28)

There was a mixed response from learners' about the extent to which their curriculum requirements were met, with some learners feeling that what they were being taught was "above and beyond what I was supposed to get out here" (WMS 6), while others felt mental health teaching at the practice "only partially meets our needs" (WMS 2).

Teaching and learning within the MLL practice

Both negative and positive remarks were made regarding teaching and learning in the MLL environment, regardless of whether the topic was mental health or another topic. Issues identified included time, pitching to the right level for everyone, teacher training and learners' involvement in teaching roles.

Time and teaching and learning in MLL

All practices had teaching and learning times for multi-level medical learners, although some struggled with coordinating full participation at sessions. For many, time pressures were the major barrier preventing effective teaching and learning sessions:

> *It would be great just to sit down and [sic] with the GPs after we have been through a patient … there is a little bit of time pressure just because they're seeing you, they're seeing these patients and they've still got to see their other patients as well. Apart from that protected teaching time, there isn't really any real time to kind of sit down and have a chat with them about the patients.* (MI 36)

Teaching to an MLL group is "time-efficient" (MOGP 25) for GP teachers.

Benefits and challenges of MLL groups

Most reported that overall MLL general practices are an excellent environment in which to teach and learn. Different perspectives and dynamics are brought to the group when learners are at different levels:

> *There is this business of cross fertilisation of how people see various topics, and these days the students and the interns and the doctors can come from very varied, nonmedical backgrounds as well, both in terms of nationality, in terms of what sort of occupations they've done before … So those are all sorts of rich backgrounds that you can weld in really.* (MGPS 8)

More thorough learning takes place within MLL groups; learners are stretched, and even senior learners and teachers learn from junior learners:

> *I think not only are the junior doctors learning, but the GPs learn as well. I learn as well. Everybody that is involved in it learns something from it because some of these young kids are coming in with fresh relevant knowledge, whereas some have been doing it for a number of years, and the ability to just up-skill and take on board what's brought through is fantastic.* (MPM 39)

Hitting the appropriate learning level(s) for all learners is a challenge for GP supervisors. Learners are sometimes frustrated when information is pitched too low or high:

> *It can be challenging in that what the registrars need to know is different to what I need to know.* (WMS 13)

> *If you've got a junior learner who is asking some really basic questions and the registrar is a quite senior registrar, they can be quite frustrated by that.* (MOGP 25)

Learners losing face in front of peers, and especially senior learners, such as registrars, in groups with junior learners, was something GP supervisors were not always aware of in an MLL environment. Language sometimes contributed to fear of losing face:

> *First of all, I mean English is my second language. I'm not feeling comfortable talking in front of a junior doctor … you know, different levels have different expectations, and most of the time when they're sitting in, I can't ask, or I can't discuss whatever I need to be discussed … I don't have the courage.* (WR 22)

Training in teaching

The majority of GP teachers had no specific formal training in teaching, and many remarked that most of their teaching skills were learnt "on the job" (MOGP 19). The importance of GPs having training in teaching was stressed by many GPs:

> *You have to realise how poorly trained teaching-wise I am. … I would love there to be some system of training doctors so at least we know the basics of how to do it.* (MGPS 42)

> *What we need are people who are really clever at teaching doctors how to teach to come to the practice and delivering [sic] teaching on site to us. I mean none of us have got any formal teaching training.* (MGPS 20)

Learners as teachers

Involving learners in teaching roles in the MLL practice is particularly effective for both junior learners and senior learner–teachers "because it clarifies how I do things so I can explain them better" (WR 30).

