



Beyond a Spin of the Wheel

Ensuring timely and appropriate
mental health care from GPs



“...it’s an issue when people are ill with mental health, with depression, they are so de-motivated they don’t even see the point in going to the GP, the depression is so heavy, and when you have to fight to get an appointment, and I mean fight in front of other people, it’s demoralising and devaluing and it’s not doing anybody any good for confidence and self-esteem.”

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WHO WE ARE



Participation and the Practice of Rights (PPR) is a human rights organisation located in Belfast. Established in 2006 by human rights activist and trade unionist Inez McCormack, PPR supports marginalised groups to use human rights tools to realise their social and economic rights. In 2012, PPR's unique approach was recognised by the United Nations Office of the High Commissioner for Human Rights as a good practice example of how communities can claim their rights.

The Mental Health Rights Campaign is a group of people affected by mental health issues, their carers, and families bereaved through suicide who campaign for improvements in mental health services and the realisation of our right to the highest attainable standard of mental health.

OUR CAMPAIGN

This report marks the launch of our campaign asking decision-makers to ensure that everyone who needs it has access to adequate, timely and appropriate care of their mental health needs in a primary care setting. Through our research – which consisted of a dozen focus groups and a survey completed by over 100 mental health service users and their carers – we have identified key barriers which prevent people accessing adequate mental health care from the GP.

These issues are firmly rooted in international human rights law to which Northern Ireland is bound, specifically Article 12 of the International Covenant on Economic, Social and Cultural Rights, the right to the highest attainable standard of health. While the list of issues was long, groups we worked with highlighted the following three areas as most important to make change on:

1. Lack of mental health expertise among GPs.
2. Barriers to accessing appointments for mental health care.
3. The over prescription of medication to deal with mental health issues.

The group intend this report to mark the start of a campaign for practical, rights based changes on the issues above. They will develop human rights indicators which they will use to monitor if their right to health is being progressed in line with international obligations.

FOREWORD BY DR. JOHN KYLE

This report makes for compelling reading.

It is particularly timely given the ‘perfect storm’ we are facing; a National Health Service under unprecedented pressure, General Practice in crisis, the incidence of mental health problems at an all-time high and a growing epidemic of prescription drug abuse.

It is hardly surprising that the report states *‘people overwhelmingly reported not being able to get their mental health needs met’*. And while questions could be asked as to how representative of the patient population the participants were, the message is loud and clear - General Practice is falling short of the standards of care to which it aspires. A system that *‘makes people feel worthless and unimportant’* is clearly unacceptable.

The report acknowledges the pressures which GPs are under. It identifies three broad areas of concern: lack of mental health expertise among GPs, difficulties in getting GP appointments and over prescription of medication by GPs.

It goes on to make recommendations to address these shortcomings. Improving the service will not be quick or easy, but these recommendations deserve serious consideration. Greater financial investment however is unavoidable.

I would encourage PPR to meet with the Royal College of General Practitioners. A greater level of engagement between the two would bring helpful perspectives to the discussion. Improving the care and wellbeing of patients with mental health problems will require a team effort involving the Primary Care community, the Department of Health and patients and their families.

There is much work to do.

EXECUTIVE SUMMARY

Accessing timely and appropriate mental health care is a human right. This is recognised under the International Covenant on Economic, Social and Cultural Rights which the UK ratified in 1976. **However the reality is very different.** While mental health prevalence in Northern Ireland is between 24-44% higher than England, spending per capita is 10-30% lower. According to the British Medical Association we have the lowest GP coverage per head of population in the UK, and a 20% shortage of GPs in the region. The impact is that eight out of 10 GPs say their workload is unmanageable, and 64% of people report not being able to book an appointment with their GP within the same week. This has specific and detrimental impacts for those who seek to access mental health care through their GP. While many also experience good levels of care and attention, the experience of others shows that realising the right to mental health care can be a matter of luck.

During 2016 the Mental Health Rights Campaign, supported by PPR, carried out focus groups with over 70 mental health service users in Belfast, Bellaghy, Cookstown, Derry and Draperstown. A range of barriers encountered by people going to the GP for mental health treatment were identified. On 8 April, PPR and 30 mental health service users identified three key areas which were most problematic:

1. Lack of mental health expertise among GPs
2. Difficulties with getting GP appointments
3. Over prescription of medication by GPs

This report details service users' experiences, examines international human rights obligation and policy standards and sets down some solutions which would begin to remove these barriers. These include:

- Mandatory mental health training for GPs and other relevant staff
- A designated phone line for mental health appointments
- A 'red flag' system on patients' files to alert the receptionist that a caller has mental health issues.
- Provision of double or longer appointments for people with mental health issues.

'Beyond a Spin of the Wheel – Ensuring timely and appropriate mental health care from GPs' marks the start of a campaign. The Mental Health Rights Campaign intend now to campaign for the changes outlined in this report and monitor if and how people's experience at the GP change. In the words of Karen McGuigan of STEPS, a member of the Mental Health Rights Campaign:

"We all have the same issues but if we are one big voice shouting it will get heard a lot quicker."

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1. PRIMARY CARE, MENTAL HEALTH AND INTERNATIONAL HUMAN RIGHTS STANDARDS

Human rights standards exist in relation to the many barriers to accessing help from the GP for mental health problems as identified through the research presented in this report.

Under international human rights law, people have a right to enjoy the highest attainable standard of health, a standard which applies to both physical and mental health. This holistic understanding of health to mean *'a state of complete physical, mental and social well-being, and not merely the absence of disease or infirmity'* is contained in the Declaration of Alma-Ata adopted at an international conference on primary health care in 1978.¹ This same declaration also underlined the fundamental role of primary care for the entire health system.

Article 12 of the UN Covenant on Economic, Social and Cultural Rights, ratified by the UK government in 1976, spells out the relevant duties imposed on the NI Executive. At the broadest level it demands *'the creation of conditions which would assure to all medical service and medical attention in the event of sickness'*.²

The UN Committee on Economic, Social and Cultural Rights, which monitors the government's compliance with the provisions of that treaty, has set out in more detail what specific rights people with mental health problems are entitled to. These include *'timely and appropriate health care, confidentiality, skilled medical personnel, access to information, and access to appropriate mental health treatment and care'*.³

As the research presented in this report will show, people with mental health problems seeking help from their GP have all too often experienced a denial of their rights across all of these areas. In particular, their right to both timely and appropriate health care for mental health problems is undermined. Evidence of significant difficulties being experienced in getting GP appointments, the lack of appropriate GP expertise on mental health and the over prescribing of medication for patients presenting with mental health problems all demonstrate how people's rights are being denied.



¹ Declaration of Alma-Ata: International Conference on Primary Health Care, Alma-Ata, USSR, 6-12 September 1978.

² UN International Covenant on Economic, Social and Cultural Rights Article 12.2.4

³ UN Committee on Economic, Social and Cultural Rights General Comment No 14 (2000) The Right to the highest attainable standard of health paragraphs 11 and 12

The UN Committee on Economic, Social and Cultural Rights acknowledges that the right to health under Article 12 is subject to progressive realisation, and that even in times of austerity vulnerable groups must be protected. It makes clear that there is an obligation on the government to take steps towards that goal, steps which must be *'deliberate, concrete and targeted towards the full realisation of the right to health'*⁴.

