



PARTNERS IN MENTAL HEALTH

In England and Scotland

First National GP Survey of Mental Health in Primary Care



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1

methodology

A questionnaire was distributed to 1,966 general practitioners in England, using a stratified random sample. The sample frame was as follows:

Region	POPULATION DENSITY			Total	Variation Response vs sample frame (%)
	High (Urban)	Medium (Suburban)	Low (Rural)		
Eastern	11 (1)	177 (26)	26 (8)	214 (35)	
London	176 (26)	108 (15)	0 (0)	284 (41)	-1
North West	40 (5)	199 (19)	8 (4)	247 (28)	-4
Northern & Yorks	28 (3)	201 (27)	19 (7)	248 (37)	-2
South East	37 (7)	279 (62)	34 (8)	350 (77)	+6
South West	18 (4)	170 (31)	32 (4)	220 (39)	+1
Trent	20 (4)	163 (30)	21 (1)	204 (35)	+1
West Midlands	23 (4)	162 (26)	14 (3)	199 (33)	0
Totals	352 (54)	1,459 (236)	154 (35)	1,966 (325)	

Responses are shown in brackets

The sample frame represents 6% of all GPs in England, and is in proportion to their overall geographical distribution, according to NHS region and their degree of urbanisation/rurality.

Population densities of enumeration districts for over 9,000 general practices in England were derived, and bandings were applied to create proxy measures for urban (high population density), suburban (medium population density) and rural (low population density) areas. The separate report Commentary on the Analysis contains the bandings, a copy of the questionnaire, and the responses to each question.

From the 1,966 questionnaires distributed, 325 usable questionnaire forms were returned. A response rate of 17%. These reflected the sample frame as follows:

	Urban	SITUATION Suburban	Rural
Sample Frame	353 (18%)	1,459 (74%)	154 (8%)
Responses	54 (17%)	236 (73%)	33 (10%)

Figures in brackets show the percentage of the total questionnaires distributed and received.

The sample is broadly representative of the geographical and situational distribution of GP practices in England.

It should be noted that some respondents may have omitted certain sections of the questionnaire. For this reason the number of observations may vary for each question.

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the key findings

- GPs spend on average 30% of their time on mental health problems - the equivalent of 11/2 days every week.
- GP training in mental health, and involvement in it beyond primary care is limited and for some GPs this is a reason for wanting to spend less time on mental health.
- Fewer than half GPs (42%) are satisfied with the time they spend on mental health, with 34% wanting to spend more, though 24% would like to spend less time.
- In terms of their total available time, GPs spend 15% on anxiety and depression, 5% on psychosomatic problems and 3% on elderly mental health.
- Drugs and alcohol problems consume more time of urban GPs, whilst psychosomatic and elderly problems are a bigger concern for rural GPs.
- GPs wanting to spend more time felt constrained by the physical element of their workload (90%), whilst 10% felt that it was the extensive time required to deal with mental health consultations which prevented them from doing more.
- Of those wanting to spend less time, 48% of responses concerned the knock-on effect for their physical workload, 18% had no strong interest in mental health and 17% felt that they lacked the necessary skills/training.
- GPs expressed least satisfaction with psychology services, addiction services and home support services.
- Consultant domiciliary visits, elderly care and community care teams broadly appear to be well perceived by GPs. Services for neuroses and the recruitment and retention of staff are not considered to be strengths of local mental health services.
- Over 50% of practices have attached CPNs and counsellors, 1 in 10 have access to a social worker, psychologist and psychiatrist.
- The top priorities for GPs in terms of the support that they wish to see attached to their Primary Care Team were CPNs, followed by social workers and home support workers. This suggests a strong inclination towards more joint working.

- GPs are not well supported in terms of the training required to deal more effectively with mental health. Very few have any exposure to mental health issues beyond the primary care setting. Given the volume of mental health work being undertaken by GPs the BMA, RCGP, Health Authorities and Primary Care Groups (PCGs) should work together to improve the availability, accessibility and take-up of GP training in mental health.

- Health Authorities and PCGs need to take a pro-active role in developing mental health services by addressing:

Training

If PCGs are to address clinical governance issues around mental health then they must play a key role in addressing their local training needs.

Specialisation

Better use of GP time and targeting of expertise could be achieved through some degree of GP specialisation, for example, in drugs and alcohol dependency and teenage mental health.

Support Mechanisms for GPs

GPs with an interest in mental health need the support of colleagues. Creating a supportive climate towards mental health is a critical PCG role, and should include a PCG wide support network.

Patient Education

Further work is required to educate patients about the wider determinants of mental health, to help them understand the limits of medical intervention in this area.

Appropriate and effective alternatives to GP consultation

More experimentation and research needs to be done both locally and nationally on effective alternatives.

