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Assessing service provision and demand in the management of mild to moderate mental health difficulties in primary care

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There is continuing support both politically and professionally for the provision of mental health care within primary care (Department of Health, 1999; The Scottish Office, 1993; 1997; 1998). However tensions exist between the supply and demand for mental health resources in primary care (Department of Health, 2000). In addition to resources, perceptions of need, knowledge and training are likely to influence the services offered and the uptake of these. This study reviews general practitioners' (GPs) and patients' perceptions of need, availability of services and GPs' ability to access mental health services in two local areas using a new assessment tool. The Mental Health Management Options (MHMO) form, a brief instrument, was developed to provide information about GPs' preferred and actual management options with people experiencing mild to moderate mental health difficulties seen during routine consultations

Sixteen GPs each completed 10 copies of the MHMO, providing data on 160 consultations. Analysis found that discrepancies arose in 69% (n = 109) of the consultations in relation to the action GPs wished to take but were unable to do so. This was related to the inability to access services, to patients who declined to follow suggested management options and to a lack of time and/or ability to manage the patient.

This study highlighted the barriers GPs face in managing people with mild to moderate mental health problems in primary care but also demonstrated the content validity and utility of the MHMO. The MHMO may be a useful new tool in identifying GPs' perceptions of patterns of management and gaps in services.

Key words: management; mental health; primary care

Introduction

The management of people with mild to moderate mental health difficulties is largely undertaken in the primary care setting, involving the general practitioner (GP) and 'in-house' support (Wright, 1995). There has been political support for this (Scottish Office, 1993; 1997; 1998) with the NSF for mental health advocating that patients with depression should be managed within the primary care setting (Department of Health, 1999). The benefits of managing people with mental health problems in primary care include: improved access to services; early intervention; reduced stigma and continuity of care (Crawford and Carr, 2001; Keegan, 1997; McCollam and Hopton, 2002). Depression is the most common mental health problem under the diagnoses considered as neurotic disorders (ICD-10) (Blacker and Clare, 1988) with up to 17% of the British population experiencing debilitating depression during their lives (Angst, 1997; Davidson and Meltzer-Brody, 1999). It has been suggested that 70% of those with depression will seek help from their GP (Davidson and Meltzer-Brody, 1999). The management of people with mild to moderate mental

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health problems has increasingly moved outside of the remit of community mental health teams (Cotterill and Barr, 2000). In the past decade, directives have targeted resources in the form of specialist mental health care providers, to the patient group defined as those with severe and enduring mental illness (SEMI) (Cotterill and Barr, 2000). The number of patients with SEMI on community mental health nurse caseloads increased by 85% between 1990 and 1996 (Brooker and White, 1997).

A number of innovative models of providing primary care based mental health services have evolved, however, these developments are often not evaluated and there is limited research evidence to inform service development (Gask and Sibbald, 1997; McCollam and Hopton 2002). The NHS Plan (Department of Health, 2001) proposed the creation of a new role in primary care to assist with the management of common mental health problems: the primary care mental health worker (PCMHW). To date it is not clear how PCMHWs should be employed to be most effective (Bower, 2002). In addition to issues of manpower within primary care, further issues facing the GP managing people with mild to moderate mental health problems include increased emphasis on the need to recognize and manage depression (Anderson *et al*., 2000; Freeling and Tylee, 1992; Kendrick, 2000), the difficulty of treating depression (Hawley *et al*., 1997), and the time consuming nature of regular reviews (Goldman *et al*., 1999; Jackson *et al*., 2000). In addition to these issues GPs may be reluctant to explore and pursue psychosocial issues with patients and deal with the emotional burden that can result from this (Howe, 1996; Rogers *et al*., 2001). GPs have also cited the paucity of available resources as barriers to providing care (Chew-Graham *et al*., 2002; Telford *et al*., 2002; Von Kroff *et al*., 2001) further impeded by communication barriers with mental health specialists (Goldberg and Gournay, 1998; Goldman *et al*., 1999; Little *et al*., 1998; Railton *et al*., 2000; Secker and Pidd, 2000). As part of a study of the management of mental health problems in one Health Authority (Whitehead and Dowrick, 1998), this paper explores the GP management of people with mild to moderate mental health difficulties and explores issues around management decisions.

Method

Sample

Thirty-four GPs agreed to take part in the study, 30% of those approached, representing one third of the GP practices in the Health Authority. The sample was representative of GPs practising in the Health Authority in terms of gender, practice size, location and deprivation index of the area served.

Data Collection

Quantitative data

Ten copies of the MHMO form were sent to each GP (n = 34) who was asked to complete forms for 10 consecutive patients meeting the study criteria, directly following the consultation.