One such step the Committee views as comprising a core obligation is *'appropriate training for health personnel'*.⁵ The UN Special Rapporteur on the Right to Health (2005) has made it clear that *'in the context of mental disabilities (sic) this means that, for example, health professionals should be provided with adequate mental health-care training'*.⁶

A number of other international human rights bodies have also expanded on the rights of people with mental health problems to the highest attainable standards of health and health care, including at the primary care level. In 1991, the UN General Assembly adopted Principles for the Protection of Persons with Mental Illness and for the Improvement of Mental Health Care⁷. Included in these principles are the right to the best available mental health care, the right to be treated with humanity and with respect for the inherent dignity of the person, the right to confidentiality of information, the right to care and treatment in accordance with the same standards as other ill persons and the right to make a complaint. The research presented in this report highlights how all of these principles have either been ignored or undermined at different times.

The World Health Organisation has drawn attention to the importance of integrating mental health care into primary health care and has echoed the UN Special Rapporteur on Health's call for mental health training for primary care staff. It noted that such training is a pre-requisite to the management and treatment of mental disorders in primary care, thereby enabling the largest number of people to get *'easier and faster access to services'*.⁸

At the European level, Article 34 of the Charter of Fundamental Rights of the EU, while not specifically referencing mental health, does include the right to health care, which in line with international human rights instruments must include mental health: *'everyone has the right to preventive health care and the right to benefit from medical treatment'*.⁹

⁴ UN Committee on Economic, Social and Cultural Rights General Comment No 14 (2000) The Right to the highest attainable standard of health paragraph 30

⁵ Ibid Paragraph 36

⁶ Report of the Special Rapporteur on the Right of Everyone to the enjoyment of the highest attainable standard of physical and mental health. Paul Hunt. 11 February 2005 E/CN.4/2005/51

⁷ UN General Assembly (1991) Rights of mentally ill to protection and care – Principles for the Protection of Persons with Mental Illness and for the Improvement of Mental Health Care

⁸ World Health Organisation (WHO) World Health and Mental Health- New Understanding and Hope Report (2001)

⁹ Charter of Fundamental Rights of the EU (2000) Article 35

Finally, while not having the legally binding status of the various human rights instruments outlined above, the European Definition of General Practice/Family Medicine adopted in 2011 provides some useful commentary on the importance of GPs addressing health issues in a holistic manner: *'[the GP] deals with health problems in their physical, psychological, social, cultural and existential dimensions. Illness behaviour and patterns of disease are varied by many of these issues and much unhappiness is caused by interventions which do not address the root cause of the problem for the patient'*.¹⁰

Time and time again, people experiencing mental health problems and those caring for them have pointed to the failure to deal with their problems in a holistic manner which addresses the underlying cause. In order to fulfil the rights of people with mental health problems to timely and appropriate health care as outlined above, the Mental Health Rights Campaign is calling for the implementation of the practical, rights based changes set out further on in this report.

¹⁰ The European Definition of General Practice/Family Medicine. WONCA. Europe. 2011 Edition. Paragraph 3.1.1.1.

2. MENTAL HEALTH IN NORTHERN IRELAND

The situation of mental health inequalities in Northern Ireland is severe. According to the Department of Health the estimated figures for mental health prevalence in Northern Ireland are between 25% - 44% higher than in England while, inversely, the actual per capita spending on mental health services was in fact 10-30% lower in 2016.¹¹ According to a 2015 study published by the Department of Health on health inequality gaps in Northern Ireland, health outcomes appear to be generally worse in areas identified as “*most deprived*” when compared both with areas identified as “*least deprived*” and region-wide results.¹² Focusing on mental health outcomes, findings reveal that almost one in five (19%) of those surveyed in NI indicated that they may have a mental health problem.¹³ Further, the rate in the most deprived areas (30%) in NI was double the rate in the least deprived areas (15%).¹⁴ These survey results were obtained through the Health and Social Care Inequalities Monitoring System (HSCIMS), a biennial survey which includes a basket of indicators monitored over time to assess area differences in mortality, morbidity, and health and social care service access and utilization.¹⁵ The previous Health Minister described these mental health inequalities as “*completely unacceptable*”.¹⁶ In addition, while mental health accounts for approximately 25% of health cases it currently receives only 5.5%¹⁷ of the health budget.

Campaigners recently called on the Health Minister to ensure funding of mental health services in line with need.¹⁸ While the previous Health Minister has said they are committed to achieving a parity of esteem between mental and physical health,¹⁹ there is no evidence of any progress in this regard.

The high level of mental illness and low level of care forms part of the picture of why Northern Ireland has the highest rate of suicide on these islands. In 2014 the rate of suicide in Northern Ireland was 16.5 per 100,000 compared with 9.2 per 100,000 in England. Just over three quarters of those who died were male. Since the Good Friday/Belfast Agreement 1998 more people have taken their own lives than were killed in the conflict.²⁰ Rates of suicide in the most deprived areas are over three

¹¹ Dept of Health NI; *Systems, Not Structures: Changing Health & Social Care*. Expert Panel (Bengoa) Report. 2016. P.34

¹² Department of Health, Social Services and Public Safety. (2015).<https://www.health-ni.gov.uk/sites/default/files/publications/health/hscims-report-2016.pdf> [Accessed: 5 April 2017].

¹³ *Ibid.*

¹⁴ *Ibid.*

¹⁵ *Ibid.*

¹⁶ NIA - Committee on Health, “Official Report (Hansard) - Transformation of Health and Social Care: Mrs Michelle O’Neill MLA (Minister of Health)” (Northern Ireland Assembly, October 27, 2016), <http://data.niassembly.gov.uk/HansardXml/committee-19527.pdf>.

¹⁷ Health Minister response to AQW 3186/16-21 from Mr Chris Lyttle MLA on 04 Nov 2016

¹⁸ Unfair Share <http://www.pprproject.org/more-dough-needed---mental-health-rights-campaigners-call-on-the-minister-for-health-to-fund-mental>

¹⁹ *Health And Wellbeing 2026 Delivering Together*. Department of Health. 2016. P. 17.

²⁰ ‘Suicide kills as many as the Troubles’ The Detail 10 February 2014 (<http://www.thedetail.tv/articles/suicide-kills-as-many-as-the-troubles>)

times (29.9 per 100,000) those for the least deprived areas (9.3 per 100,000).²¹ Northern Ireland has the highest rate of Post-Traumatic Stress Disorder (PTSD) of 28 countries examined by the World Mental Health Survey Initiative – including countries with on-going or more recent conflicts such as the Lebanon and Israel.²² This situation means that the Northern Ireland Executive is failing to achieve the objectives of the draft Programme for Government (2016), specifically Outcome 4: ‘*We enjoy long, healthy, active lives*’. Objectives listed under this outcome include improving mental health and ensuring that people get the right treatment at the time of need. The failure to improve people’s mental health invariably has a negative impact on physical health outcomes also, given the dynamic relationship between all elements of health. It also has much wider societal impacts which reach across outcomes in relation to education, employment, homelessness, levels of crime and the economic well being of a society as a whole, in essence, across the entire Programme for Government.

²¹ *NI Health and Social Care Inequalities Monitoring System – Health Inequalities In Northern Ireland: Key Facts 2015*. Department of Health. 2015.

