



What do GPs want from mental health services?

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Abstract

In the context of a primary care-led NHS, a questionnaire survey of GPs' views of mental health services was undertaken in Sheffield and Norwich. Most GPs are willing to let mental health teams make the decision about allocation of referrals at least for some cases, but only half want to give up that control for all patients. They favour consultants seeing patients in a community mental health centre rather than GP surgery or out-patient clinic, although they would like some flexibility. There is a clear preference for community mental health nurses being based in GP practices. Better liaison is required with all disciplines, and although the best relationship is with nurses, only a quarter regard it as good. Two-thirds want more GP counselling resources. The variation in the approaches of GPs is striking and mental health services should not impose a single working model on all GPs.

Introduction

Since the pioneering work of Shepherd *et al.* (1962) there has been more awareness of the size of psychiatric morbidity unmet by mental health services and the central role of the GP in the detection and management of these disorders. Not only is the GP the professional most often contacted for psycho-social problems (Corney, 1990), but also many patients with severe mental illness rely on their GP for on-going psychiatric and medical help (Parkes *et al.*, 1962).

Recent government policy has sought to increase the influence of primary care on secondary services through the introduction of the purchaser/provider split (Ferguson & Varnum, 1994). General practice will continue to set the agenda in the new NHS through Primary Care Groups (Department of Health, 1997).

Surprisingly little systematic research has been published about what GPs want from mental health services, although descriptions of how GP fundholders have influenced purchasing over recent years, particularly through multi-funds, have started to appear (Wright, 1997). Previous work has included the finding that GPs seem willing to share responsibility for patients with long-term mental illness but most do not want to take on the primary responsibility or the keyworker role (Kendrick *et al.*, 1991). They prefer direct referral to community mental health nurses (CMHNs) rather than through psychiatrists, and favour CMHNs having a base in general practice (Monkley-Poole, 1995).

This study was undertaken in Sheffield and Norwich to help clarify the demands of GPs for mental health services from the perspective that their views can lead to innovation and improvement and that NHS trusts need

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not be so defensive about GPs determining changes that they have traditionally regarded as their area of expertise.

Method

Study setting

Sectorised community mental health services based on GP practices are provided for adults aged 18–65 in both Sheffield and Norwich.

Sheffield

The sector surveyed (population about 120,000) was South East sector, at that time one of five acute sectors. Services are community-orientated and an innovatory ward domiciliary service has been developed, in which ward staff provide outreach to patients at home with the intention of reducing their length of stay in hospital. There is also an acute day hospital that functions as an alternative to admission. Referrals to the team have been pooled to a single point of entry in a community mental health centre for several years.

Norwich

The sector surveyed (population about 48,000) was based in Norwich city and was one of 10 consultant-led patches in East Norfolk. The community team was in the process of development and was in a temporary base in the hospital. Separate referrals to different disciplines of the mental health team had been the usual practice.

Survey Procedure

Sheffield

The project was part of a process of improving relationships between primary care and the community mental health team. All practices in the sector (except one, which was a single-handed practice), were visited and a report summarising concerns and require-

ments of GPs was produced. At the end of the meeting with GPs questionnaires were left with the GPs to be completed and returned. One further attempt by post was made to obtain completed forms from those that had not replied.

Norwich

The project was part of a process of familiarisation with GPs in a new area. Services in East Norfolk were in the process of reconfiguring to accommodate two new consultant psychiatrists as part of the strategic development of community mental health teams in the area. All the practices in one GP group (except one who declined the offer) were visited. A letter was sent to each GP after the visit enclosing the questionnaire. A letter and questionnaire were also sent to the GPs of the practice who declined the offer of a meeting. No follow-up contact was attempted for non-responders.

Questionnaire design

The questionnaire was designed by reference to previous published reports and surveys in the literature and from surveys conducted locally by the Public Health Department in Sheffield. It included questions both quantitative and qualitative, covering areas such as: evaluation of the service; communication; referrals; allocation; information; liaison; GP counsellors; emergency services and service development. The questionnaire was relatively long, amounting to 17 pages, although questions were well spaced out on each page, giving ample room for answers and comments.

