Essential characteristics and components of primary care mental health services

Final Report

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I. Interview Schedule

Executive Summary

Introduction: Globally, mental disorders are a significant disease burden and often interwoven with other chronic diseases such as cancer, heart disease and HIV/AIDS. National strategies and implementation guidance have been published for adult mental health services in England and Wales, which provide a strong steer about the ways in which mental health care should be organised and delivered. In Wales, the recent introduction of new legislation, *Mental Health (Wales) Measure 2010* for the care and treatment of people with mental health care needs provides a further driving force to the changing landscape of mental health services. In recent years there has been a shift to ensuring more and more mental health care provision through primary care with the emphasis on managing mental health needs and delivering as much mental health care as possible within the primary care setting. On this basis, the views of healthcare practitioners delivering mental health care within the primary care setting were of interest.

Aim: To explore healthcare practitioners' views of mental health care provision in the primary care setting.

Methods: A qualitative study was undertaken using semi-structured telephone interviews with 28 healthcare practitioners across Betsi Cadwaladr University Health Board, North Wales. Participants were General Practitioners, Mental Health Practitioners working in Primary Care, Specialist Nurses and a Mental Health Team Manager. General practitioners were selected from small, medium, and large practices in rural, semi-rural and urban areas across North Wales. All interviews were recorded, transcribed, and analysed using a thematic framework method.

Results: Several themes of interest emerged from the interviews. These include the following:

- There is a need to raise profile of mental health in Primary Care
- Services are overstretched in some areas due to lack of resources. Lack of time was a particularly prominent theme for GPs

- There is patchy provision across North Wales. Some areas have good provision of, or access to, counselling and therapies whilst other areas are limited
- Placing Mental Health Practitioners in surgeries is popular with all participants. There is a general belief that this increases communication and reduces waiting times
- Presently, there are 'gaps' in provision particularly for dual diagnosis and complex mental health problems. Patients are often 'bounced back' from Specialist or Secondary Care services due to narrow focus of service, leaving GPs with no specialist mental health provision for patients
- There are notable problems of 'over triage' due to current service configuration and management. GP's often unable to refer directly to services, particularly Psychiatrists, or therapies. This results in people dropping out of the system
- Although most practitioners felt adequately qualified, many felt specific skills training was lacking to adequately perform their roles in many cases
- Some GPs did feel well supported. These generally had MHPs and Counsellors in-house and good communications with Community Mental Health Teams and Psychiatrists. However, these were a small minority in the study and should be seen as a model of good practice
- It was felt by many that a general change of focus was needed. A person centred approach should be at the heart of the service and we should move away from a service led approach

Discussion: This study has revealed that health professionals in North Wales share a genuine desire and commitment to providing a comprehensive mental health service for their patients and clients. Primary care is seen as the most appropriate setting to deliver these services. Overall healthcare practitioners in this study felt confident that robust services could be effectively delivered through primary care providing that sufficient resources were available to fulfil this objective. Study participants felt that they were currently under-resourced and felt under pressure to

deliver services and mental healthcare provision without adequate resources and sufficient support from specialised services. It is believed that in an environment where mental illness is on the increase and secondary mental health services are seeing reductions in hospital provision and acute beds, primary care is being expected to take more responsibility without necessarily having the resources required to follow these patients. A lack of communication between agencies and lack of knowledge about services provided were identified in some areas across the study region which would result in referrals being bounced back or between services. Important gaps in provision were also identified, most notably inadequate provision and support for managing and treating dual diagnosis and complex cases. .

Conclusion/ recommendations: To fulfil the statutory duty being implemented shortly in Primary Care (Mental Health (Wales) Measure 2010), funding and resources need to follow the additional responsibilities. There is a need to raise the profile of mental health, both in the general public's awareness of mental well being and through NHS prioritisation. There are examples of good practice and well supported GP practices in North Wales, but unfortunately, these appear to be the minority of those interviewed and should be seen as the standard to be adopted throughout Wales. This study shows that primary care mental health provision requires 1) adequate resources and time to provide quality care; 2) access to a range of different therapies and services; 3) well trained Mental Health Practitioners who are equipped to provide a wide range of quality interventions to suit the needs of their patients; 4) robust Secondary Care Mental Health support for Primary Care practitioners, including Mental Health Professionals who work within GP surgeries, 5) adequate provision of counsellors for the size of the practice population, and 6) direct access to Psychiatrists and therapies when required.

1. Introduction

Globally, mental disorders are a significant disease burden and often interwoven with other chronic diseases such as cancer, heart disease and HIV/AIDS. For this reason there is a major drive worldwide to increase mental health care provision within primary care. A joint report by the World Health Organisation and World Organisation for Family Doctors (2008) provides the rationale and guidance on integrating mental health care into the primary care setting. The report highlights that most mental disorders continue to be undetected and therefore untreated, resulting in a substantial yet avoidable burden to patients, families and communities. The report also demonstrates that integrating mental health care provision into primary care ensures the largest number of people can access services in a way that minimizes stigma and discrimination. According to the report primary care mental health provision forms an essential part of both general primary care and comprehensive mental health care, and treatment of mental disorders in primary care is cost effective; notwithstanding the need for such a service to be supported by other levels of care such as community-based and hospital services.