²² ‘Suicide Among the Ceasefire Babies’. *The Atlantic*. Lyra McKee. Jan 20, 2016. <https://www.theatlantic.com/health/archive/2016/01/conflict-mental-health-northern-ireland-suicide/424683/>

3. THE CRISIS IN GP SERVICES IN NORTHERN IRELAND

The NHS is in crisis. Across the UK the health service has been hit by records levels of privatization and disinvestment, resulting in long waiting lists, overworked staff and some services closing down completely. Yet, as the British Medical Association (BMA) has stated *“The current crisis in the health service extends well beyond A&Es, with all parts of the NHS, including GP surgeries.”*²³ While clearly connected, there are separate issues contributing to a potential collapse in GP services. Indeed GP leaders have stated the Conservative government is trying to ‘scapegoat’ GPs for the NHS Crisis.²⁴ NHS England has shown that *“800 GP practices faced average losses worth more than £50,000 per year”*²⁵ due to contract changes. Recent research showed that *“GPs in England deliver over 25% more appointments per week than a safe limit proposed by the BMA”* while last year *“a BMA poll found that more than eight out of 10 GPs say their workload is unmanageable”*.²⁶ GPs highlight the increasing amount of administrative work they must complete, and, as part of this increasing work – an indication of the drive to turn public services into border posts – there are plans to require GPs to report patients’ immigration status.²⁷

3.1. CHALLENGES FACING GP PROVISION IN NORTHERN IRELAND

As with other health and care services, the crisis in GP services in Northern Ireland is even more acute. We have the lowest GP coverage per head of population in the UK, and a 20% shortage of GPs in the region.²⁸ GPs have complained about increased strain, as the *“number of GP consultations has increased by 76% in the last 10 years”*²⁹ with the *“administrative workload processed by general practice [increasing] by 115%”* over a similar period.³⁰ In addition, GP *“list sizes have increased by 13% over the last 10 years”*.³¹ Yet this increase has been met with a reduction in funding: *“The total spend on general medical services equates to approximately 6% of the overall spend on health and social care, a decrease from 11% in 2003”*.³² This is despite

²³ ‘GP coverage and the NHS crisis’. British Medical Council. 25 Jan 2017. <https://www.bma.org.uk/collective-voice/committees/general-practitioners-committee/gpc-current-issues/gp-coverage-and-the-nhs-crisis>

²⁴ ‘Government has tried to ‘scapegoat’ GPs for NHS crisis, say angry GP leaders’. *GP Online*. Neil Roberts. 16 Jan 2017. <http://www.gponline.com/government-tried-scapegoat-gps-nhs-crisis-say-angry-gp-leaders/article/1420961>

²⁵ ‘Exclusive: NHS England report reveals hundreds of GP practices facing five-figure funding cuts’. *GP Online*. Neil Roberts. 1 March 2017. <http://www.gponline.com/exclusive-nhs-england-report-reveals-hundreds-gp-practices-facing-five-figure-funding-cuts/article/1425823>

²⁶ ‘Exclusive: GPs in England deliver 1m appointments per week over ‘safe limit’’. *GP Online*. Nick Bostock. 21 March 2017. <http://www.gponline.com/exclusive-gps-england-deliver-1m-appointments-per-week-safe-limit/article/1427972>

²⁷ ‘GPs could be forced to report patients’ immigration status in NHS charging scheme.’ *GP Online*. Neil Roberts. 6 Feb 2017. <http://www.gponline.com/gps-forced-report-patients-immigration-status-nhs-charging-scheme/article/1423430>

²⁸ *General Practice in Crisis – a report on primary care in Northern Ireland* British. BMA Northern Ireland. 2016. P. 3.; *Delivering change for general practice. A strategy for improving patient care in Northern Ireland*. Royal College of General Practitioners Northern Ireland. 2015. P.2.

²⁹ *Delivering change for general practice*. RCGP NI. P.2.

³⁰ *General Practice in Crisis*. BMA NI. P.3.

³¹ *General Practice in Crisis*. BMA NI. P. 4

³² *General Practice in Crisis*. BMA NI.p3

primary care delivering 90% of health contacts.”³³ Brexit also poses a threat – in Northern Ireland, EU nationals represent 11% of the GP workforce, and the loss of EU doctors would hit Northern Ireland hard.³⁴

3.2. IMPACT ON GPs

Increasing workloads, underfunding, and the compounding of health issues in deprived areas due to austerity and welfare reform, all means that GPs are over stretched. It is thus no surprise that when surveyed “*over half of GPs (54%) feel their current workload is unmanageable or unsustainable*”³⁵ and a staggering “*76% said workload is affecting their family life or work-life balance*”.³⁶ The BMA concluded that “*The impact of unmanageable workloads, too few GPs and inadequate resources are putting practices on the brink of collapse*”.³⁷

And indeed they have. For example, in Co Fermanagh a rapidly growing number of GP practices are closing down as GPs reach retirement age or decide not to continue as sole practitioners.³⁸ Elsewhere GP surgeries are also facing collapse, and it has been reported that a further 20 could close this year.³⁹ The impact of the loss of their GP practice on rural villages and towns across Northern Ireland cannot be overestimated. The combination of a poor transport infrastructure, economically disadvantaged communities as well as poor digital coverage means that some communities are effectively being left without any access to timely and appropriate health care, including mental health care. The lack of a primary health care service will undoubtedly have negative impacts on other aspects of the health system, with failures at the primary care level being transferred onto already overstretched Out of Hours services and hospital emergency departments.

In March 2017, GPs in Northern Ireland voted overwhelmingly for mass resignations, the motion stating it was needed as “*the only way to save general practice in Northern Ireland from the destruction of the service by our department of health*.”⁴⁰ The BMA General Practitioners Council chair for Northern Ireland, Dr Tom Black has warned that 6% of practices in Northern Ireland could collapse within a year.⁴¹

³³ *Delivering change for general practice*. RCGP NI p2

³⁴ ‘Brexit could force 2,137 GPs out of NHS, warns RCGP.’ *GP Online*. Nick Bostock. 27 May 2017 <http://www.gponline.com/brexit-force-2317-gps-nhs-warns-rcgp/article/1434247>

³⁵ *Delivering change for general practice*. RCGP NI p5

³⁶ *General Practice in Crisis*. BMA NI p10

³⁷ *General Practice in Crisis*. BMA NI p11

³⁸ ‘Top doctor warns Fermanagh GP practices will halve within year’. *Irish News*. Seanin Graham. 27 April 2017 <http://www.irishnews.com/news/2017/04/27/news/top-doctor-warns-fermanagh-gp-practices-will-halve-within-year-1008725/>

³⁹ ‘20 GP surgeries face closure in Northern Ireland affecting 120,000 patients, warns top doctor’. *Belfast Telegraph*. Claire O’Boyle. January 19 2017 <http://www.belfasttelegraph.co.uk/news/northern-ireland/20-gp-surgeries-face-closure-in-northern-ireland-affecting-120000-patients-warns-top-doctor-35379190.html>

⁴⁰ ‘Northern Ireland LMCs vote for ‘nuclear option’ of mass GP resignation.’ *GP Online*. Nick Bostock. 4 March 2017 <http://www.gponline.com/northern-ireland-lmcs-vote-nuclear-option-mass-gp-resignation/article/1426270>

⁴¹ *Ibid*.

4. PROVISION OF MENTAL HEALTH CARE BY GPs

GPs are the entry point to primary care. According to figures from a 2003 National Survey of NHS patients, approximately 91% of people with a mental health problem will be treated within the primary care system. UK wide estimates are that 1 in 3 GP appointments are mental health related.⁴² Additionally, a Scottish study has shown that *“Mental health problems, and GP consultations involving mental health problems, are more than twice as prevalent in deprived areas as in affluent areas.”*⁴³

In view of the rising levels of mental ill health and rates of suicide in Northern Ireland, as outlined earlier, GPs clearly play a pivotal role in the provision of mental health care. It is worth noting that GP care is also perceived by people with mental health problems as more accessible, less stigmatising and more comprehensive as it manages both physical and mental ailments. Frequently however people with symptoms of mental health conditions such as depression and anxiety do not report this to their GP but instead focus on details of their physical symptoms only.



“You have to learn about thousands of diseases, but I only have to focus on fixing what’s wrong with ME! Now which one of us do you think is the expert?”