- The quality of secondary and tertiary mental health services will depend upon the ability of PCGs to commission and negotiate improvements. PCGs must make this a high priority and very rapidly develop the knowledge and skills to do it effectively

- More research is required on the effectiveness of specialisation and substitution in mental health in primary care. The Department of Health should commission some work through the Research & Development Directorate, whilst more local pilots should be established either as part of PCG led strategies or under the PCAPs programme.

3

Analysis and discussion

3.1 Mental Health in Primary Care - First National Survey

General practitioners in England report that they are spending, on average, around 30% of their available time on mental health problems.

Typically, 1 ½ days of every week is spent by GPs dealing with mental health. This is a substantial amount of time when GPs have access to little specialist training and experience.

Although many GPs are satisfied with this level of time commitment, most would like to spend either more or less time in this field. In this report we examine some of the reasons given and consider the implications for Health Authorities and PCGs.

Of all mental health conditions, anxiety and depression take up by far the most GP time, whether in urban, suburban or rural settings. Psychosomatic problems and elderly mental health issues are also a significant feature of GP workload.

Drug and alcohol dependencies, although not vast consumers of GP time, appear to be highly contentious issues and cause increasing concern amongst GPs. Our survey confirms that these problems are greater in urban areas than elsewhere.

Services to support GPs vary across the country. We also examine some emerging themes which need to shape the agenda for those responsible for planning and commissioning mental health services.

This survey is the first to be undertaken on a national basis. As a first survey it inevitably raises more questions than answers.

These questions about the current and future state of mental health are significant, particularly because the amount and range of the workload is so significant - as is the importance of getting it right and providing a good service.

GPs anticipate increasingly stressful lifestyles, a further destigmatisation of mental health and demographic changes (for example, more elderly people with mental health needs). These changes will increase the pressure on primary care. With so many GPs expressing concerns about their abilities to manage their current mental health portfolio, it is right and timely that we begin to understand their anxieties.

3.2 Do CPs Know Enough About Mental Health?

Over the twelve months prior to the survey, GP involvement in mental health beyond the primary care appears minimal. Only 3% of GPs held hospital posts within this period, and GPs with a diploma in psychological medicine are extremely rare.

Going back five years, the percentage of GPs who have held hospital posts in mental health rises only to 13%, whilst diplomas are still exceedingly rare.

On the face of it, there seems to be little exposure to other ways of thinking about mental health, yet only 10% of GPs express any concerns about their skills or training needs.

Few people raised skills and training issues amongst the three challenges which they foresaw for mental health in primary care.

Those that did either focused on GPs:

"(We need) protected time for training with adequate central funding to ensure that time away from the practice is available."

"Meet the education needs of GPs re mental health problems."

"Educate 'coal face' workers [GPs] on services available and the best method of management/referral."

Or the primary care team:

"Added training and skills for primary care teams." "Spend more time on training primary care staff."

Or others...

"Improve calibre and continuity of general psychiatrists."

"Improvements in education are absolutely necessary to help the public understand their own inability to achieve health without help."

Amongst almost 1,000 comments on mental health challenges received from GPs, very few touched upon this issue of skills and training.

In an area which is complex, consumes vast amounts of GP time and which is growing, this seems remarkable. It suggests that there may be a "recognition" problem. Not so much the recognition of mental health symptoms, but the recognition of the knowledge, skills and connections required to deal with them.

3.3 Specialisation, Substitution and Support

Many GPs who want to spend more time on mental health feel held back. Largely it seems to be because of the extensive time commitment required which has a knock-on effect on their other practice workload.

A strong feeling amongst those wishing to spend less time was exactly the same. They were concerned that mental health problems were having a detrimental effect on their ability to manage their overall workload.

PCGs need to address this as a key strategic issue. It will be difficult for individual practices to break this cycle. There are a number of policy implications:

3.3.1 Specialisation

There seems to be at least the possibility for some form of win-win arrangement, whereby GPs wanting to do more mental health work take on a specialist role, whilst those wishing to do less compensate by taking on additional non-mental health consultations.

This is an idea which would benefit from evaluation in a number of pilots to test its effectiveness.

This may be difficult for small and single handed practices, and it is only likely to work with larger practices, groupings of practices or even PCG wide collaborative working. This will be much harder than it sounds and a high degree of creative thinking will be required. However, if a cross-PCG approach to specialisation can be achieved, it will be the beginnings of corporateness, upon which the success of PCGs depends.

3.3.2 Substitution

For the most time consuming areas of mental health, PCGs and individual practices should consider the concept of substitution. That is not to be seen as a euphemism for "off loading", it is simply a case of being more aware, open minded and willing in respect of appropriate alternatives.

The take up of alternatives is very patchy and sometimes related to availability. Most GPs see the priority areas for additions to the Primary Care Team to be CPNs, social workers and home support workers.

Many of the mental health issues could be incorporated into programmes around Healthy Living Centres for which there is currently £300 million available, though GP and PCG involvement in this initiative so far is relatively modest.