In England and Wales national policies and strategies, particularly in the form of National Service Frameworks for Mental Health and implementation guidance, have been published to drive forward mental health services (1-16). This political driving force has led to a changing landscape for mental health services in recent years with much more of a focus on managing and delivering mental health care provision through primary care. In Wales, further political support for mental health care provision in primary care comes with the recent introduction of new legislation, *Mental Health (Wales) Measure 2010* (17) for the care and treatment of people with mental health care needs. There are 5 broad policy aims within the Measure. Of particular interest here is part one of this legislative framework which specifies the need to provide assessment and any necessary treatment to individuals within primary care, by placing a statutory duty for Health Boards and Local Authorities to deliver local primary mental health support services across Wales. These duties come into full effect sometime in 2012 to 2013.

On this basis, the views of health care practitioners delivering mental health care within the primary care setting were of interest. It was our intention to qualitatively explore current provision, best practice, practitioner/service needs to develop or support such a provision, along with views about future provision.

Aims and objectives

The overarching aim of this study was to qualitatively explore practitioners' views about mental health care provision in primary care.

Our specific objectives were to explore:

1) current provision available across the region
2) general views about managing mental health issues in primary care
3) best practice and practices that work less well
4) what factors contributed to successful mental health care provision and what factors contributed to less successful provision
5) confidence with competency to deliver mental health care provision
6) barriers to best care provision
7) views about future needs and provision

2. Method

2.1 Design

A qualitative study was undertaken. Information sheets and invitation letters were sent out to all GP practices across the region. Semi-structured telephone interviews were carried out with consenting healthcare practitioners from across Betsi Cadwaladr University Health Board, North Wales between February and March 2011. All interviews were digitally recorded and transcribed for analysis.

2.2 Participants

We recruited 28 healthcare practitioners to take part. Participants were General Practitioners (n=15), Mental Health Practitioners working in Primary Care (n= 10),

Specialist Nurses (n=2) and a Mental Health Team Manager (n= 1). General practitioners were selected from small (n=4), medium (n=9) and large (n=2) practices in rural (n=5), semi-rural (n=8) and urban (n=2) areas across North Wales. Mental Health Practitioners working in Primary Care (MHPs) also covered a range of practice sizes and of varying rurality across the study region, typically working with several practices.

2.3 Ethics and research governance

The study was approved by the Local Research Ethics Committee and NHS Research and Development Office.

2.4 Analysis

The data were analysed using a thematic approach. Particular themes and areas of conceptual commonality and difference were identified, representing a thematic approach to the data (18). Data were initially coded and a framework method of analysis (19) was used to define elements and constructs, refine categories and classify data by looking across participants to identify the higher order themes. This analysis was carried out by the first author and verified independently by the second author and any discrepancies or additional codes and sub-themes were discussed and considered within the context of the analysis and a consensus agreed. Once the key themes were agreed, sub-themes were explored. Further readings of the transcripts were undertaken in light of the identified themes to ensure saturation.

3. Results

3.1 Provision for mental health services at Primary Care practices in North Wales.

The provision of mental health services in General Practices across North Wales varies greatly. Although all services come under the umbrella of the Betsi Cadwaladr University Health Board (BCUHB), services are organised geographically, following the former Local Health Board divisions and resulting in differing provision depending on the location of the surgery or patient's home.

"In part the difficulty we have is that we are having to deal with two systems…That was I suppose the disappointment, when you know, the local health board amalgamated and we've got Betsi Cadwaladr, our patients are in Wrexham or in Denbighshire. So, we're having, because the services are based on the counties, we're having to deal with two lots of services…"

(Participant 10: GP, Wrexham/Denbighshire)

Some surgeries have no counselling or any other forms of recognised mental health provision in-house; and tend to deal with most mental health needs themselves. Other surgeries have both Counsellors and MHPs in attendance at their surgeries several times a week. Some practices buy in counselling services due to lack of provision being offered by the health service or to supplement the service provided. While some GPs felt well supported, others expressed concern that they were not being supported and felt they did not engage well with Community Mental Health Teams (CMHTs). Those surgeries who felt well supported feared losing the existing support.

3.2 Locating Mental Health provision in Primary Care

The overwhelming majority of participants in this study expressed beliefs that mental health needs should largely be catered for in the Primary Care setting. Primary Care was seen as the most appropriate place and the respondents felt that overall mental health provision worked well in this setting.

GPs felt they were in the best position to deal with mental health problems as they knew their patients, their histories, families and communities and therefore had a more holistic view of their patients. Patients could be seen quickly without waiting lists, and were easily accessible to patients in the surgery or by telephone.

"I feel that it works well. I have been in the practise since 1992 and I'm from the area as well, therefore I have a feel of the local population, what troubles them, what their priorities are, which may be different from someone in an

urban settings. So yes, I feel that I have a better feeling for the population. I know the families, the infrastructure, the local networks, the things the GP knows that the psychiatrist doesn't know, you just have more information. If I can deal with a more challenging mental health issues I will, I am not a huge referral on, I try and keep it within the Practice."

(Participant 27: GP, Gwynedd)

"I would say practice based is so much better, it's so easy for the patients. They don't have to go off somewhere; they come here and see people in a situation that they know. We meet them [MHPs], we regularly have a cup of coffee in our sort of paper work area, we touch base about patients, we will give them the referrals and then we'll talk about them because often you can tell so much more to somebody face-to-face then putting it on a piece of paper; but it's such a much more personal and efficient service and we get things done more quickly because we know who we're dealing with."

(Participant 09: GP, Wrexham/Denbighshire)

The advantage of no waiting lists, knowledge of the family and context as well as allowing early detection and intervention, were also recognised by other practitioners in this study as important. Locating MHPs in GP practices was also seen as a move in the right direction and was popular with all study participants. Having this service in surgeries was believed to reduce waiting lists by ensuring quicker access; increase communications between GPs, MHPs and other specialist or secondary care mental health services; streamline the service; reduced inappropriate referrals thereby allowing CMHTs to concentrate on cases of severe mental illness; and, reduced stigma by normalising the setting.