4.1. GENERAL MEDICAL SERVICES CONTRACT

Statutory responsibility for the provision of GP services lies with the Health and Social Care Board. General Medical Services (GMS) sits within the Integrated Care Directorate of the Board. The HSCB, supported by 5 Local Commissioning Groups (LCGs) has responsibility for commissioning of GP services since 2007. These services are commissioned via the General Medical Services contract. The existing contract was introduced in April 2004⁴⁴ and introduced a new system for funding practices designed to give GPs greater flexibility in how they deliver services while rewarding them on the quality and outcomes of care they provide. A contract exists between the HSCB and each individual practice (contractor). The status of GP practices is as *‘an independent provider of services and (not) an employee, partner or agent of the Board’*.⁴⁵

⁴² *Better equipped, better care. Improving mental health training for GPs and practice nurses.* Mind. 2016. P.6.

⁴³ *General Practitioners at the Deep End. Deep End Report 22; Mental health issues in the Deep End.* 2014. P2.

⁴⁴ *Standard General Medical Services Contract (NI) – March 2004*

⁴⁵ *Standard General Medical Services Contract (NI) – March 2004 Part 2, paragraph 6.*

The Health and Personal Social Care (GMS Contracts) Regulations (NI) 2004⁴⁶ set out the conditions which must be included in the terms of a general medical services contract between the Boards and a general medical practitioner.

The 2004 GMS contract covers a range of services that GP contractors provide. Essential services must be provided for people “*who are, or believe themselves to be ill, with conditions from which recovery is generally expected; terminally ill or suffering from chronic disease.*”⁴⁷ Appropriate ongoing treatment and care required to be provided to these patients includes consultation, treatment, further investigation, referral, and liaison with other professionals.

In addition to Essential Services GP contractors can be required to provide Additional Services as part of their contract, although they can choose to opt out of provision of these services.⁴⁸ Such services include cervical screening, contraceptives, vaccinations and immunisations and child health surveillance services. GPs can further opt to provide Enhanced Services within their contract. These are not required by the Regulations but can be agreed between the Health and Social Care Board and the Contractor. These services might include minor injury services and more specialised services for patients with specific conditions. Under the 2004 Contract GP contractors are also required to provide Out of Hours services but can choose not to have this service included in their contract.

While people with mental health problems clearly fall within the scope of services to be provided by GP contractors, there is no specific reference to GP responsibilities in relation to mental health related services to be found within the GMS contract, for example as with the inclusion of specific physical health related services within the Additional Services element of the contract.

4.2. QUALITY OUTCOMES FRAMEWORK

In 2004, as part of the new GMS contract, the NHS introduced the largest health related pay-for-performance scheme in the world—the Quality and Outcomes Framework (QOF). However Scotland is now abandoning the scheme, following criticisms of unnecessary bureaucracy, and there is growing disenchantment with it across the other UK jurisdictions.⁴⁹

The criteria used to measure GP practice performance under the QOF are grouped into 4 domains: clinical, organisational, patient experience and additional services. The criteria are designed around best practice and have a number of points allocated for achievement. Groups of indicators are used to assess outcomes under each

⁴⁶ http://www.hscbusiness.hscni.net/pdf/GMS_CONTRACT_REGS_BM3.pdf

⁴⁷ Standard General Medical Services Contract (NI) – March 2004 Part 6, paragraph 47.1

⁴⁸ Standard General Medical Services Contract (NI) – March 2004 Part 8, paragraph 58

⁴⁹ <http://www.bmj.com/content/354/bmj.i4060.full.print>

domain. Under the Clinical Domain, indicators in relation to mental health⁵⁰ and depression⁵¹ are included. At the end of the financial year the total number of points achieved by a surgery is collated by the Quality Management and Analysis System (QMAS) or other system which then converts the points total into a payment amount for the surgery. GPs self-report against the 64 indicators and the Health and Social Care Board has overall responsibility for monitoring the implementation of the QOF by GP practices.

While participation is voluntary all 347 practices in Northern Ireland, participated in the QOF in 2015/16. 64 practices achieved the full 547 points, with an average QOF achievement of 539.05 points (98.55%). The 347 practices received a total of £30.52million, with an average award of £87,950 per practice. In relation to mental health the average QOF achievement rate was 97.61% while for depression the rate was 97.29%.

The indicators in place in relation to mental health are narrowly drawn and only relate to the clinical aspects of certain specific mental health conditions, rather than overall care and management, including the patient's experience of care and treatment. The fact that those mental health related indicators which are included constitute less than 10% of the overall indicators in the QOF, despite the high levels of mental ill health among patients that GPs deal with, is an indication as to the priority given to mental health within the overall quality framework.

4.3. LACK OF INDEPENDENT OVERSIGHT OF GP PRACTICES

There is no independent regulation of GP practices in Northern Ireland. Unlike in England, where the Care Quality Commission's role extends to the regulation of GP practices, the equivalent body in Northern Ireland, the Regulation and Quality Improvement Authority (RQIA) does not have any remit in relation to GPs. The CQC, as the independent regulator of health and social care in England, inspects GP practices against a number of key lines of enquiry including safety, effectiveness, caring, responsive and well-led, and rates them accordingly. People experiencing poor mental health are included in the population group definitions used by the CQC.

In Northern Ireland the Patient and Client Council (PCC) was established as an independent, statutory body whose role is described as being to '*act as a strong, effective voice for users of independent health and social care services*', including those provided by independent contractors.⁵² However, while the PCC has produced research reports into GP services⁵³, it has no powers of scrutiny or regulation in

⁵⁰ Five separate indicators are included in relation to mental health. These include a comprehensive care plan for patients with schizophrenia or bi-polar affective disorder, records of blood pressure and alcohol consumption in the preceding 15 months, cervical screening and records of levels of medication.

⁵¹ The indicator used for depression is as follows: the percentage of patients aged 18 or over with a new diagnosis of depression in the preceding 1 April to 31 March, who have had an assessment of the physical, psychological and social aspects of the condition by the point of diagnosis. The completion of the assessment is to be recorded on the same day as the diagnosis is recorded

⁵² http://www.patientclientcouncil.hscni.net/uploads/files/StandingOrdersFinancialInstructions_PCC.pdf

⁵³ http://www.patientclientcouncil.hscni.net/uploads/research/Access_to_GP_Services_-_Full_Report.pdf

relation to GPs. It is unclear if or how any of the recommendations in relation to GP services have been acted upon by the Health and Social Care Board.

The lack of priority accorded to mental health within either the GMS contract or the Quality Outcomes Framework, coupled with the unique status of GP contractors as independent providers, as well as the lack of any independent oversight or scrutiny of provision of GP services, all contribute to the significant difficulties people in reality face in accessing adequate mental health help from their GP. In 2015, in a PPR survey of people directly affected by mental health issues, 58% indicated that waiting times to see GPs were unsatisfactory or very unsatisfactory, while less than half (41%) felt that their GP had offered them the most appropriate type of care. Three quarters of adults in Northern Ireland believe that GP waiting times are at crisis level.⁵⁴ The poll



by the Royal College of General Practitioners Northern Ireland (RCGPNI) found that patients in Northern Ireland have the longest GP waiting times. A survey by the RCGP NI in 2015 found that 64% of people were not able to book an appointment with their GP within the same week. Patient and Client Council report on access to GP services found that 52% said accessing their GP practice was 'not easy' and 63% reported it was not easy getting speaking to a doctor on the phone.⁵⁵ The findings of the research carried out by the Mental Health Rights Campaign in the past year, as detailed next, only serve to reinforce these figures.