Results

Response rate

In Sheffield there were 22 practices, with 65 GPs, of whom 17 (26%) responded. Fol-

low-up contact only increased the number of responders by three (from 22% to 26%). In Norwich there were eight practices, with 27 GPs, and 10 (37%) forms were returned, although two of these forms were said to be completed on behalf of all the partners in the practice (increasing the response rate to 59%). Any form said to be completed on behalf of several partners was only counted once for the purposes of analysis of results.

Comparison between Sheffield and Norwich

Significant differences were as follows-

- Norwich GPs are less likely than Sheffield GPs to want to share the ‘burden of care’ with mental health services ($t = 3.3, df = 23, p=0.003$).
- Norwich GPs are more likely than Sheffield GPs to have access to GP counsellors (Fisher’s exact test, $p=0.015$), and see a role for counsellors separate from mental health services (Fisher’s exact test, $p=0.04$).
- Norwich GPs prefer direct access to psychiatrists rather than as part of a team referral with other disciplines (Fisher’s exact test, $p=0.046$).

Key findings in questionnaire responses

- GPs on average find the quality of the service adequate to good, but want more of it.

- Some GPs say they have so little experience of in-patient or day units that they are unable to comment on their quality.
- The quality of written communication is rated significantly more highly than oral communication.
- Most GPs (96%) are willing to let mental health teams make the decision about allocation at least for some cases, but only half want to give up that control for all cases.
- GPs favour consultants seeing patients in a community mental health centre rather than GP surgery or out-patient clinic, although they would like some flexibility on this matter (see Table 1).
- There is a clear preference for community mental health nurses being based in GP practices (see Table 1).
- GPs are more likely to want direct referral to psychiatrists and clinical psychologists than community mental health nurses and social workers ($F=3.94, df=24, p=0.02$).
- Better liaison is required with all disciplines and although the significantly best relationship is with nurses ($F=4, df=24, p=0.02$), only a quarter regard it as good.
- Most GPs (70%) want links with one identified nurse and one identified social worker.
- Two-thirds of GPs want more counselling resources.
- Two-thirds would prefer to hand over re-

Table 1: Expressed preference for base and venue for consultations

Expressed preference for base	CMHC	GP surgery	No preference	
Community mental health nurses	11%	74%	15%	
Social workers	56%	22%	22%	
Expressed preferences for venue for consultations	CMHC	GP surgery	Out-patient clinic	Combination of these
Consultant psychiatrists	44%	4%	4%	48%
Clinical psychologists	44%	11%	0%	44%

quests for admission to a crisis team rather than manage admissions themselves.

- Few GPs (17%) thought that fundholding had led to a reduction in referrals.

Discussion

The key findings, of course, need to be interpreted with caution. GPs are known to be very poor responders to postal surveys (McAvoy & Kaner, 1996). The low response rate means that results may not be generalisable. However, the response rate in this study does not appear to be of a different order to other published work. For example, in South Australia, a survey to assess GPs' attitudes towards developing closer working practices with psychiatrists had a response rate of only 30% (Barber & Williams, 1996). The available evidence from previous studies suggests that responders do not differ vastly from non-responders, particularly if demographic characteristics are examined, although there may be some differences in the response to issue-specific questions (Templeton *et al.*, 1997). The risk of reporting studies which may not be representative needs to be weighed against the need for information, as there are few published studies in the literature about what GPs want from mental health services.

GPs in Sheffield and Norwich may not be typical of views nationally. Indeed, despite the small sample size significant differences between Sheffield and Norwich GPs were detected. This could reflect the different socio-economic conditions of a larger city with inner city deprivation such as Sheffield compared with a smaller city such as Norwich. Also, the degree of development of community mental health services varies considerably and this will affect attitudes. For example, GPs in SE Sheffield had become accustomed to a pooled referral system, which

probably explains why they were more prepared to accept it, whereas in Norwich it was a new initiative.

The number of community mental health centres in the UK has increased dramatically over the last decade (Sayce *et al.*, 1991). Such bases can improve accessibility and co-ordination of services. They may perhaps not have been utilised to the full in many places as it is still common for consultant psychiatrists to be based in hospital. However, GPs in this survey had hardly any demand for patients to be seen by a consultant psychiatrist or clinical psychologist exclusively in an outpatient clinic of a hospital or for that matter in the GP surgery. The majority preferred site was a community mental health centre, although there was also a requirement for some flexibility on this matter.