"Researcher: What are your views about managing mental health care in a primary care setting, do you think it's a suitable place?

Participant: Yes, I think it is for a lot of people particularly if you get them, I think people who are sort of either first episode, for them, or just giving people an opportunity to talk rather than seeing them sort of escalating and becoming a longer term entrenched problem, really, I think it's really important to do that, avoid coming into secondary care services because…people often wait if they're not deemed to be risky for example, so I think it's a better service to be seen earlier than when people have lost their jobs or difficult to get back into jobs and everything just starts falling down then."

(Participant 24: MHP Conwy/Denbighshire)

Whilst there was a general consensus that MHPs, counsellors and therapists should deliver their assessments and interventions within practices, there was a recognition that on the whole, space for such consultations in surgeries was extremely limited and in some cases not available at all.

3.3 Characteristics of a good consultation.

Participants were asked what elements were important for a good consultation, specifically, what works well and what prevents a consultation going well in their experience. Several themes emerged; interpersonal skills, the patient's readiness, patients' and practitioners' knowledge, good access to services, and the general approach of the practitioner.

3.3.1 Interpersonal skills

Interpersonal skills were seen to be very important to the success of a consultation by all participants. Those skills mentioned are generally accepted as necessary for a therapeutic relationship, including; good listening skills, allowing opportunity to talk, empathy and compassion, building rapport and a good relationship, building trust and confidentiality, good communication skills (in a way that is accessible to the patient), empowerment (giving patients options), patient centeredness, being non-judgemental, providing support, reassurance, validation and respect.

> *"I think it's forming relationships with the patient, so a lot of that is going to depend on perhaps your previous relationship with that individual patient. I think its being a good listener and really understanding, you know listening and understanding why the patient is there, you know what's troubling them really. So it's being very person centred in your approach. So I think there's always that pressure for GPs to sort of tick the boxes for the QOFs because that's how we get paid so it's actually being able to form a relationship with the patient."*
>
> *(Participant 10: GP, Wrexham/Denbighshire)*

> *"I think sort of, you know, really active listening skills and empathetic reactions are really important and reassuring. I think sometimes people have these*

intense emotions that it's, you know, they view themselves as being really strange or they're told that they're 'nutters' or something like that…"

(Participant 24: MHP, Conwy)

3.3.2 Practical issues

Practical issues were also seen as important to the success or failure of a good consultation. There was a strong sense for GPs that having sufficient time for a consultation and general mental health management was of major significance. They generally felt that the allocated consultation time was not nearly enough to provide the best mental health care. In contrast, MHPs felt that they did have adequate time for consultations but they recognised the need for GPs to be able to allocate more time in their consultations. Lack of time by GPs was the single most reported barrier to providing the kind of mental health care provision as they would like. Some GPs report using crisis teams or emergency psychiatry services to help deal with some cases when time does not allow for a thorough consultation or intervention.

Timing was also recognised as a factor that could affect the success of a consultation. For example, if a patient's appointment falls at the end of a long session for a GP, they might not be as receptive as they may have been had the appointment been earlier in the session.

"Yes, the problem is having time to deal with mental health problems in a ten minute appointment is the biggest problem I would say, and if I want to do cognitive behavioural therapy, I can do that, but you have to find the time to do that, finding the resources for counselling, for instance a simple counselling some people need is very difficult to get hold of."

(Participant 02: GP, Denbighshire)

The physical space was also seen as an important element that could enhance or hinder a consultation. It was frequently mentioned that some surgeries had very little space and this resulted in either limiting the amount of time a Counsellor or MHPs could physically have in the surgery or that conditions were so cramped that some MHPs were forced to conduct consultations in unsuitable rooms such as store

cupboards. Interruptions and disruptions were also mentioned as a problem in consultations if they were not held in an appropriate consultation room.

> *"…the GP practice I work in, I have room that I can use. I have worked in other places before where I've had to use a staff room without a computer and all those types of things, so I think the environment is a big issue if we haven't got the appropriate room or resources and that's obviously going to impact on the service that you provide as well."*
>
> *(Participant 25: MHP Conwy/Denbighshire)*

Several GPs suggested that continuity of care was very important. GPs felt that they could provide this by being local to their patients and knowing them. This continuity could be compromised by appointment systems that don't allow for pre-booking or if the GP is a locum and is moved to another practice.

Another practical issue mentioned was the GPs' ability to provide assistance by tackling related problems that the patient might be experiencing, such as drug and alcohol problems. The ability to refer patients to a suitable and timely service was seen as important if further consultations were to go well.

> *"lack of being able to get the appropriate help that was needed at the time, for example, some young people get on the wrong end of fairly badly co-ordinated intermediate and secondary care services where there is too much triage and not enough action, and can get disillusioned or disheartened by the whole system and just fall out of it instead."*
>
> *(Participant 07: GP, Wrexham)*

3.3.3 The patient's readiness

Another major contributor to a successful consultation is the patient's readiness for change and willingness to engage and disclose to practitioners. This was seen by many participants as vital to a successful consultation and seen as a major stumbling block to progress if the patient was not ready for change. It may be that patients have come for an appointment to see the GP through pressure from family members and does not recognise that they have a mental health problem.