⁵⁴ 'The right to timely and appropriate help from your GP for mental health problems'. PPR Project.

www.pprproject.org/the-right-to-timely-and-appropriate-help-from-your-gp-for-mental-health-problems

⁵⁵ *Your voice in health and social care. Access to GP Services. Summary Report.* Patient and Client Council May 2014.

P.2. http://www.patientclientcouncil.hscni.net/uploads/research/Access_to_GP_Services_-_Summary_Report.pdf

5. MENTAL HEALTH RIGHTS CAMPAIGN ACTION RESEARCH

During 2016 PPR/MHRC carried out action research with over 70 mental health services users and carers in the following areas of Northern Ireland – Belfast (8 different groups) Bellaghy, Cookstown, Derry and Draperstown. In addition a GP checklist was completed by 110 mental health service users and carers.

The checklist was completed during or after a person's visit to their GP practice and focused on issues such as experience at GP reception, ability to see preferred GP, information displayed on making appointments on mental health and the practice's complaints policy and procedures. The focus groups were structured around the various stages of a person's engagement with their GP, from making an appointment, the waiting room, time with the GP and any follow up. Out of these focus groups eighteen issues – fitting under four broad and overlapping themes – were identified as major barriers to having the right to mental health care in primary setting realised.

Barriers identified in relation to making appointments included the lack of availability of appointments, difficulty getting through on the phone, a lengthy wait between booking appointment and seeing the GP, and receptionists presenting barriers to making appointments – such as asking too many questions.



In the GP practice itself it came across strongly that there was not sufficient information displayed on mental health. A lack of information on the system for booking the different types of appointments as well as the practice's complaints policy and procedures were identified. The environment in the GP practice itself was at times perceived as quite negative, exemplified by the attitude of receptionists as well as negative signage.

One of the main issues identified through the research was that of GPs not having the expertise to properly address the patients mental health concerns, coupled with the totally inadequate time allocated for appointments, the 'ten minute rule'.

Respondents also felt that there weren't avenues for complaints or for their feedback or participation following an appointment. Those who had experience of making complaints reported having had very negative experiences.

It's clear that the cumulative effect of these barriers would have at the very least an additional detrimental impact on someone's mental health, especially when they are in crisis, as this quote from one service user reflects:

“many people with mental health problems don't have confidence and this system makes them feel worthless and unimportant and puts more pressure and stress on them”

It's important to note that while people overwhelmingly reported not being able to get their mental health needs met, some very positive experiences were also highlighted through the research. These experiences underscore the value of the personal relationship between a patient and their GP, something attributed in part by the European Definition of General Practice to *'the communication skills of the family doctor which is in itself therapeutic.'*⁵⁶ It is important to both acknowledge and learn from these experiences also; details of and reflections on the same will be provided later in the report.

⁵⁶ The European Definition of General Practice /Family Medicine. WONCA. Europe 2011 edition.

6. MENTAL HEALTH RIGHTS CAMPAIGN- PRIORITY ISSUES FOR ACTION

On 8 April 2017, PPR and 30 mental health service users from nine groups across Northern Ireland held a campaign strategy session at The Elk in Toomebridge, Co Antrim. The purpose of the session was to review the results of the action research, prioritise the issues identified, and prepare for a campaign for change on the issues. It was vital that the issues were strongly rooted in international human rights standards and reflected the priorities of those with direct experience of trying to access mental health care from their GP. Out of an initial 18 issues identified through the focus groups and checklists three were prioritised to campaign for change around. These were as follows:

1. *Lack of mental health expertise among GPs*
2. *Difficulties with getting GP appointments*
3. *Over prescription of medication by GPs*

The following section looks at these three priority issues in more depth. Qualitative evidence from the focus groups and checklists completed in relation to each of these issues is presented, including examples of good practice shared.

6.1. LACK OF MENTAL HEALTH EXPERTISE AMONG GPs

People reported that GPs simply did not have the experience or training with mental health to provide appropriate care, noting that GPs have on occasion given incorrect or inadequate advice. They highlighted that this was a specific issue in relation to mental health rather than an issue with lack of expertise overall.

“I feel my GP surgery is very good most of the time but with mental health they struggle to understand and I think they aren’t trained to deal with it.”

“the doctor I had, all the rest of the family went to him, and out of unity I wanted to stay with him but he couldn’t understand mental health, he couldn’t understand self-harming for a start”

People felt that the lack of expertise was compounded by a severe lack of time available to GPs to see patients and stressed that people with mental health problems very often need more time alongside the appropriate expertise:

“Doctors [...] should make more time for people with mental health problems, which they don’t do. I don’t think they do and sometimes to bring up mental health problems is bad news to a doctor.”

Others reported having had very negative responses from their GP when they raised mental health issues or reported having had suicidal ideation:

“After having to wait for appointment I have been told I need to pull myself together and just get on with it.”

“My nephew went in to the doctor and he said ‘do you feel suicidal’ and he said ‘yes I do’ and the doctor said ‘well at least you haven’t tried it yet’ and he walked [home] with his mammy crying cause he walked out the way he walked in.”

One woman, having witnessed the lack of appropriate treatment or response by the GP to her brother’s mental health problems made the following observation:

“I’ve never been to the doctors with mental health (problems) but I wouldn’t fancy going to the doctors with mental health; if I felt like that I wouldn’t go to the GP’

When asked where she would go to seek help the young woman replied ‘I don’t know’, before identifying the co-ordinator of a local suicide bereavement group as the person she would turn to.

A ‘tick box’ approach to consultations in relation to mental health was also seen as an indication of the GP’s lack of expertise and skill in assessing, diagnosing and responding appropriately to mental health issues

“the GP sits you down in front of a computer and you answer no, and you do that test to see whether you are mentally stable, and then they come in and say sorry you are too far advanced for the computer thing”

Not receiving the appropriate help from the GP when needed for mental health problems can have a profound effect on people, as this quote illustrates:

“[The poor service] affected the next 5 years of my life. Had [my GP] known more- I could have had a different path.”

As mentioned above, in addition to the negative experiences highlighted, examples of people receiving the appropriate care they needed from their GP were also shared.

“I’m very lucky at the minute. I have an excellent doctor. She spotted the symptoms of my Borderline Personality Disorder very quickly. No other doctor ever did. She is knowledgeable, calm, astute and kind. I can say that meeting her/registering with her has changed my life.”

“After waiting almost 7 weeks I got to see my GP. She gave me 45 minutes of her time. She was/has been the first doctor to do so - she went back through all my medical history. She looked at my past episodes of depression and worked out which anti-depressants would be best suited to me given my previous/existing medical conditions. I felt she listened and even gave me a follow up call. I felt a lot better leaving her that day.”

“my GP is very very helpful and he goes over and above his duty to help. I’ve never had any issues with him or other doctors in the surgery”

There are a number of obvious factors common to all of these positive experiences – knowledge, time, attitude and good listening skills. The importance of these skills being engaged in GP consultations with carers of people with mental health problems was highlighted, with one carer commenting that her GP *‘listens well, [is] sympathetic, takes time with you as a carer as well as a person with a mental health problem’*.

There has been widespread acknowledgement, including from GPs themselves, that they are ill equipped to deal with the range of mental health issues that people present with.

A joint study carried out by the Public Health Agency and Ulster University *“found widespread acknowledgement that GPs are ill prepared for the management of mental illness.”*⁵⁷ Relevant factors included a high workload, 10-minute appointments, delays in referrals, inappropriate prescription of anti-depressants, failure to offer alternatives to medication, and lack of relevant training.

The lack of mandatory training in both mental health and in suicide awareness has resulted in relatively few GPs being adequately trained or feeling sufficiently confident to deal with mental health issues or patients who are suicidal.