Though not all learners are interested in teaching:

> *We're also getting people of different levels to present, so we get the GPs to present, and we also get the students and the interns to do a case presentation … so the presentation side of things are coming from all levels.* (WOGP 43)

> *It depends if we're on the same wavelength or not. With registrars, some are interested [in teaching] and some aren't.* (MOGP 28)

Interviewees suggested that MLL environments should not replace one-on-one teaching and learning:

> *I've found the one-on-one teaching here [is] probably the most beneficial experience I've had.* (WMS 6)

Mental health and MLL environments

Both formal and informal mental health teaching occurred in the MLL practices. The general challenges of MLL outlined above applied, including time and varied curricula requirements, but for many, learning about mental health was easier when taught in an MLL environment:

> *With a thing like mental health, where there are lots of elements of compassion, empathy, that kind of stuff is much easier to get a feel for by talking in a group.* (MGPS 8)

> *It's good to get the different levels of experience … everyone can input a little bit of different advice about what they've learnt about mental health.* (MI 36)

> *Some of these people have done more of a particular topic—it could be psychiatry—than anybody else. So you can draw on these experiences. We've had people whose primary degree has been psychology before.* (MGPS 8)

Teachers and learners favoured role plays and case studies over didactic forms of teaching for mental health:

> *Using case studies seems to work really well … what's really good too is people being able to role play certain situations, particularly if we're trying to teach a therapeutic intervention or how to actually go through an appointment or an interview with someone.* (WMHS 1)

An MLL environment is ideal for holistic mental health teaching where different level learners address different parts of a scenario, but all observe the whole scenario:

> *An acute nice scenario would be someone coming in with [an] acute psychotic episode … and you would get the medical student to take a history of them. Throw in some beautiful psychotic symptoms … and I would ask the registrar to come in and handle it. I would discuss the escalation methods, and then I would throw in a more senior doctor, and say, "Okay, how are you going to manage this situation with the coppers all around … Do you have an involuntary admission?" Okay, we jam him with some … intramuscular midazolam, and he stops breathing. How would you manage that?* (MGPS 28)

Utilising mental health specialists

Some GP teachers feel overwhelmed when teaching mental health:

> *There are lots of issues to mental health which go beyond what us [sic] GPs are trained for, and have the time for … so many of the problems are multifactorial … it's a challenging field of medicine, and I think most of us feel sometimes a bit overwhelmed by it.* (MOGP 7)

Having mental health specialists teach mental health is therefore valued:

> *Last time we had an "adolescent" psychologist come and talk about self-harm in adolescents and cutting. And, so that really helped me understand the theory behind it I guess and the minds behind this act.* (WOGP 29)

Underutilisation of mental health specialists as teachers was apparent:

> *Something that I don't think that the clinic taps into is the specialist services that come up who provide information on, or services for, mental health. Now, I don't think it's the clinic's fault, I think it's a two-way communication … But if specialists services such as Spectrum are coming to town to talk about personality disorders, why on earth haven't we got them taking a talk at the clinic?* (WMHS 1)

Knowing the mental health specialists and groups in the region is therefore important:

> *I think it requires us also to be familiar with the local resources because it's hard for us to recommend local solutions if we are not at least up to speed as well as the registrars with what sort of personnel we have in the community to use.* (MGPS 3)

A lack of access to specialist mental health services was noted in the rural practices:

> *It would have been useful to have some particular teaching about the region. It's one thing to diagnose depression; it's another to know where to send them for psychology, for support, for social work*. (MR 40)

Discussion

The study found that the five practices engage in mental health teaching to varying extents and that scheduling time to teach mental health is important due to the complexity of the topic. All medical practitioners agreed that mental health care constitutes a large part of a general practitioner's role (Blashki et al., 2003), yet there is a discrepancy between the importance of mental health in general practice and the exposure of the medical learners in our study to both structured and practical learning (with patients) (Blashki et al., 2003).

The interview data suggest that GP opinions about their role in mental health care may influence the importance placed on mental health education within their practice and that practice attitudes to mental health education dictate the emphasis on mental health in dedicated teaching time. Learners urged more emphasis to be placed on teachers' awareness of learners' mental health curricula, as not all GPs addressed curricula when teaching. The noted lack of clear theoretical or practical frameworks to guide the integration of mental health care into primary care (Lynch, Askew, Mitchell, & Hegarty, 2012) makes it unsurprising that mental health teaching within these environments is also wanting.