The Mental Health Management Options Form (MHMO) was devised by CD and LW, and piloted with 10 GPs outside of the study. The MHMO lists 11 possible actions that a GP may take in managing a client with a mild to moderate mental health difficulty. GPs are asked to tick the options followed in a given consultation and in the next column any options they would have liked to undertake in that consultation but were unable to. The third column is used to indicate why a discrepancy had arisen, with reasons chosen from a list (see Appendix).

Qualitative data

All GPs who had completed the MHMO forms were invited to take part in an interview on their management of patients with mild to moderate mental health problems and nine GPs agreed to be interviewed, representing a range of practices by size and location in the Health Authority. Semi-structured interviews of between 30–45 minutes were undertaken at the GP surgery. The interviews covered the areas of GPs' feelings about managing people with minor mental health difficulties, how effective they felt in managing this patient group, the problems they experienced, and any gaps that existed in the existing service.

The interviews were transcribed verbatim and thematic analysis employed. Thematic analysis involves the identification of themes from the transcribed interviews and a systematic identification of all data that relates to the identified classified patterns (Aronson, 1994; Spradley, 1979). Themes are defined as units derived from patterns such as

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'conversation topics, vocabulary, recurring activities, meanings, feelings' (Taylor and Bogdan, 1989: 131) and identified by 'bringing together components or fragments of ideas or experiences, which often are meaningless when viewed alone' (Leininger, 1985: 60). Once the themes were identified, further analysis of the data was undertaken to identify any sub-themes within the main thematic groupings (Patton, 2002). The reliability of the analysis was supported through discussions of the findings with the second author (CD). The use of a computer software package such as NVIVO to organize the data was not felt necessary because of the small number of interviews.

Results

Quantitative data from the MHMO

One hundred and sixty copies of the MHMO were returned by 16 GPs, a response rate of 47% with a comparable return rate from the north and the south of the Health Authority. The MHMO was completed for people with a range of mild to moderate mental health difficulties. The majority of patients were diagnosed with depression (n = 81), depression and anxiety (n = 28), or anxiety (n = 28). Two forms were completed for patients with inappropriate conditions. The MHMO was completed for 102 women and 56 men.

Management of the client group

The management options employed were mainly 'in-house', i.e., those available in the practice. The GPs recorded giving advice on managing the illness and specific symptoms in 94% of the consultations. The second most popular activity was writing a prescription, undertaken in 70% of the consultations. In nearly one quarter (24%) of the consultations a referral was made to the practice counsellor, and a smaller percentage (13%) to an outside agency.

Discrepancies between management undertaken and desired management

A discrepancy arose between management undertaken and the management options the GP would have preferred to undertake in 69% (N = 109) of consultations These have been grouped into three categories: issues around referral; patient choice; and lack of time or skills (Table 1).

Table 1 Discrepancies between GPs' first choice of action and actual event

	Discrepancy (%) in consultations (N = 158)
GP unable to make a referral	32% (N = 51)
Patient declined option offered by the GP	21% (N = 33)
GP perceived a lack of time or skill to deal with issue in a given consultation	16% (N = 25)

Referrals

In 32% (N = 51) of consultations, GPs felt that a referral to another specialist would have been appropriate, but found that they were unable to do so. A break down of this figure showed that in 11% of consultations a referral to a community psychiatric nurse (CPN) was thought most appropriate but this option was not available. A referral to a clinical psychologist was required in 11% of consultations but the waiting list precluded this option. The GP wished to involve the practice counsellor in 10% of consultations but this option was either not available, the waiting list too long, or patients declined. Issues around accessing relevant services was higher in the south of the HA, noted in 30% of consultations as opposed to 17% of consultations in the north of the HA. The difference was not statistically significant.

Patient choice

In over one fifth (21%, N = 33) of the overall consultations, patients declined management options offered to them by the GP. This percentage was higher (30%) in the south of the HA, compared to figures for the north (25%). The majority of those refusing a management option offered (15% of overall consultations) declined a referral to a practice counsellor. The prescription of an antidepressant was declined in 7% of consultations.

Time and skills

In 16% (N = 25) of the consultations, GPs wished to undertake a form of counselling themselves but were unable to, mainly related to GPs' perceptions of lacking the necessary time or skills. In 21% of the consultations in the south of the HA, GPs felt that a shortage of time or skills impacted

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on management in a given consultation. This problem was not noted by any GP in the north of the HA ($p < 0.001$) as impinging on the care of these patients.