A response to a Freedom of Information request by PPR in 2016 indicated that only half of the annual cohort of trainee GPs have to undertake a placement in a mental health facility. Practising GPs are not obligated to undertake mental health training as part of their mandatory continuous professional development (CPD).⁵⁸ This is consistent with figures from the mental health charity Mind’s 2016 survey which found that less than half (46%) of trainee GPs undertook a training placement in a mental health facility.⁵⁹

Practising GPs in Northern Ireland who are interested in gaining qualifications in relation to mental health currently have little opportunity to do so. The option of obtaining an accreditation as a Practitioner with a Special Interest in Mental Health, which exists in England, is not available to GPs in Northern Ireland.⁶⁰

Further information obtained by PPR through the Freedom of Information Act showed low levels and uneven uptake of suicide awareness training under the Protect Life 1 Strategy, and the evaluation of this strategy highlighted the need to consider introduction of mandatory suicide prevention training for GPs as part of the Protect Life 2 Strategy currently being developed.

⁵⁷ <http://www.research.hscni.net/suicide-prevention-research>

⁵⁸ *Better equipped, better care*. Mind. p5

⁵⁹ ‘GPs and practice nurses aren’t getting enough mental health training’. Mind. 1 Nov 2016

⁶⁰ Health and Social Care Board response to a Freedom of Information request by PPR (Ref NO: 72716) received on 3 November 2016. Available on request.

6.2. DIFFICULTIES MAKING APPOINTMENTS

A number of factors were identified which affected people's ability to obtain a timely appointment for mental health issues with their GP. These included lack of knowledge of the appointment booking system as well as a lack of transparency in relation to the appointment booking system, difficulty getting through on the telephone, receptionists acting as 'gatekeepers' for the GP, long wait between making an appointment and being seen by the GP and simply no appointments available.

Many people reported having to wait up to 3 weeks for a routine appointment, with only a very small minority of people indicating that they had no difficulty in getting an appointment when they needed it.

"You can wait 3 weeks for an appointment"

"Having tried on several occasions to get an appointment every time it is 'unless it's an emergency we don't have appointments' and when I say he needs to be seen by a doctor the receptionist wants all the details to see if he really needs an appointment. Appointments can only be booked by phoning on day you want appointment for and when you ring there is none left."

The majority of people who participated in the research indicated that they booked their appointments by telephone, but the issue of getting through on the phone was raised by several people:

"Telephoning is very frustrating, could be hours before I would get a reply and then to be told they were fully booked"

" it took 11 minutes to get through to then be told I must ring back next Monday, six days later to see if I can have an appointment. That's why people use Beldoc (out of hours service)".

The element of chance perceived to be involved in securing an appointment was frequently mentioned:

"if you get an appointment you are lucky, you can stand in a queue of 50 people and wait on an appointment and if you are lucky you'll get one in Julember"

The lack of transparency around the appointments booking system described by people seems almost Kafkaesque:

"appointment systems are changing all the time if you don't phone on the mornings the rota systems are out you have to wait to the next time and it could be a few weeks"

“we can only make appointments on a Monday, when you try to ring and make appointments the line is busy all day, by the time you get through there are no appointments left and then you have to wait until the next morning to try again”

“ring at 8.30am and told to ring back after 9am and when you do all appointments are gone”

There were differing levels of awareness of the options of booking either an emergency or a double appointment, with some people commenting that they had never heard of a double appointment.

While it is readily acknowledged that difficulties with securing a GP appointment are widespread and exist across the entire GP service, it should be noted that the impact of these difficulties for people with mental health problems or indeed in a mental health crisis can be extremely serious and can serve to exacerbate an existing problem, as illustrated by this quote:

“it’s an issue when people are ill with mental health, with depression, they are so demotivated they don’t even see the point in going to the GP, the depression is so heavy, and when you have to fight to get an appointment, and I mean fight in front of other people, it’s demoralising and devaluing and it’s not doing anybody any good for confidence and self-esteem”

A UK-wide study published last year showed that 40% of people having to discuss their symptoms with a GP receptionists could prevent them from making an appointment. Women and people from lower socio-economic backgrounds are even more likely to report this.⁶¹

Currently no waiting time target for being seen by a GP exists, following the removal in 2012 of the previous 48 hour target for routine appointments. The Royal College of GPs has repeatedly expressed its extreme concern at the soaring waiting times for appointments. A survey of 831 GPs published by the Pulse GP newsletter in June 2016⁶² found that the average waiting time for GP appointments had increased by 30% in one year. The average waiting time in 2016 was just under 13 days, with the expected average time estimated to climb to around 17 days in the next year. In Northern Ireland, Dr. Janine O’Kane, said that she expects waiting times to hit 5 weeks by 2017, commenting that *“there is no limit to demand”*.⁶³

⁶¹ Moffat J, et al. Identifying anticipated barriers to help-seeking to promote earlier diagnosis of cancer in Great Britain. J Public Health (Bangkok) 2016

⁶² ‘Average waiting time for GP appointment increases 30% in a year.’ *Pulse Today*. Jaimie Kaffash. 10 June 2016. <http://www.pulsetoday.co.uk/your-practice/access/average-waiting-time-for-gp-appointment-increases-30-in-a-year/20032025.article>

⁶³ Ibid.

6.3. OVER USE OF MEDICATIONS

People highlighted an over-reliance by GPs on prescribing medication for mental health issues - *“they give medication too quickly”*. This issue is related to the lack of mental health expertise among GPs, but also to structural and resource problems, such as 10-minute appointments being insufficient time within which to conduct a mental health assessment. One woman reported that after losing her son to suicide that she would not take families/friends advice to see the GP, as she wanted to talk about her son’s death but the GP only prescribed medication. Another person said:

“Personally I think with my daddy, if people go in and say they are depressed, they write you a prescription, they don’t question anything, like how do you think things are, what would help you, it’s not like a conversation they have its just like well here’s tablets go ahead, it’s never like do you think we could help you with speaking to somebody.”

The long waiting times for psychological therapies were identified as one possible reason as to why GPs rely on providing medication only for mental health problems *“many GPs end up prescribing drugs as the waiting lists are too long”*.

A UK-wide report from Mind has noted that the *“most common support GPs offer people with mental health problems is medication even though this may not be the most appropriate option.”*⁶⁴ The BMA has shown that there was a 28% rise in overall prescriptions over a ten year period, with repeat prescribing rates increasing by 41%.⁶⁵ The UK has the seventh highest rate of anti-depressant medication prescriptions for all OECD countries. However, if Northern Ireland is taken as a separate jurisdiction within the UK it would take the highest spot.⁶⁶ This high prevalence is due to a number of factors, including legacy of the conflict, higher rates of social deprivations and linked mental health issues this brings.

It is also part of a worrying overall trend - a recent study on patterns of deaths by suicide in Northern Ireland highlighted that over a quarter of people (27%) who died by suicide *“were in receipt of more than four prescription medications, with 38.5% in receipt of a prescription for antidepressant medication.”* Shockingly, almost 1 in 10 of these people had no mental health diagnosis.⁶⁷ The study further noted that *‘many relatives highlighted their dissatisfaction with medication’*, echoing the concerns raised by people who participated in focus groups for this research.