The kind of ideal model that seems to emerge from these survey findings is that GPs are happy to work with a multi-disciplinary team which accepts pooled referrals, as long as there is some flexibility about allocation within the team. They see community mental health services as independent, based in a community mental health centre, although they would like an identified mental health nurse and social worker for each practice, with the majority preferring the mental health nurse to be based in the surgery. GP counsellors seem to have a role, whatever the development of community mental health services.

It may seem surprising that GPs are willing to give up control of allocation, but they seem to appreciate the advantage of a single point of referral. Mental health teams should retain some flexibility to respond to particular demands in some cases. In these cases it is direct access to consultant psychiatrists and clinical psychologists that GPs require.

It is important to emphasise the diversity of GP opinion. Obviously this has implications

for creating national policy, which needs to retain enough flexibility to allow GPs to develop individual relationships with local mental health services. Indeed, the results of the survey suggest that mental health teams will encounter significant differences of attitude within a sector of GPs and need to accommodate these differences by, for example, developing different working practices with each surgery. GPs vary in their interest and knowledge of mental health services and in their confidence and skills in dealing with mental health problems. Flexibility is required to adapt to local needs rather than expect that uniform guidelines can solve the complexity of health care (McKee & Clarke, 1995).

Primary care psychiatry has developed over the last few decades and the recent policy of encouraging general practice to take the lead in service provision and development can only refocus attention on the issues in this field. The way ahead is unclear (Shepherd 1995). It is important to take account of the diverse views of GPs to find the best way to provide and develop mental health services.

References

- Barber, R. & Williams, A.S. (1996). Psychiatrists working in primary care: A survey of general practitioners' attitudes. *Australia and New Zealand Journal of Psychiatry*, **30**, 278-286.
- Burton, M.V., Sadgrove, J. & Selwyn, E. (1995). Do counsellors in general practice surgeries and clinical psychologists in the National Health Service see the same patients? *Journal of the Royal Society of Medicine*, **88**, 97-102.
- Corney, R. (1990). A survey of professional help sought by patients for psychosocial problems. *British Journal of General Practice*, **40**, 365-368.
- Department of Health. (1997). *The New NHS, Modern, Dependable*. London: The Stationery Office.
- Ferguson, B.G. & Varnam, M.A. (1994). The relationship between primary care and psychiatry: An opportunity for change. *British Journal of General Practice*, **44**, 527-530.
- Kendrick, T., Sibbald, B., Burns, T. & Freeling, P. (1991). Role of general practitioners in the care of long term mentally ill patients. *British Medical Journal*, **302**, 508-510.
- McAvoy, B.R. & Kaner, E.F.S. (1996). General practice postal surveys: A questionnaire too far? *British Medical Journal*, **313**, 732-733.
- McKee, M. & Clarke, A. (1995). Guidelines, enthusiasms, uncertainty, and the limits to purchasing. *British Medical Journal*, **310**, 101-104.
- Monkley-Poole, S. (1995). The attitudes of British fundholding general practitioners to community psychiatric nursing services. *Journal of Advanced Nursing*, **21**, 238-247.
- Parkes, C.M., Brown, G.W. & Monck, E.M. (1962). The general practitioner and the schizophrenic patient. *British Medical Journal*, **i**, 972-976.
- Sayce, L., Craig, T.K.J. & Boardman, A.P. (1991). The development of community mental health centres in the UK. *Social Psychiatry and Psychiatric Epidemiology*, **26**, 14-20.
- Shepherd, M., Cooper, B., Brown, A.C. & Kaltou, G.W. (1966). *Psychiatric Illness in General Practice*. London: OUP.
- Shepherd, M. (1995). Primary care psychiatry. Health services research is not enough. *British Journal of Psychiatry*, **166**, 1-3.
- Templeton, L., Deehan, A., Taylor, C., Drummond, C. & Strang, J. (1997). Surveying general practitioners; does a low response rate matter? *British Journal of General Practice*, **47**, 91-94.
- Wright, C. (1997). What general practitioner fundholders want to buy from a psychiatric service. *Advances in Psychiatric Treatment*, **3**, 225-232.