The data show that the majority of teaching is directed at less experienced learners by more senior doctors, but in these multi-level practices, learners are also utilised as teachers of peers and superiors when appropriate. There is an ethos of all participants learning from each other during teaching sessions, which was expected (Anderson & Thomson, 2009).

Our results show that MLL is well accepted by the majority of GP supervisors and all levels of medical learners, who agree that mental health teaching in general practice is suited to the MLL environment, as this environment allows for the cohesion of a range of skills and experiences of teachers and learners (Dick et al., 2007). Whilst multi-

level learner education is seen to be time saving (Anderson & Thomson, 2009; Dick et al., 2007), it should not wholly replace one-on-one teaching, which is regarded as extremely valuable to learners in our study.

Mental health is a complex area, and the study suggests that changes are needed to improve teaching and learning of mental health. Interviewees remarked upon the complexity of mental health, which demanded a high time commitment when teaching and learning. The data strongly suggest that changing some learners' negative attitudes to mental health is necessary for effective mental health teaching to take place. Some GPs had concerns about their own knowledge of the topic. It is therefore important that GP mental health teaching is supplemented with input from mental health specialists, as suggested by other studies (Blashki et al., 2003; WHO & World Organization of Family Doctors, 2008). Currently, mental health specialists are underutilised in this setting (Blashki et al., 2003). Our data suggests that familiarity with local mental health services is vital.

This study suggested that mental health learning is best facilitated through non-didactic teaching methods, such as role plays, case studies and, most importantly, patient interaction. The results suggest that when using these methods, GP teachers should be aware of barriers that may affect the success of their teaching sessions, such as learners' fear of losing face. As suggested, a combination of "lectures" and case discussions is more effective than didactic teaching alone (Blashki et al., 2003). It is also essential to have a balance of formal and informal teaching (Kramer, 2004). In addition, an increase in teaching training is desirable (Christensen & Thistlethwaite, 2009), as many GPs were concerned with their lack of teacher training.

Problems were encountered by some study participants when educating learners of different knowledge and ability levels in the same practices. Even organising a group of learners to be in one place at a particular time could be difficult. Both issues could be overcome with better organisation and by employing diverse teaching methods tailored to learner needs (Blashki et al., 2003).

The small sample size restricts extrapolation of findings to all general practices, but there is sufficient evidence to suggest that appropriate mental health learning can occur in rural MLL general practices. A larger study could confirm this. Another limitation was the use of purposive sampling. This study had an automatic interest in MLL environments; therefore, purposive sampling was chosen to attain responses from participants with experience of the MLL environment. However, what can be inferred from this study is that there is considerable room for improvement in teaching mental health topics within general practice (Blashki et al., 2003; Kerwick, Jones, Mann, & Goldberg, 1997; Oakley-Browne, Lee, & Prabhu, 2007; P. Ryan et al., 2004). Further research into ways to aid mental health teaching in general practice is desirable.

In summary, the study suggests mental health teaching and learning in MLL practices could be improved by: prioritising more time for mental health and including more mental health professional input into teaching; taking care to pitch information at the correct level and be sensitive to the individual competencies and cultural identity of

different learners; offering one-on-one and same level teaching, which is also valued and should supplement MLL; and providing GP supervisors with training in teaching, particularly for mental health.

Conclusion

The relative amount of time given to mental health teaching and learning in MLL general practices should at least reflect the amount of mental health care occurring in practices. While there are challenges in balancing the needs of learners' multiple curricula in busy general practices, the rural MLL environment provides benefits for mental health teaching because of multiple opportunities for learning in groups with a diversity of experiences, skills and knowledge.

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Appendix: Data collection instruments

Interview guide

- Tell me about how you are learning or teaching about mental health in this practice.
- What impact do you think having multiple levels of medical learners has on teaching and learning in general/in regards to mental health teaching and learning?