Moreover, there are also significant evidence of inequalities in the prescription of medication for mental health problems in Northern Ireland. For example, the prescription rate for mood and anxiety disorders in 2013 was 66% higher among

⁶⁴ *Better equipped, Better care.* Mind.p 13

⁶⁵ *General Practice in Crisis.* BMA NI.P3

⁶⁶ ‘The Script Report’. *The Detail.* 2014. <http://script-report.thedetail.tv/>

⁶⁷ *Understanding Suicide and Help-seeking in Urban and Rural Areas in Northern Ireland.* Gerard Leavey, Karen Galway, Sharon Mallon, Lynette Hughes, Janeet Rondón-Sulbarán, Michael Rosato. 2016.

women than men, and twice as high in the most deprived areas than the least deprived areas.⁶⁸

Despite the dramatic increases in prescribing over the last few decades, studies have consistently shown that the increased number of prescriptions have not led to any clear improvements in population health. For example, national surveys from the United Kingdom show no decline in the overall prevalence of depression or anxiety despite dramatic increases in antidepressant use.⁶⁹

A number of people drew attention to the rapidly escalating problem of vulnerable people with mental health problems abusing drugs prescribed to them by their GP, drugs which have replaced 'legal highs' within communities across Northern Ireland. A community based drugs counsellor recently highlighted the massive issue that exists in relation to the misuse of prescription drugs *"every day we see people who are taking drugs to deal with mental health issues and every day we are dealing with cases involving prescription drugs from Lyrica, blues and yellows, anti-depressants and people misusing medication"*.⁷⁰

⁶⁸ Information Analysis Directorate. (2015). Health Inequalities in Northern Ireland: Key Facts 2015. Information Analysis Directorate. Retrieved from <https://www.health-ni.gov.uk/sites/default/files/publications/dhssps/hscims-2015-key-facts.pdf>.

⁶⁹ Michael Moore et al., "Explaining the Rise in Antidepressant Prescribing: A Descriptive Study Using the General Practice Research Database," *BMJ* 339 (October 15, 2009): b3999, doi:10.1136/bmj.b3999; McManus S, Bebbington P, Jenkins R, Brugha T. (eds.) (2016) Mental health and wellbeing in England: Adult Psychiatric Morbidity Survey 2014. Leeds: NHS Digital.

⁷⁰ Sharon Nelson, Falls Community Council Drugs Programme quoted in *Andersonstown News* article 'Drugs Crisis: Heartbreaking stories told at drugs meeting' 13 May 2017

7. SOLUTIONS TO PRIORITY ISSUES

A range of potential solutions to all three priority issues for action have been developed. These are based on group discussions as well as research and policy analysis and examination of models of good practice.

The main solutions proposed by the groups to each priority issue are outlined below.

7.1. LACK OF MENTAL HEALTH EXPERTISE BY GPs

Solutions proposed include the following:

- **Mandatory mental health training for GPs and other relevant GP practice staff (e.g. receptionists)**
- **Other health professionals with the necessary skills and expertise in mental health to work alongside the GP as part of a multi-disciplinary team**

The Royal College of GPs NI has recommended including a fourth year of training, which “*would allow trainees to extend their portfolio of expertise*” into areas such as mental health. The BMA has called for more GPs to be allowed to specialise. The mental health charity Mind is calling for compulsory mental health training in medical school (the mental health-related option currently offered is in psychiatry, which is based in hospitals and secondary care-focused). Mind has also recommended that the relevant bodies “*should specify a set proportion of annual Continued Professional Development (CPD) credits for GPs to undertake which have a mental health focus*”. This would be an attractive option as there would no additional cost or time allocated than there already is.

There is widespread acknowledgment amongst health care professionals and mental health organisations alike that GPs must be given the support and incentives to undertake mental health training.

The use of multi-disciplinary teams and collaborative working approaches in primary care have moved centre stage in current narratives, including for the former Minister for Health who has stated that primary care multi-disciplinary teams were part of her vision for the transformation of the health service and would be rolled out over the next five years, with more funding intended for mental health interventions in primary care.⁷¹ The inclusion of mental health care professionals within primary care teams has also received endorsement from a range of other bodies and professionals. The previously referred to joint Public Health Agency/ University of Ulster study also recommended the presence of mental health professionals in order to benefit

⁷¹ ‘Health and Wellbeing 2026: Delivering Together’ October 2016, p15 <https://www.health-ni.gov.uk/sites/default/files/publications/health/health-and-wellbeing-2026-delivering-together.pdf>

primary care – specifically Community Psychiatric Nurses. Both the RCGP NI⁷² and BMA NI⁷³ have recommended this approach. However the collapse of the Northern Ireland Executive in February 2017 means that the way forward on these proposals is uncertain. The Health and Social Care Board (HSCB), is currently working with one of the local GP Federations, and a number of other bodies (Public Health Agency, Northern Ireland Practice and Education Council for Nursing and Midwifery, and the University of Ulster), in planning the development of the first five Advanced Nurse Practitioners in Primary Care. The role of an advanced Nurse Practitioner would be, inter alia, to “*assess, identify and refer patients presenting with mental health needs.*”⁷⁴ Developments such as these are to be welcomed. However, delivering in full on the vision for multi disciplinary teams in primary care will require decisive action by the NI Executive including significant investment, both of which have been absent to date.

CASE STUDY

*Mental healthcare was restructured in Quebec, Canada starting in 2005 within local healthcare networks where providers combine primary and specialized care services. Patients and staff were transferred from hospitals to primary care centres referred to as health and social service centres (HSSCs), where mental healthcare teams were implemented. To co-ordinate mental health resources, single-access points are in operation in the 95 HSSCs serving more than 50,000 inhabitants, where mental healthcare teams can provide evaluation, psychotherapy and follow-up or referral to psychiatric services. Collaborative or “shared care” has also been promoted in all Quebec local networks, with a few psychiatrists, also known as “responding psychiatrists”, appointed to assist GPs and HSSC mental healthcare teams.*⁷⁵

⁷² England, Dr. E ‘The extraordinary potential of primary care to improve mental health’ in Royal College GPs Clinical News June 2014

⁷³BMA NI ‘16; BMA ‘15 (A range of staff such as counsellors and physiotherapists in practice would allow more services to be provided BMA NI 2015); <https://www.bma.org.uk/collective-voice/influence/key-negotiations/training-and-workforce/northern-ireland-general-practice-in-crisis>

⁷⁴‘Investment in GP Practices’. Health and Social Care Board NI. www.hscboard.hscni.net/our-work/integrated-care/gps/investment-in-gp-practices/

⁷⁵ Fleury et al., “Collaboration between General Practitioners (GPs) and Mental Healthcare Professionals within the Context of Reforms in Quebec.”

7.2. DIFFICULTIES MAKING APPOINTMENTS

Solutions proposed include the following:

- **The option of pressing a designated number for help in a mental health crisis. A separate line would mean that the receptionist would know it is a mental health concern, and thus minimize questions that patients find a barrier in making appointments.**
- **A separate appointment system – with a certain percentage of all appointments kept aside for people with mental health problems.**
- **A ‘red flag’ on a patients’ file so receptionists know that patient has mental health issues.**

Throughout our focus groups, the difficulties people had in making appointments was a consistent theme. A 2015 report from the National Audit Office in England stated that 27% of patients said it was not easy to get through to their GP surgery on the phone. This was a rise from 19% in 2011-12.

The role of reception staff in facilitating access to the GP is vital. The RCGP NI has highlighted the need to *“invest in training for health professional administrative staff. It is imperative that GPs are supported by a highly skilled, well resourced administrative team.”* As such the role of the RCGP Northern Ireland Practice Managers Forum, which has a remit to identify training needs within their team and share best practice, should be explored in relation to removing barriers for mental health patients. The NHS Practice Management Network guide⁷⁶ highlights the need to involve patients in decisions about the practice and includes ‘consult’ ‘communicate’, and ‘evaluate’ as among its five core principles. It states the importance of consultation with patients about systems in the practice and highlights that the GP practice’s booking system must be transparent and easily understood and warns against operating a ‘telephone lottery’ and requesting patients call back at particular times.