"Sometimes the clients are to be referred on for a more appropriate form of therapy, they feel that they have been sent and that they don't want to come, it might have been someone else's idea, a relative, that they attend or the GP has sent them for the assessment and they are not willing or that they don't want to change or that they can't access their thoughts or feelings which is difficult, if they can't express themselves very well"

(Participant 23: MHP, Conwy)

The patient may also have a mismatch in expectations of what the practitioner can or is willing to offer. The expectations of the patient may not match that of the practitioner's or of the service model in terms of treatment. For example, a patient may be expecting to be prescribed an anti-depressant while the practitioner feels the level of depression indicates talking therapies. There may also be a lack of understanding of mental health problems or of the self if the patient is young, or if there is a misinterpretation of the information provided by the practitioner. The complexity of an illness and the social and physical problems experienced by many patients can also prevent a consultation being as effective as a practitioner might wish. An example given was if a patient arrives at a consultation intoxicated and then becomes aggressive.

"I think it's different patient expectations. Perhaps some of my attitude. Sometimes, I think if patients expect different things from myself. If we are talking about conditions like addiction, then the patient may have an expectation of a prescription from myself, I might not be happy. If my attitude is either counterintuitive, either I might not have clicked on the situation or that the patient expects a different attitude from myself, or they perceive my attitude to be different from the way I plan to put over, then those kind of things can create a huge problem at the beginning of care which is then very difficult to get over afterwards really."

(Participant 05: GP, Gwynedd)

3.3.4 Knowledge

Knowledge of the patient in the context of their previous history and family history was mentioned by several GPs as a contributor to a successful consultation, enabling a person's mental health problems to be seen in the wider context of their

lives. It was also mentioned by MHPs that ensuring that the patient had knowledge of the nature of their illness and knowledge of possible treatments that could be offered contributed to a better consultation.

"I think being clear what the outcome of the consultation, to say, what it's about, what it's purpose is, the reason why you are seeing them in the first place, so the client is really clear what the process is that they are embarking on. That for the practitioner, that is really helpful, otherwise people can be suspicious or concerned about why it is they are getting seen. So reminding them of the purpose and the likely outcomes, I think, just explaining that you might see them again or you might refer them to someone else, so you might just let the GP know, give the GP a summary of the discussion then that usually puts people at ease cause they know where you're going then."

(Participant 16: Mental Health Team Manager)

Also mentioned was the problem of lack of knowledge by some GPs of other services, resulting in a misinterpretation of what MHPs could offer to the patient. This can raise unrealistic expectations for the patient which could lead to disappointment.

"Yeah, it's difficult because it's hard to know because the boundaries between primary and secondary care are quite blurred in mental health, because you try and refer to a CPN for some sort of support or some sort of intervention I suppose that's kind of secondary care really but it's not. I always consider that is Primary Care but it's a bit of both, you try to refer to secondary care and it goes straight to the community mental health team anyway, which is really essentially the same as referring to CPNs anyway, so it's slightly confusing as well because I have no access to psychiatrists, not as a GP."

(Participant 02: GP, Denbighshire)

Practitioners having the knowledge to deal with common mental health problems and the skills to deal with severe mental health problems were also cited as important in the success of a consultation and its outcome.

It was also felt that it was necessary to raise the profile, knowledge and acceptance of mental health issues in the general public. This was seen as important in breaking down barriers to help seeking behaviours, resistance to change and differences in expectations between patients and clinicians.

3.3.5 Access to Services

Access to services and support was one of the key issues raised by participants. There was significant concern expressed by GPs that they did not have direct access to a Psychiatrist. They felt content to manage most mental health needs in Primary Care and that they would only seek specialist psychiatry input when this was required. Several GPs stated that they needed to be able to bypass CMHTs and refer directly to Psychiatrists in some cases. Some GPs felt that they had to jump through hoops to get their patients seen by a Psychiatrist or psychiatric services even when they know their patients well and feel it would be appropriate. There was a sense that there was better access for severe over more common mental disorders. It was felt that good access to appropriate services was an important element in a successful consultation, which meant good communication with services and early interventions. Consultations with MHPs were helped by receiving appropriate referrals from the GPs. Also, consultations were said to run smoother when MHPs made it clear to patients about what the service could offer and what the process involved.

By contrast, consultations are made difficult if there are long waiting lists to access services resulting in people losing heart and dropping out of the system. This was typically reported for patients with complex needs such as drug and alcohol problems or complex physical needs with long waiting lists for treatment. In complex cases, the patient is often redirected to other services leading to over-triage and having to tell their story over and over again. This is particularly true for those who the GP feels need psychiatry input but have to be referred to various services first. This can result in a lack of trust in the system by practitioners but more importantly, allow for deterioration and loss to services as people are waiting in the system for the right care and treatment.

"well if we have a patient who we may have been involved with for some time, they may have been on medication to try and help them, and they are not responding very well, its sometime difficult to have confidence in being able to seek support when we feel that, as I say, we haven't got the confidence in the people we're referring to"

(Participant 14: GP, Gwynedd)

Participant: "there is a huge inequality over the North Wales coast. You know if you live in Bangor or on Anglesey, you can have everybody, you can access counselling sessions, up to six, that's my understanding, I know it used to be that, I don't know whether with the recent restraints on NHS services, whether they have been able to continue that, but that's always been my understanding of it."

Interviewer: "And you don't, because you obviously said you don't have access to that same…"

Participant: "No we don't, and we never have had in the 19 years I've been here."

(Participant 03: GP, Conwy/Denbighshire)

3.3.6 General approach of the Practitioner

It was felt by all participants that the general approach adopted by professionals had a great impact on a consultation, with agreed decision making between practitioner and patient about treatment and goals being important to a successful consultation.