Qualitative data

GPs described the management of people with mild to moderate mental health problems as a major part of their caseload:

> It's just a big part of the job, no hang-ups with that. I think it's impossible to be a GP and not have that as a big part of your job.
>
> (Dr 3)

Whilst all of the GPs embraced the management of this group the majority also acknowledged the emotional difficulties of working with people with mental health problems:

> I find it quite rewarding, sometimes slightly depressing for myself as well. Interesting to see a full range of human misery.
>
> (Dr 5)

> Half of me loves it actually, the other half gets very tired and stressed with it.
>
> (Dr 4)

GPs were asked how effective they felt they were in managing people with mild to moderate mental health problems. GPs discussed three issues that undermined their ability to manage people with mild to moderate mental health problems effectively: lack of time, the need for further knowledge or training, and, a lack of services.

Time

All of the GPs interviewed described a lack of time as impacting on their ability to manage people with mild to moderate mental health problems. This could affect the quality of the care provided:

> I judge my effectiveness as just adequate. I don't feel I'm doing a quality job, I just keep my head above water.
>
> (Dr 7)

The demand placed on GPs could also affect management decisions. When describing the large number of patients that he sees one GP stated:

> I think I feel I probably reach for the tablets earlier than I would like to, but it's because of time and because I don't know what else I can do.
>
> (Dr 8)

This quote highlights both the issue of time and gaps in knowledge around management options an area addressed next.

The majority of the GPs felt that they had not received adequate training to work with people with mental health but had built up their skills through 'experience on the job'. All GPs described difficulties in managing people with anxiety, those with obsessive-compulsive disorders and people with personality disorders.

> The management of various types of anxiety, into the realms of personality problems is much more difficult, especially personality disorder type problems, as to whether that fits into treatment or just . . . that's life.
>
> (Dr 3)

Compounding difficulties in managing people with mild to moderate mental health problems was the perceived and actual inability to make referrals for this group. In the former case, some GPs described an expectation that people with mild to moderate mental illness should always be managed within primary care:

> I think the expectation is that you should be able to manage mild mental illness yourself. Whether that's something that all GPs feel but I get this attitude from the hospital that says 'Don't bother us with this trivia'.
>
> (GP 1)

> You get the very, very strong impression from psychiatrists of 'Good God, haven't we got enough to do with the severely psychotic sectioned community with an indefinite care need'.
>
> (GP 7)

> . . . they don't respond to any but the most serious of cases they say '**** ***', this is nothing to do with us, this is far too trivial a matter, look after it yourself.
>
> (GP 5)

> . . . mild is the worst because if you ever have to send anyone with mild symptoms that you're finding difficult to manage you

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> instinctively get the impression that your colleagues regard you as a failure because 'what's this patient doing in this clinic?' you know, this is something that a family doctor should have been able to sort out.
>
> (GP 9)

The perceived difficulty in referring patients was further compounded by the actual barriers in doing so. All of the GPs interviewed discussed the inability to involve CPNs in patient care. GPs felt they had lost a useful link in managing this group of patients:

> I think that the role of the CPN has changed, and the problem is that CPNs used to be the link person that you could contact to see somebody in a bit of a crisis situation and not necessarily somebody who was severely mentally ill, and threatening suicide. Now it appears that that's the only category of people that they look after.
>
> (GP 9)

> Five or six years ago we did have a CPN that used to come to the surgery and he would see quite a few of the patients with mild or moderate mental illness that didn't need to see the psychiatrist but needed extra support and extra time and that was useful.
>
> (GP 3)

> . . . there's nobody to look after them now because the CPN will say 'I'm sorry, that's not under our indicators for our caseload', so as a result they just walk out and so they're just left.
>
> (GP 5)

GPs felt that CPNs could play a valuable role in assessing and managing a patient with mild or moderate symptoms at an early stage of development, or could intervene in a crisis situation to prevent the development of this. The long waiting lists for counsellors and clinical psychologists was discussed and GPs felt that they could only refer people with long-standing problems where waiting time times prohibited the management of people in a crisis situation. GPs rationed the use of clinical psychologists and counsellors:

> I only reserve certain things to the counsellor because she's got a waiting list as well, like sexual abuse in childhood or bereavement.
>
> (GP 6)

> Clinical psychologists are pretty well . . . difficult to access, long waiting lists which makes them, to a degree irrelevant to lots of peoples' problems because crisis presents and it has to be resolved within a short length of time, not two years down the line.
>
> (GP 3)

> I never refer anybody to the clinical psychologist, virtually, because I know there's no point. I know it's a terrible thing to say but I give them a private address, but I try not to refer people to the (NHS) psychologists.
>
> (GP 4)

GPs were asked to discuss what would make the management of people with mid to moderate mental health problems more effective. These are set out in Table 2.