Potential solutions to consider include an ‘Auto Alert’ system similar to the ‘red flag’ system recommended by the Mental Health Rights Campaign which is described in the NHS Practice Management Network guide. The system would alert receptionists to a patient’s particular needs enabling them to respond accordingly. According to the guide; *“most GP systems provide auto alerts or flags that ‘pop up’ on the computer screen when a patient’s details are accessed.”*⁷⁷

⁷⁶ *Improving Access, Responding to Patients: A how-to Guide for GP Practices’* NHS, 2009, http://www.practicemanagement.org.uk/uploads/access_guide/090702__improving_access_responding_to_patients_final.pdf 1

⁷⁷ *Improving Access, Responding to Patients: A how-to Guide for GP Practices’* NHS, 2009, http://www.practicemanagement.org.uk/uploads/access_guide/090702__improving_access_responding_to_patients_final.pdf 114

A further option to be considered is the AskmyGP system currently being trialed in part of Belfast and Derry which involves the implementation of a telephone triage system. Patients access AskmyGP via a link from their GP practice website and answer a series of questions about their symptoms. This enables the GP to quickly assess the best way to help the patient and decide whether they need a face-to-face consultation. Normally, a same day response is provided.⁷⁸

CASE STUDY

An observational study of 463 GPs in England revealed that primary care practices that implemented the use of “open access scheduling” – also known as advanced or same-day access – has shown favourable results and demonstrated a reduction in wait times. Telephone consultations or follow-ups have been reported as a successful intervention to reduce wait times for primary care appointments.⁷⁹ Additionally, telephone consultation has been shown to be beneficial due to its ability to improve public access to medical information, and ensuring adequate follow-ups for individuals affected from chronic care conditions. By offering more efficient methods of communication, unnecessary appointments can be eliminated, which in turn enables additional patients to see their GP in person.⁸⁰

7.3. OVER-USE OF MEDICATION

Solutions proposed include the following:

- **Longer appointments including option of routinely booking a double appointment for mental health issues**
- **More mental health expertise among GPs**
- **Provision of counselling and/or CBT on site**

In our surveys and focus groups it came out clearly that, as well as lack of expertise, there was not enough time during appointments to discuss their mental health issues and possible remedies. This leads to an over-reliance on prescribing medication, at the expense of other treatments (i.e. CBT). The mental health charity Mind has drawn attention to the limits of short appointments in building a positive rapport with a patient suffering from ill mental health.

⁷⁸ See <http://www.hscboard.hcsni.net/our-work/integrated-care/gps/investment-in-gp-practices/>

⁷⁹ Mark Pickin et al., “Evaluation of Advanced Access in the National Primary Care Collaborative,” *The British Journal of General Practice* 54, no. 502 (May 1, 2004): 334–40.

⁸⁰ Dominique Ansell et al., “Interventions to Reduce Wait Times for Primary Care Appointments: A Systematic Review,” *BMC Health Services Research* 17 (2017): 295, doi:10.1186/s12913-017-2219-y.

GPs themselves have also highlighted the problem, with the Chairperson of the Royal College of GPs NI, Dr. John Kelly saying that *“Five or ten minutes is not sufficient, especially for patients who have multiple and increasingly complex conditions”*⁸¹. GPs have also proposed solutions - 72% of GPs surveyed by the BMA believed that *“they should be able to offer longer consultations for certain groups such as patients with long-term conditions.”*⁸² The Royal College of GPs NI has recommended allowing *“practices to adapt their appointment system to meet the needs of their patients, enabling GPs to spend more time with patients with complex needs.”*⁸³ GPs in Scotland are lobbying for their contract to stipulate 15 minute GP appointments as a ‘minimum requirement’.⁸⁴

The challenge for GPs to reduce the level of prescribing of medication is reflected in the Royal College of GPs’ five tests of new models of care, which include the following tests - being person-focused; responding to the needs of the individual and protecting them from over-medicalisation, and; working with specialists to contribute to the holistic care of the individual.⁸⁵

CASE STUDY

*In a pilot study conducted on GPs working in Oslo or Akershus County, Norway, a communication skills training program aimed at improving physician communication skills to decrease emotional distress of their patients showed promising results in improving: (1) responding empathically; and (2) exploring the patient’s perspective. Emphatic responses have been found to be effective in decreasing patients’ anxiety. On the other hand, getting information about the patient’s thoughts helped understanding the patient’s explanatory model and, thus, aids in diagnoses and developing an appropriate plan of action. The pilot study also found that there was a 25% increase in consultation length with consultations averaging 3 min and 48 seconds longer after training than before.*⁸⁶

⁸¹ ‘Delivering Change For General Practice In Northern Ireland’. RCGP NI. 2015

⁸² *General Practice in Crisis*. BMA NI P8

⁸³ *Delivering change for general practice*. RCGP NI. P. 5.

⁸⁴ ‘Scottish LMCs demand GP workload cap, 15-minute appointments and income protection.’ *GP Online*. Nick Bostock. 3 March 2017. <http://www.gponline.com/scottish-lmcs-demand-gp-workload-cap-15-minute-appointments-income-protection/article/1426114>

⁸⁵ Stensrud et al., “Improving Communication in General Practice When Mental Health Issues Appear.” *Patient Educ Couns*. 2014 Apr;95(1):69-75. doi: 10.1016/j.pec.2013.12.005. Epub 2013 Dec 14.

⁸⁶ Dominique Ansell et al., “Interventions to Reduce Wait Times for Primary Care Appointments: A Systematic Review,” *BMC Health Services Research* 17 (2017): 295, doi:10.1186/s12913-017-2219-y.

8. CONCLUSION

Primary care, as the point of first contact with health services, has been described as an inherently a more equitable level of care than other levels of care⁸⁷ because of cost-effectiveness and its ability to narrow health disparities between more and less socially deprived population groups.⁸⁸ GPs play a pivotal role in the provision of mental healthcare with international studies showing that roughly a third of GP consultations consist of individuals with a detectable mental disorder, representing one of the most important groups to seek GPs' advice.⁸⁹

GPs are currently placed squarely at the centre of current primary healthcare reforms, being at the entry point to primary care, and responsible for much of care coordination and patterns of service use.⁹⁰ As such it is vital to get mental health care right.

Many of the issues that have come out through our research echo concerns from GPs and their bodies – under-funding, lack of time, and lack of resource to provide care. The Mental Health Rights Campaign looks forward to engaging positively with GPs and their representatives to implement solutions that benefit both patients and GPs and ensure the right to the highest attainable standard of health is made a reality.

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⁸⁷ Barbara Starfield, Leiyu Shi, and James Macinko, "Contribution of Primary Care to Health Systems and Health," *The Milbank Quarterly* 83, no. 3 (September 2005): 457–502, doi:10.1111/j.1468-0009.2005.00409.x.

⁸⁸ Bo Burström et al., "Equity Aspects of the Primary Health Care Choice Reform in Sweden – a Scoping Review," *International Journal for Equity in Health* 16 (2017): 29, doi:10.1186/s12939-017-0524-z.

⁸⁹ Marie-Josée Fleury et al., "Collaboration between General Practitioners (GPs) and Mental Healthcare Professionals within the Context of Reforms in Quebec," *Mental Health in Family Medicine* 9, no. 2 (June 2012): 77–90.

⁹⁰ Tonje Lauritzen Stensrud et al., "Improving Communication in General Practice When Mental Health Issues Appear: Piloting a Set of Six Evidence-Based Skills," *Patient Education and Counseling* 95, no. 1 (April 2014): 69–75, doi:10.1016/j.pec.2013.12.005.

NOTES



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