"It's very much a patient orientated sort of decision. I try to give the patient the options and information for treatment, whether it's talking therapies, counselling, information regarding books and literature for self help guides, or medication, it's giving them the information available, giving them advice so they can come to an agreed decision about their diagnosis so that they can move forward with their problem, that would be the ideal approach."

(Participant 05: GP, Gwynedd)

3.4 Management of Mental Health in the Primary Care setting

Participants were asked how they felt the management of people with mental health problems could be improved and what prevented them giving a good service to their patents. Several areas were identified as requiring improvement to give people better mental health provision in Primary Care, these included better resources, access to existing services, improved communication, improved patient management and systems.

3.4.1 Resources

Many of the MHPs interviewed believed their service was underfunded and overstretched and felt this was preventing them from providing a good service to their patients. Several MHPs believed this underfunding was impacting on their ongoing professional training and development. It was believed that skills needed to be augmented to deal with mild to moderate mental health problems. It was also mentioned that raising the profile by raising public awareness of mental health issues was important to gaining needed resources.

> *"…It's becoming more and more difficult because, like it or not, whatever people are saying, we definitely are losing huge amounts of beds on the acute unit, and because of that, more and more people with serious mental illness are not getting into SMI teams. There are no key workers for them because we've all been informed very clearly that there will be no replacements if anyone leaves, dies or whatever…we just get bigger and bigger caseloads so there are less and less key workers…so patients that before would have had a key worker and support worker, we're now keeping a lid on, just like a policing job, more than what we should be doing, if you know what I mean."*
>
> *(Participant 22: MHP, Conwy)*

> *"Mainly resources, our caseloads are huge, the admin work is diabolical, it restricts the quality of care that you can give. In primary care we are restricted to 6-8 sessions per client, and it is a number game, it is about numbers not quality of care. It is not centred towards the individual. People look at the quantitative stuff not the qualitative stuff, and that's what does need to be looked at. We need more defined policies and pathways and focus more on the quality and reduce the ridiculous admin which is getting in the way of the care."*
>
> *(Participant 21: MHP, Conwy)*

A lack of specialist services and general training in skills to manage complex or specialist conditions was not adequate and often not offered at all. GPs would report that this would result in people ‘falling through the net’ without adequate care, either because they did not neatly meet the criteria for existing services or because the services do not exist in the first place. The services highlighted by participants in this study as lacking or insufficient included; drug & alcohol services for dual diagnosis; adult learning difficulties; eating disorders; Asperger’s syndrome; anger management; children's services; ADHD for young adults; personality disorder; PTSD; and dementia.

“we’ve learned to miss out such phrases, they may have had issues with alcohol in the past or whatever, because if the mental health team get one whiff of a hint that at any time in their life in the past they may have taken a bit too much alcohol or smoked a joint, that’s it they won’t see them"

(Participant 14: GP Gwynedd)

“ Issues I can think which I think probably has a deficiency in we seem to struggle with people who are adults with learning difficulties and adults with perhaps Aspergers Syndrome, there doesn’t seem to be a lot out there for their care and the only other area that I identified was kids who’ve been treated for ADHD and then become adults seem to drop out of the system as well, so there doesn’t seem to be much in the way for them”

(Participant 12: GP, Denbighshire)

“There are rapid changes on the expectation upon us at Primary Care e.g. ADHD, Aspergers but we have had no formal training and we don’t have back up services for that client group. Anger management is often being asked for by the surgeries because it is reflecting the emotional instability of young people; anger management is not a successful vehicle per se. Plus we have not been trained for it and do not have a specific service set up for it. Secondary Care will not also embrace that client group. There are lots of grey areas and we will have to see if we get the back up.”

(Participant 20: MHP, Conwy)

There was also a fear amongst some MHPs that their patients were sometimes being put at risk because difficulties were experienced trying to refer more seriously ill patients to Secondary Care. They felt that the resistance to take on patients was because Secondary Care providers were also under-resourced and struggling to cope with the workload. There was a sense for all participants that there needed to be more clarity about roles and services across the region.

> *"Sometimes it is very difficult to get someone transferred from Primary to Secondary Care, a block or a reluctance to pick up. I think Secondary Care do not understand our role in terms of what we can do and offer, and what our limitations are as well. We are not key workers and that we are not involved in the care programme approach and that we are not supposed to be involved with clients long term, but often we are and carry a lot more risks than we should be carrying a lot of the time. I don't think they understand the role."*
>
> *(Participant 23: MHP, Conwy)*

3.4.2 Improved access to existing services

Several GPs voiced a wish to have better access to CBT and other talking therapies for mild to moderate depression, indicating a patchy service for them in this regard currently. This limited ability to refer, due to a lack of therapies, was also mentioned by GPs as interfering with providing adequate care. Referrals are often 'bounced back' or delayed and many GPs wanted to refer directly to a Psychiatrist when they felt the patient needed to be seen. The inability to do this was strongly believed to affect patient care. They also generally wanted to exercise more control over referrals to services. However, this differed from one practitioner's views that there should be a clearer pathway of referrals through a Primary Care Mental Health Service.

GPs overall felt confident in managing most mental health issues in Primary Care but felt that in complex cases where they needed a psychiatric opinion by a Psychiatrist, this was largely not available to them, at least not in a direct way. As noted previously, there was significant concern that, as service are currently configured,

patients had to be repeatedly assessed before being seen by an appropriate specialist.

