The Place of Highland General Practitioners in the Provision of Mental Health Services

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Social Geographies of Rural Mental Health
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Introduction

This report emerges from an *Economic and Social Research Council* funded research project on mental health in the rural Highlands (2001-3). This project primarily investigated the social experiences of users of psychiatric services in four contrasting locations (Inverness, Easter Ross, Skye and North West Sutherland). For a full account of the rationale, methods, background and major findings of this project, see the summary report by Philo, Parr and Burns (2003) to be found at:
http: //www.geog.gla.ac.uk/Projects/website/main.htm.

Throughout the course of this research, the crucial role played by General Practitioners (GPs) in the everyday lives of people with mental health problems became apparent. GPs - whether in rural or urban settings - are the frontline of the health care system. We explored their role in enabling and assisting those with mental health problems, especially in rural areas. Key to this was to identify what GPs see as their role, the problems that they face in fulfilling tasks, the importance and extent of secondary support services available to them and the impact of the Mental Health Framework[1] on their day to day delivery and practice of care. Through in-depth qualitative interviews with a sample of GPs in three of the four study areas (excluding Inverness), we explored these and other issues, such as GP views on the attitudes of the wider community with respect to mental health issues. We also used a bespoke postal questionnaire sent to all GPs practising in the Highlands of Scotland. This survey aimed, through the use of closed and open questions, to elicit responses around the themes mentioned above. Our secondary intention was to 'test' the applicability of information already gained from service users and service providers with regard to the important GP role.

The report is divided into several sections. The first two provide a brief comment on the research methods used, response rates and basic background data. The paper then turns to GPs views on the roles they assume in the care of those with mental health problems. Throughout the remainder of the paper we situate GP roles in the delivery and management of mental health care in a variety of contexts, considering the social, physical, service and policy environments in which they operate. We also consider GP views on improving service provision in their area. What basically emerges from the analysis of these data is that physical geography matters in the daily management and delivery of mental health services in the Highlands. GPs are also acutely aware of the role that places, in terms of their physical, social, cultural and economic location, play in the health and well being of their patients.

[1] The Mental health Framework was published in 1997 to assist joint working in the planning, provision and implementation of mental health services at the local level. Statutory, voluntary sectors as well as informal carers and users of mental health services are involved in the development of strategies. The purpose of the framework is to enable the implementation of existing policy rather than the creation of new policy.

Methodology

Eight in-depth interviews were carried out with GPs across the three study areas of Easter Ross, Skye and NW Sutherland. With the exception of one, where notes were taken, interviews were taped and transcribed with the permission of the GPs. In addition, a bespoke postal questionnaire was sent to all GPs in the Highlands, with the exception of those interviewed: a total of 229 GPs in winter 2002 (see Appendix 1 for a copy of the questionnaire). Fifty-one GPs responded to the questionnaire, leading to a 22 per cent response rate. While this is a low response rate, the data acquired in conjunction with our interviews with service providers throughout the region provides us with interesting and valuable insights into the experiences and views of GPs throughout the Highland region. Given the design of the questionnaire, more qualitative responses were elicited from GPs and we have included some of these responses throughout the report. These are signified by a unique identifier, highlighting the area of origin by LHCC (see Table 1 for signifiers) for example CN01, denoting a GP from Caithness LHCC. In addition, the interviews with GPs in three of the four study areas are denoted by areas descriptor codes SL (Skye and Lochalsh); NWS (North West Sutherland); and ER (Easter Ross). Questionnaires were analysed using SPSS to elicit descriptive statistics, such as frequencies and cross tabulations. The questionnaire also elicited qualitative responses and these data were incorporated into a more qualitative analysis alongside the GP interviews.