Thinking about teaching and learning in this practice in general:

- Can you tell me about an example, **on any topic**, where the teaching and learning experience was really effective? Take me through how the teaching and learning occurred and why it worked so well.
- Can you tell me about an example, **on any topic**, where the teaching and learning experience was not effective? Take me through how the teaching and learning occurred and why it did not work. How could it have been done better?
- To what extent do the teaching and learning methods in this practice match the way you prefer to learn/teach? (What is your preferred educational format?)
- Do you like learning/teaching in a multi-level learner environment? Why?
- What are the barriers to vertically integrated teaching?

Coming back to mental health:

- To what extent do you see mental health care as part of a general practitioners role?
- To what extent is what you are being taught/how you are teaching about mental health (if supervisor) meeting your (or your learners') needs/expectations?
- What are the barriers to mental health teaching and learning?
- Is there anything you would like to add about how multi-level learning in this practice could be altered to improve your learning/teaching experience? In general/regarding mental health in particular?
- Are there other people who work in the practice or who could be drawn on from elsewhere who could improve mental health teaching and learning?

For learners:

- How confident do you feel in addressing patient mental health issues with patients in general practice settings?
- How confident do you feel in contributing to teaching about mental health issues in general practice?
- Is what you are being taught going to help you to meet the needs of your patients?

For teachers:

- How confident are you that what you are teaching, in regards to mental health, is going to meet the needs of your learners' future patients?
- How did you acquire your teaching skills?
- What motivates you to teach?
- Are you paid for your teaching?
- Does whether or not you are paid for teaching affect your decisions about time devoted to teaching?

Questionnaire

- Are you a: (*circle one*)

  GP supervisor

  Other GP

  Practice nurse

  Mental health trained nurse

  Admin staff

  Visiting specialist

  Psychologist

  Psychiatrist

  Allied health professional

  Medical learner

  Other _____

If Medical Learner:

- What educational stage are you at: (*fill in details as appropriate*)

  Medical Student:
  University_____
  Year level _____

  Junior Doctor:
  University _____
  Year level _____

  PGPPP/Prevocational GP,
  Year level _____

  GP registrar (ACRRM / RACGP),
  Year level _____

If Health Professional:

- What country did you train in?

  _____

- Number of years in: a) your current role (*Circle one*), b) this practice

a)	b)
<1 1–5 6–10 11–20 >20	

- Age group *(Circle one)*

  18–25
  26–35
  36–45
  46–55
  56–65
  Over 65

- Sex: (*Circle one*)
  Male / Female

- On a scale from 1–5, where 5 is very interested and 1 is not interested, how specifically interested in mental health are you? (*Circle one*)

  Very interested 5 4 3 2 1 Not at all interested

- Time committed to learning/professional development about mental health in the last year: (*Circle one*)

  none
  <5 hours
  5–15 hours
  >15 hours

  If none in the last year: How long is it since you did some learning about mental health: (*Circle one*)

  <2 years
  2–5 years
  >5 years

Describe what mental health activities you have done in the last 10 years

- Please list any learning sources in regards to mental health that you would recommend to others:

For GP's and medical learners:

On a scale from 1–5, where 5 is very confident and 1 is not confident at all:

- How confident are you that you know or have learned what you need to know to *diagnose* mental health issues in a general practice setting?
  5 4 3 2 1
- How confident are you that you know or have learned what you need to know to *treat* mental health patients in a general practice setting?
  5 4 3 2 1
- How confident do you feel in *diagnosing* specific mental health issues:
  Organic mental disorders
  5 4 3 2 1
  Psychoactive and substance use disorders
  5 4 3 2 1
  Psychoses
  5 4 3 2 1
  Mood disorders
  5 4 3 2 1
  Anxiety disorders
  5 4 3 2 1
  Personality disorders
  5 4 3 2 1
  Eating/body dysmorphic disorders
  5 4 3 2 1
- How confident do you feel in *treating* specific mental health issues:
  Organic mental disorders
  5 4 3 2 1
  Psychoactive and substance use disorders
  5 4 3 2 1
  Psychoses
  5 4 3 2 1
  Mood disorders
  5 4 3 2 1
  Anxiety disorders
  5 4 3 2 1
  Personality disorders
  5 4 3 2 1
  Eating/body dysmorphic disorders
  5 4 3 2 1