> *"The difficulty is we have to refer everybody through [a MHP] for our Wrexham patients and that's been one of the frustrations really … you know and there have been issues when, one of my partners had a patient who was acutely mentally ill and unwell and tried to refer him to the community mental health team and it was bounced back to [a MHP] and you know there's a wait of about three weeks… so that did not work well at all, but you know everything has to be funnelled through…it's not good really because they keep being assessed and referred on and assessed and you know they could be seen and assessed by four different people before they get accepted for say psychological therapies, and so that bit didn't work well."*
>
> *(Participant 10: GP, Wrexham/Denbighshire)*

One GP reported trying to follow the NICE guidelines but found this difficult because some recommended services and treatments were simply not available in the area or were difficult to access in a timely way, such as CBT counselling.

3.4.3 Improving communication

Although many reported good communication between GPs and specialist Mental Health Services, those that did not, believed better communication was important and that locating MHPs in GP surgeries was a way to increase the quality of communication between practitioners and services.

> *"Sometimes there is an issue with the mental health team, they would say you mentioned alcohol in their referral letter, therefore they should be referred to the drugs and alcohol unit, but actually it is just a psychiatric issue, they are too blinkered, too dogmatic about who should be dealing with mental health. GPs are the front line, we know these people they should accept that. The main feedback we get is that we refer inappropriately, I feel that we don't. They read things not knowing the patient like we do. This was the sort of thing that was discussed in our monthly face to face meetings. Psychiatrists should be coming out of their acute units every 2-3 months and visiting the community. I do wish they would come here and meet us, we have asked if they would do this but no. Up to a couple of years ago we had a succession of psychiatrists, we have had*

nothing positive about a meeting, I think they are a bit detached. I wish they would engage more with us."

(Participant 27: GP, Gwynedd)

Concern was voiced about the early discharge of people with serious mental health problems to Primary Care and there were worries that this was an increasing trend. There were concerns from one GP that people were being discharged from hospital with no key worker. Often letters from hospitals were delayed leaving GPs unsure of the patient's treatment and medication management.

3.4.4 Improvements in systems and management of patients

It was believed that person centeredness and continuity of care should be at the heart of the service; that the system at present was not patient focused and that there needed to be defined pathways of care that focused on the quality of care. Currently, we have a service led 'tick box' referral system approach which blocks referrals.

"The referral form is problematic, it's the usual gripe of practitioners, that with a multiplicity of referral forms all with different boxes to tick, and they're paper based, so an electronic form which was integrated to our system would be a big help, big step forward and it would also help signpost, possibly preventing inappropriate referrals by sign posting, you know, in the form"

(Participant 13: GP, Conwy)

Time was also seen as something that was often lacking and should be improved. The ways in which systems were run could be revised, such as changing appointment systems in GP surgeries to allow for (1) forward bookings, (2) a reduction in paperwork for practitioners giving added time with patients, (3) the introduction of an electronic referral system rather than a paper based system as at present in specialist mental health services, and (4) the suggestion that MHPs either focus on crisis patients or routine patients (by seeing both, the routine patients' appointments are often delayed due to needing to spend time with crisis patients).

3.5 Training Issues

GPs felt that they were adequately trained to deal with most common mental health problems in general practice but top-up training was patchy and often difficult to access due to location and timing of training. Some did not have any particular training but expressed the opinion that experience was equally important. GPs mentioned that they were confident that the practice nurses were reasonably well trained or experienced enough to support mental health provision in Primary Care.

> *Participant: "Yes, I think certainly a long time ago, yes I did 6 months psychiatry as an SHO trainee, but certainly no I'd say, more recent updates have been limited to some degree, last year I did a little reading and checking up on CBT but, no I'd say less than adequate updating there."*
>
> *Interviewer: "ok so if it was offered to you do you think you would take that up?"*
>
> *Participant: "I think it's fitting it in, Ideally yes, but would depend on how I could fit that into my timetable."*
>
> *(Participant 05: GP, Gwynedd)*

The MHPs interviewed felt they were well qualified to do the job, mainly mental health nurses or social workers, but many of those interviewed expressed concern that they were not trained in the specific working skills required for the job, including CBT, counselling and assessment training. Some believed this was due to funding constraints.

> *"It's a difficult one really, I think yes, we are you know, we get training to a certain degree and obviously we're experienced, but for on-going training and techniques then you know, there's limited places. You might not always get on."*
>
> *(Participant 24: MHP, Conwy)*

3.6 Future provision

Many of those interviewed wished to see a well funded and well resourced service for mental health in primary care. It was felt that raising the profile of mental health

by increasing awareness and reducing the stigma of mental health were key elements to achieving this.

> *"Well you know 40% of general practice is mental health issues, isn't it really, so I'm interested in it, and think we can do an awful lot more in general practice given the opportunity, the time and the resources."*
>
> *(Participant 03: GP, Conwy/Denbighshire)*

> *"In an ideal world I would love to see that the primary care that we get now, which is excellent in the sense that it actually gets people back into work, that copes with lots of things and people would get trained better, there would be more of us, we wouldn't have such huge waiting lists and amounts of patients and lack of counselling, you know general counselling could be given to the mild to moderate, which isn't happening."*
>
> *(Participant 22: MHP, Conwy)*

> *"I'd like to see mental health seated firmly in primary care, I'd like to get a bit more attention from the organisations in terms of the recognition of what we do, we see a huge amount of clients per year and they are very thinly resourced… none of them are well resourced as far as I'm aware. They need to, give a bit more eminence in terms of adult services as well, there is a degree of discrimination within the service as well for primary care, for example, we can't refer, the whole treatment has to go through CMHT, and I think primary care can't refer into support services because there is a fear that they will be swamped because the numbers are high. Because of that, people who have common mental health problems have less access to services than someone who functions less well. I can see the reason behind it but I don't think it's that fair sometimes."*
>
> *(Participant 16: Mental Health Team Manager)*

A well supported service where MHPs and counsellors were based in surgeries was also seen as important to improve access to services. GPs also wished to see a service where they had more ability to directly access Psychiatrists and talking therapies which is currently not available, at least not consistently across North Wales at present.