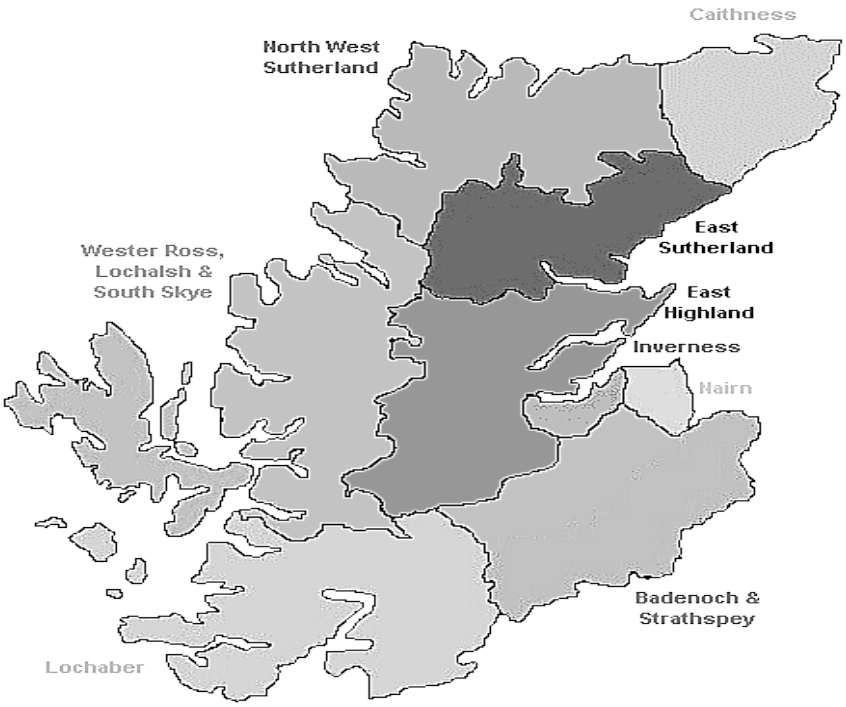
The Highland LHCC areas are diverse in terms of socio-economic characteristics and physical landscape (see map 1). Table 1 outlines the various response rates from each of the LHCCs within Highland with Inverness, Wester Ross and Lochaber comprising almost three fifths of total responses. Response rates vary, with Wester Ross and Lochaber having the highest rates, and Nairn, Caithness and Marginal[2] practices the lowest.

Table 1: Response rates from each LHCC

Practice area and signifier		Q sent	Q received	Response rate %
Inverness	INV	48	9	19
East Sutherland	ES	10	2	20
West Sutherland	WS	5	2	20
Wester Ross	WR	29	11	38
Badenoch and Strathspey	BS	19	4	21
East Highland	EH	48	7	14.5
Nairn and Ardesier	NA	10	1	10
Lochaber	LB	10	23	43
Caithness	C	20	2	10
Marginal Practice	MP	16	2	12.5
TOTAL		229	51	22

[2] Marginal practices are those practices that are situated at the edge of, or within two regions e.g. Highland and Grampian, Highland and Argyll and Bute.

Map 1: LHCC areas



Source: courtesy of SDCMH

Geographically, responses between east and west practices are almost equal (52% east and 48% west). This is in fact a bias toward the west given the relative number of GPs contacted in the west compared to the east, resulting in a 42 per cent response rate of western GPs compared to 15 per cent of eastern GPs. Reasons for this bias in response rate are unclear. However, following from the responses of GPs in the west we may conjecture that this is due to the GPs perceived under provision of mental health services in the west and perhaps therefore more of an impetus to respond to this issue.

Background information

The bias toward the west is reflected in the categorisation of practice areas, with 37 per cent of respondents (n=19) describing their area as 'remote' compared to 12 per cent (n=6) describing their areas as 'urban', all of which were located in the Inverness LHCC. Just under a third (32%, n=16) of GPs described their practices as 'mixed urban rural'. Practices varied in size from 150 to 11,500 patients. The mean patient list size per GP is around 1000. Two thirds (n=34) of GPs who responded have been in post for over five years, many of whom have been in post for over ten years, while 8 per cent (n=4) have been in post for less than a year.

Figures are patchy for diagnosis levels throughout the areas. As one would expect, rates of depression are higher than for the psychotic illnesses such as schizophrenia and bi-polar. GPs were divided on the issue of underdiagnosis with 42 per cent (n=19) of those who responded believing it to be a problem in their area, while 37 per cent (n=17) did not

and 21 per cent (n=9) being unsure. Of those interviewed, a number noted that mental health featured as a significant component of many of their consultations, with one suggesting that 60 per cent of consultations featured such a component:

> *A lot of, a quick audit of consultations which I did, about a year ago, there's something like 50/60 per cent of all consultations have a mental health component, so it may not be the prime reason for people coming, but there's something else there, there's anxiety or there's depression or there's something else. There's an underlying part of that consultation, so a large proportion of the work that we do is about mental health.* [GP2, SL]

Another GP comments:

> *[P]robably 40 per cent of consultations with doctors have a psychological basis for the consultation, that varies from doctor to doctor of course, but that's a huge aspect of our work and within that when I say psychological, within that I would include mental illness.* [GP1, SL]

The findings below represent key themes which have emerged from both interview and questionnaire data, and expand on GP perspectives on mental health issues.