Voluntary services were felt to be useful in complementing other services. Barriers to accessing these included the absence of an up to date directory that collated the contact details of all services in the area and the provision of clear referral criteria was required. Without this, some GPs were reluctant to spend time making a referral:

Table 2 GPs' recommendations to narrow the gap between preferred and available management options for people with mild to moderate mental health difficulties

Service	Number of GPs who discussed this option
CPN involvement in managing people with a minor/moderate mental illness	N = 9
Reduced waiting times for clinical psychology services	N = 6
Increase in practice counselling hours	N = 5
Better links with voluntary services	N = 2
Better links with social services for advice	N = 2
A wider range of self-help groups to encompass marginalized patients	N = 3

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> . . . voluntary organizations have very strict criteria of who they will see and unless we get a proper list then we end up sending people and they say 'I'm sorry I can't see you because you've got a drug problem, I don't deal with drugs, I deal with mental problems but not drugs as well'.
>
> (GP 9)

The need for further self-help groups for more marginalized patients was raised, particularly men with mental health problems and postnatal depression.

Discussion

The study has shown that the majority of people with minor mental health difficulties managed by their GP receive 'in-house' care. Advice on managing the illness and the issue of a prescription are the two most common activities. A high level of discrepancy was found between a GP's proposed management during a given consultation and the ability to follow this. The three main issues impacting on this were the availability of a given service, patients' choice and preference, and having the necessary time and skills to undertake a management option. The outcome of a consultation may be quite different to the original plan formulated by the GP.

The interview data supported the findings of the MHMO. GPs expressed difficulties in managing people with mild to moderate mental health problems related to time, skills and the lack of support from other professions. GPs felt that they were expected to manage people within the primary care setting. This is an option that could be further included in the MHMO. The increased inability to access key groups such as CPNs who could provide prompt assessment and intervention with people with mild to moderate mental health problems or in a crisis situation was further noted as an issue in managing patients.

This study was completed before the policy changes involving the introduction of mental health workers in primary care in England took place (Department of Health, 2000). In Scotland, practice based mental health worker posts are developing in a sporadic manner. One of the authors (LW) is currently involved in evaluating this service. From their remit, these posts would appear to address the gaps in assessment and care of people with mild to moderate mental health problems described by GPs.

This study has found that GPs were able to complete the MHMO for people with a range of minor to moderate mental health difficulties. The instrument was sensitive enough to detect difference between GPs, patients and areas. The latter divided in terms of deprivation index, and also highlighted the issue of a division in access to services between the two areas. There were no major items missing from the instrument.

The limitations of the study centre on the relatively small number of GPs involved in the study and the modest MHMO return rate. Further work to validate the MHMO with a larger sample size and a wider range of geographical locations is required.

The MHMO is therefore proposed as a useful tool in assessing the management options and management decisions of GPs. In particular, it may be valuable in identifying potential gaps in skills and services at a local level, from the perspective of the general practitioner and also divergence between areas.

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Appendix: Mental Health Management Options Form

Table 3

GP: Date:

Patient:

Main mental health problem:

Please tick the box or boxes below which best describe what you did, and what you would have liked to have done in managing the mental health problems of this patient during the last consultation undertaken. If there was a difference between what you did and the options you would have liked to have followed, then choose a reason for this from the following list and put the corresponding number in the third column. *For example if you wanted to prescribe antidepressants but the patient declined this option then you would place a tick in the second column 'You would have like to' and enter '1' in the third column.*

	You did	*You would have liked to*	*Difference?*
Prescribe antidepressants	[ ]	[✓]	[1]

1. My patient declined this option
2. This option is not available
3. This option is available, but the waiting list is too long
4. I forgot about this option
5. I don't have the necessary skills or training for this option
6. I don't have the necessary time for this option
7. Other reason (please write in the relevant space)

	You did	**You would have liked to**	**Difference?**
a. Give advice	[ ]	[ ]	[ ]
b. Undertake counselling	[ ]	[ ]	[ ]
c. Prescribe antidepressants	[ ]	[ ]	[ ]
d. Prescribe tranquillisers	[ ]	[ ]	[ ]
e. Prescribe other drugs (please state)	[ ]	[ ]	[ ]
f. Refer to practice counsellor	[ ]	[ ]	[ ]
g. Refer to practice nurse	[ ]	[ ]	[ ]
h. Refer to CPN	[ ]	[ ]	[ ]
i. Refer to clinical psychologist	[ ]	[ ]	[ ]
j. Refer to psychiatrist	[ ]	[ ]	[ ]
k. Refer to someone else (please state)	[ ]	[ ]	[ ]
l. Did something else (please state)	[ ]	[ ]	[ ]

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