The provision of improved services for dual diagnosis and complex mental health problems was also a key feature of how professionals would like to see a future service. Also, more group classes based in practices such as assertiveness, anxiety, anger management and mood.

> *" I think there's a, I think when people commission services they think of isolating chunks of the service, and they sort out these isolated chunks but it's the, it's where the complex patients, where they have multiple problems, they often fall down - in between the cracks."*
>
> *(Participant 13: GP, Conwy)*

More resources should be put into a highly skilled workforce which includes relevant skills training for MHPs and increased training and support for GPs in the management of severe mental health problems due to an increase of cases in Primary Care.

> *"I would like to see it provided with primary care being at the centre, because it is anyway, with excellent record keeping, with reduced administration and burden of triage for patients, and continuity of care introduced, so we need an increased skill level, from my perspective, I know it's easy for me to say this but, from my perspective as a GP what I can see, from my little perch, is that we need highly skilled people who are available to work with us, who we can make direct referrals to without going through too much additional bureaucracy, paperwork and triage and get the kind of psychological interventions that our patients need quickly."*
>
> *(Participant 07: GP, Wrexham)*

Generally a change in focus was mentioned as important for future services. This change in focus includes designing a service that is science rather than politics focused, which is person-centred and holistic in approach. Practitioners would like to be able to offer 'real' help for people's practical and social problems, and a service that encouraged patient empowerment by offering people real choices of treatment.

Overall, there was concern that provision was service led or criteria-based rather than needs led. Participants were confident that most mental health issues could be managed in primary care but that services need to be joined up, working together for the individual rather than bouncing them back and forth between services because

they did not meet their criteria. GPs were content to manage straightforward cases and less confident with more complex cases, regardless of diagnosis. For example, GPs felt content and competent to mange straightforward cases of psychosis but less equipped to manage a mood disorder with substance or drug misuse. To a large extent this related to complexity rather than illness diagnosis or treatment. Not having the support of Secondary Care or specialist services was also a contributory factor. The general feeling was that services should work to meet the complexity of cases rather than be criteria-based or diagnosis-based.

> *"Individuality, what services works for one person will not work for the other. The danger is that we clump them all together under symptoms i.e. treating the schizophrenic, treating the depressive as opposed to treating the person. There is a more illness focus than person focus. We need to look at the person holistically, in their home situation, their lifestyle, their childhood, their physical health and doing basic checks. Have they got thyroid problems, are they anaemic which could affect their low mood in the first place?*
>
> *(Participant 21: MHP, Conwy)*

4. Discussion

This study has highlighted some key issues, both positive and negative, for practitioners across North Wales about mental health care provision within the primary care setting. Overall there was a positive view in favour of this ongoing shift to increase mental health care provision in this setting with a firm commitment to see this happen. The notion of placing MHPs in GP surgeries was popular. There is a firm belief that this service model increases communication and reduces waiting times resulting in a better service for patients. Participants felt confident and competent to deliver effective services providing that sufficient recourses were available. Some GPs did feel well supported. Those who felt well supported had MHPs and Counsellors in-house and good communications with CMHTs and Psychiatrists. However, these were a small minority in the study and should be seen as a model of good practice.

Importantly, it seems that GPs in particular had concerns that services were too heavily criteria-focused rather than person-focused, leading to distrust between services and practitioners. In essence, GPs seemed to feel that the ‘closed door’ approach to services demonstrated the lack of trust in their clinical judgment about their patients’ needs. Since GPs had good knowledge of the patient in their medical, social and family context, they believed that they would only call upon specialist or Secondary Care services when truly needed. In addition to feeling that they themselves were not trusted to make the most informed judgements, many GPs did not have a great deal of trust in the services that were available or provided. Furthermore, some GPs indicated that they were resigned to managing virtually all the mental health needs of their patients because they were reluctant to refer patients on to services that they did not believe would serve their patients well. Many GPs had experiences of their patients being turned away from some services, in long waiting lists for others, and in some cases having repeated assessments as part of the triage or ‘gate-keeping’ processes. Overall, GPs seemed to feel that they had to jump through hoops in order to secure any kind of specialist or secondary care service for their patients. The need for a more receptive and open approach to services was also supported by the MHPs who recognised the challenges faced by GPs, not least the lack of sufficient time with patients.

The lack of specialist services and poor access to existing services were of major concern. These findings mirror those of previous work in England where barriers were found in accessing primary and secondary mental health services as well obstacles being faced when referring patients to mental health services (20).

GPs seemed to want direct access to all services including a Psychiatrist or other specialist through an appropriate referral scheme. Overall participants were dissatisfied with the current referral mechanisms through CMHTs and with ‘over-triaging’. Instead, they seem to want a responsive and coordinated service that would get the right care at the right time for their patients. A joined up service is needed where channels of communication are open not only between a given service and the GP but also between specialist services themselves to ensure the right level of input is provided for each case. This suggests that a paradigm shift is

required in the way we think about how Secondary Care or specialist services are organised to support Primary Care in delivering the best mental health care for the patient. At the very least, there needs to be a consistent approach and service models across the patch to minimise cross-border issues and ensure that GPs are fully aware of what services were available to their patients. This would also ensure appropriate referrals to the appropriate specialists or teams as needed.