GP Roles

Unsurprisingly, GPs in both the east and west of the region, and also in urban and rural practices, view themselves as being 'front-line' in the delivery of mental health care in the Highlands, by virtue of their role as gatekeepers to secondary care services. Again, understanding the roles played by GPs in the Highlands in relation to mental health requires attention to the social and physical geography of the area in which GPs operate. Some rural GPs question the extent to which their urban counterparts address mental health problems to the same depth as themselves, suggesting that, due to where they are based and the resulting problems of access to secondary support services, they are perhaps more likely to attempt to deal with an issue first before referring onto secondary services, one comment was that: *'The practices to a large extent out here are on their own to deal with mental health problems'* [GP6, NWS]. Similarly:

> *I think we're taking perhaps more responsibility for where their care should be. Obviously that's relying on our experience and any mental health training we've happened to have here and vocational training during the course of our general practice careers. So yeah, we're a bit relied on to make ... the only extra decision we're really making is what facilities they need centrally in Inverness, if any, or whether we can manage them out here. In essence, that means a high case load for the CPN, the only CPN too available for the north and west coasts.* [GP5, NWS]

This burden is seen to be partly a function of the lack of local services focused around mental health, with the GP and CPN often being the only daily professional support available. In light of the practical problems in terms of accessing Inverness for care, GPs will often attempt to deal with an issue on their own before referring onto secondary services. GPs draw upon the specificity of working in rural and remote areas to

understand the breadth of roles that they adopt, although some are unsure whether this is any different to the experiences of city based GPs: '*I don't know – maybe we don't refer, try and treat first. I don't know if we do that more than city GPs.'* [GP3, ER]; *'I think part of it as well is that we manage a lot of things here because we don't have services so it would only really be the unmanageable that would go off*' [GP7, NWS].

GPs describe their role in the care of those with severe and enduring mental health problems in diverse ways, highlighting the variety of support provided by themselves on a day to day basis. Table 2 represents the main management roles. As can be seen, GPs understand their roles to be diverse, ranging from the management to the delivery of care.

Table 2: GP Roles

Roles	Count	Responses %	Cases %
Co-ordination of care	27	21	60
Monitoring of patient	25	19	56
Main carer	16	12	36
Referral to agencies	16	12	36
Medication	15	12	33
Diagnosis	12	9	27
Support for family	6	5	13
Support for patient	12	9	26
Total	**129**	**100**	**287**

However, the roles performed by GPs are not only expressed in terms of functionality or utility, but also in relation to what this means for the GP personally, with one GP expressing their role as '*important, consistent, stressful, satisfying'* [IN39].

GPs were also asked about other types of services they provide in their practices and the relative importance of such services (see Table 3). Emphasis is placed on a range of interventions, relating to both chemical and talking therapies, although as we discuss later, access to talking therapies beyond the GP/CPN-patient relationship can be difficult for rural residents. GP interviews corroborate the importance placed on talking and listening to patients, with some feeling that opportunities to talk with patients are perhaps more available in rural areas due to smaller practice lists:

> … *we spend time with patients here, and if they need half an hour or 45 minutes we take the view that it doesn't matter if the surgery is busy, they will get the time that they need, and if anybody complains they are told if you need it you will get it as well, so don't complain. The patients accept that if we are running late it's because there are genuine problems.* [GP7, NWS]

Table 3: Interventions offered by GP

Roles	Provide service %		Very important	Important	Unimportant	N
	Yes	No				
Counselling	70	26	50	41	9	49
Administering drugs	56	36			8	47
Prescribing drugs	96	2	72	26	2	50
Psychological therapies	18	72	34	61	5	46
Talking/listening to patients	96	2	85	15	0	50

However, the desire for more talking based therapy provided by GPs themselves or secondary care services is juxtaposed against the reality of stretched service provision in the Highlands, as we discuss later.

While it may be argued that the experiences of Highland GPs are not so very different from GPs throughout the country in relation to the roles played in the delivery and management of care of those with mental health problems, there are, we would argue, specific issues which set the experiences of Highland GPs apart, particularly in the west. Overall, there is a sense in which GPs working in remote and rural areas are operating within a context of isolation: social, physical and service isolation which determines the roles in which they find themselves.