3.3.3 Support

PCGs will need to think strategically about providing an effective support network for practices to enable them to improve mental health services.

This will require a combination of training, commissioning and negotiating improvements in mental health secondary and tertiary services, and some work to influence the culture of primary care practitioners to provide a more supportive environment for those wishing to prioritise mental health.

Currently, the least satisfactory services from a GP perspective appear to be psychology, addiction services and home support services.

3.3.4 Challenges & Issues - Concerns for the Future

GPs were invited to outline three challenges which primary care will have to deal with over the next three years, if it is to provide a better service for those with mental health problems. Broadly, these tended to address six themes:

[1] Morale & Recruitment

The rate of change and the threat of 'burn out' for GPs was a common theme, as was the recruitment and quality of secondary care staff.

[2] Training

The need for GP training in mental health was recognised by GPs. It was also seen to be important that other professionals receive proper training and that patient education is improved.

[3] Service Issues

These comments covered a wide range of issues, many reflecting particular local difficulties. Some of the recurring themes are the need for drug/alcohol addiction management, difficulties of access to other professionals and increased patient demand for counselling against a questionable evidence base.

[4] Resources

GPs are feeling increasing demands on the service, and though many request extra staffer money, the most common plea is for more time. There are also concerns about the ability of practices to meet the costs of expensive mental health drugs.

[5] Communication & Joint Working

This was seen to be an important issue to get right, both in terms of inter-professional communication and professional/patient liaison.

[6] Policy

Concerns were the efficacy of Care in the Community policies; the role of PCGs and the importance of getting up to speed with mental health; and the 'imposition of arbitrary targets!

3.4 Issues for Debate, Research and Action

Many GPs raised the issue of the need for more time. For some, there is a feeling that mental health problems are becoming too big a diversion from the physical workload of the GP - diagnosis, treatment and referral of physiological symptoms.

Others feel that they are unable to give sufficient time towards mental health issues, despite the average GP spending 30% of total time on them.

Better, more effective use of available time is possible, and if mental health services in primary care are to improve, it is essential. In this report we suggest 6 things that PCGs can do.



Those that wish to spend more time on mental health feel that it is their physical workload which is holding them back. Those GPs wanting to spend less time on mental health were primarily concerned about the knock-on effect it was having upon their physical workload.

Other reasons for wanting to spend less time were 'lack of skills/training', 'no strong interest' and 'lack of colleague support':

A small number of GPs expressed concerns about the effect of working in mental health upon their own health.

For Health Authorities, Primary Care Groups and practitioners, there are 6 key areas to address:

[1] even amongst those who are willing to spend more time in mental health, the demands of physical practice are a major constraint. Is mental health really a priority or is it simply convenient to say that it is? If it is, in what ways can these constraints be eased?

[2] some 17% of GPs would perhaps feel more competent in mental health if their knowledge and skill levels were raised and maintained. How can this be done and how should the knowledge base and expertise of individual GPs and/or practices be shared around the PCG?

[3] some GPs admit to having no strong interest in mental health, yet they are likely to be spending 30% of their time in this area. Is there not a case for a degree of specialisation within practices, groups of practices or PCGs?

[4] how can PCGs encourage and facilitate a climate in which GPs are supportive of mental health work?

[5] how can GPs working in mental health develop their own support mechanisms to safeguard their own health?

[6] PCGs must seriously address the issue of substitution, to help GPs to deal with the mental health workload. Is it always necessary, appropriate or effective for GPs to deal with such a wide range of problems? Are there other agencies, support workers, innovations or care models which could provide more effective solutions and allow GPs to spend more focused time where they can make a real impact? In other words, is it possible to spread the workload effectively and achieve a better balance for GPs?

In the interests of those with mental health problems, GPs must use what time they have to best effect. Individually, GPs could perhaps make small changes, groupings of GPs working collectively could make an impact. In truth though, it is primarily PCGs which have to act. Only they can set the tone, make broad strategic shifts and pump-prime changes for the benefit of all.

3.5 Conclusions

Mental health problems will continue to increase, and many GPs have flagged this up as a serious concern.

If GPs are to be properly supported in dealing with this, then an urgent agenda for training, supporting and redistributing the workload is required.

With up to 75 services used by more than 1,400 individuals and carers, MACA is one of the biggest mental health charities in the UK. We are active in the community, hospitals and prisons, supporting people with severe and enduring mental health needs and their carers.

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We aim to:

- *provide high quality services for people with mental health needs and their carers*
- *influence policy and good practice relating to mental health*

We believe that people with mental health needs:

- have the same rights and responsibilities as others in society
- can make a positive contribution to the communities they live in
- are entitled to services which respect their individuality, actively involve them and support them in making informed choices about their lives

Quality of life for people with mental health needs and their carers