Although most participants felt adequately qualified, many felt specific skills training was lacking to perform roles adequately, and financial constraints were thought to contribute to this shortage in training provision. There were also practical considerations for GPs such as appropriate timing of training and location to allow them to attend. It seems that most primary care staff would welcome specific training for managing mental health in this setting but such training needs to be easily accessible, timely and beneficial to the provision offered by the surgery if any training is to be embraced. Outreach training may be needed in more rural areas together with greater use of online training facilities. Training for GPs in the use of mental health measures was also felt to be of potential benefit and has also been noted previously (22).

Overall it was felt that effort should be put into raising the profile, knowledge and acceptance of mental health issues in the general public if the majority of mental health care is to be appropriately delivered through primary care. This was seen as important in breaking down barriers to help-seeking behaviours, resistance to change, and differences in expectations between patients and clinicians. This supports the findings of Gulliver et al, 2010 (21) who looked at barriers to young people's help-seeking and found stigma and embarrassment, problems recognising symptoms (poor mental health literacy), and a preference for self-reliance as the most important barriers to help-seeking.

Study limitations

By interviewing health professionals across North Wales in a relatively short time span of 3 months, we have been able to provide a snapshot of their experiences and

beliefs about mental health services as they are configured and delivered at present, including the issues they face in providing a comprehensive mental health service in Primary Care, and how services can and should be improved. In doing so, we have provided a platform from which Practitioners working in the Primary Care setting were given a voice allowing for real grass roots knowledge to emerge and inform future developments.

Bias may have been introduced into the sample by participants being a self-selected group responding to an invitation letter. Those who responded may have done so because they have an active interest in mental health issues or because they have negative experiences of the service. However, the geographical spread of participants in this study should ensure that it does not reflect isolated problems.

Another limitation of this study is the relatively small sample size, which raises the questions about the generalisability of the findings across the UK and beyond. Importantly, the study does provide a good cross-section; it has representation from all counties in North Wales and a good range of practice size and urban/rural spread. We have gained an in-depth account of service provision, the needs of health professionals working within Primary Care and the vision for future mental health care which can only be gained by this method. We believe the findings of this study will resonate with health professionals across the UK and highlights the key issues for providing a world class mental health care service for our patients.

This study is limited to healthcare practitioners working in Primary Care. A possible extension to the study could be to explore the Primary Care Mental Health care provision from the patient's perspective. A similar method of in-depth interviews would be of significant value to establish whether the patient experiences the service differently from health professionals and to identify what works well and not so well from the patient's perspective. It may also be of benefit to undertake a similar study with Secondary Care Mental Health providers to ensure the views of practitioners in different tiers of services are considered.

5. Implications of findings

This study provides evidence about delivering and managing mental health needs within Primary Care. It seems that health professionals in North Wales share a genuine desire to provide a comprehensive mental health service for their patients and clients through Primary Care. Primary Care is seen as the most suitable place to locate these services; however, there appears to be pressure on practitioners to fulfil these expectations without adequate resources. It is believed that in an environment where mental illness is on the increase and Secondary Care Mental Health services are seeing reductions in hospital provision and acute beds, Primary Care is being expected to take more responsibility without necessarily having the resources required to follow these patients.

Based on the findings of this study we make the following recommendations:

- To increase the profile of mental health, including awareness raising and education of the general public and other health professionals
- To ensure adequate funding and resources to meet the increase in demand for mental health services in Primary Care, including resources for therapies and infrastructure
- To rethink how specialist and Secondary Care Mental Health services are organised and configured to support Primary Care in delivering mental health care at the coal face
- To provide a more coordinated and timely service with effective communication between agencies
- To ensure that GPs are fully informed of the specialist mental health services available to them and their patients.
- To ensure consistent provision of specialist services such as talking therapies
- To continue integrating Mental Health Practitioners into Primary Care and to provide resources to allow them to undertake assessments and brief interventions within GP surgeries to decrease waiting time and assist in good communication between professionals and services

- To provide timely, accessible and adequate skills training for Primary Care Practitioners, enabling the development of practical skills in both assessment and delivery of treatment
- To develop services that are ‘person centred’, taking into account the needs of the individual not their diagnosis. This requires a wider array of services and a greater skill set for MHPs and GPs to enable a service that truly meets the needs of patients
- To develop specialist services for specific areas currently lacking
- To consider integrating secondary care/specialist services into one overarching service with specialist components that could provide ‘a one stop shop’ for those with complex needs who are not effectively managed and treated within Primary Care. This would allow patients to draw upon specific specialities necessary to meet their individual needs in a meaningful way.

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Appendix 1

Essential characteristics interview schedule

1. What is the provision for mental health care in your practice?
2. What are your views about managing mental health care in primary care setting?
3. Thinking of a consultation that involved some element of mental health care or management which went well, what was it that contributed to it working well?
4. Thinking of a consultation in your current practice that didn't go well, what was it that contributed to this?
5. Are there things you avoid doing in a consultation in your current practice because you think it could have a detrimental effect? If so, what are these?
6. Do you consider your team to have adequate training to identify need and provide mental health care in your practice? If no, in what areas and what type of training do you think is needed?
7. How do you think your team could improve the way in which individuals with mental health problems are managed?
8. Does anything prevent you from providing the kind of care that is needed? If so, what are these?
9. How would you like to see mental health care provided in the future?