Challenges

A range of challenges face Highland GPs, many of which have at their root the vast physical environments in which their practices are located. Many of these issues relate to access to care. Distance to just about anywhere, but particularly to specialist care services primarily located in Inverness, is a major issue, with 51 per cent (n=24) of respondents mentioning it and a further 20 per cent (n=10) suggesting that distance in general is a problem in providing effective mental health care in rural and remote areas. As we suggested earlier in the report, interviews with GPs suggest that they are more likely to try to deal with a patient in the locality before referring patients to Inverness. In part this is due to the long distances required to be travelled by patients to receive services. The need for patients to travel to services located in Inverness is felt by many GPs to be unfair to patients, particularly given the nature of their medical conditions, which at times means that travelling can be a distressing and emotional experience:

> *Someone who requires a psycho-geriatric assessment will have 165 miles round trip to get it which is probably not very good for orientation if you are already confused, and if you have a partner ... it can mean for example taking two 80 year olds for a round trip of 165 miles to Wick, which is extremely poor.* [GP6, NWS]

Furthermore given that many people with mental health problems are not in employment, the costs of travelling to Inverness can be prohibitive, and GPs throughout the interviews and questionnaire are sensitive to the impact/role of rural poverty and deprivation in the areas where they practice. This can also impact on patients ability to access the local practice where clinics with psychiatrists, psychologists or counsellors may be available.

GPs have also raised the problem of the social and professional isolation facing them with respect to living and working in rural and remote practices. Isolation is mentioned by 11 per cent (n=5) of GPs, with a number reflecting upon professional isolation felt when working in small rural practices. Social isolation, bound up with problems of living and even socialising alongside patients in sparsely populated areas was mentioned, and reflected GP concerns over confidentiality in rural and remote practices. One interviewee mentions the issue of the health of professionals in this context, noting that:

> *You've got problems with access, you've got problems about perceived confidentiality, all sorts of difficulty about people actually getting time to go and see someone and certainly the evidence that seems to trickle in is that there are a lot of people, [with problems]*. [GP2, SL]

This issue surfaced within the GP questionnaire, with one GP noting that:

> *One difficulty often completely overlooked when designing a service (based on national guidelines perhaps) is the issue of confidentiality. What happens when patients who need a service are also workers in professions involved or working closely with those who provide the service?* [LB15]

GPs also highlight the needs of acute patients, largely in respect of emergency sectioning and quick admission to hospital. This is seen as a problem for those in the more remote and rural practices. 45 per cent (n=21) of all respondents mentioned this as a problem in providing effective care. Difficulties in sectioning revolve around the time taken for support to come from New Craigs hospital and the resulting time spent by the doctor with the individual needing care, with figures of between seven and thirteen hours not uncommon. Not only is this felt to be detrimental to the health of the patient, but can also have implications for physical safety as well as legal status of the GP. GPs are often called upon to section someone without the presence of a mental health officer due to the distances to be travelled.

Furthermore, the use of police cells as a place of safety, while felt to be necessary due to the lack of designated spaces, leaves the police in an exposed situation: *' we're aware that they themselves are under scrutiny for potentially harming patients or not noticing that patients are becoming unwell and need a doctor, so they're retreating from being as helpful as they used to be'* [GP1, SL]. In the case of emergency sections the physical isolation from the support of secondary care services and the distance from the psychiatric hospital bring very real challenges to GPs. While GPs are aware of the time taken to travel from central Inverness to Skye or North West Sutherland, there is also a sense of frustration over the bureaucracy which can result in delayed arrivals:

> *If it happens say 3 in the morning you will not get an escort until the morning shift comes on, and then when they come on it will take two or three hours to organise it, and I have seen me sitting with a fisherman in Kinlochbervie on his boat from 1 in the morning through until 8.30 when the morning staff come on, and then another two-and-a-half hours before he can be escorted* ….[GP7, NWS]

Emergency sectioning and place of safety issues do not often arise in practice, but from GP interviews it is clear that GPs are nonetheless concerned about such procedures.

GPs have also experienced problems in access for those who require rapid but routine admission to hospital:

> *What we think is – and what I think most GPs think is - you're the guy on the job with the patient, with the big, big trouble and the guy on the other end of the phone might be better qualified than you – in fact it's usually not, it's usually an SHO [Senior House Officer] – and for him to say, 'I'm not taking your patient' is pretty hard to swallow, you know, and I don't think it should ever happen. I think they should see the patient and then they can decide what they're going to do then. But people have been faced with that – I haven't actually. Maybe I shout louder than the rest of them. I know a guy in Fort William who literally sat on top of a patient for three hours while they were arguing up and down on the phone whether the consultant would take the patient. That's uncivilised, apart from anything else.* [GP3, ER]

This section has briefly reviewed some of the problems facing GPs in providing effective mental health care in their areas. In the following section we explore in more detail the role of specialist mental health services and the experiences of GPs in accessing these services, this being identified as a significant problem for GPs.

Access to services

> *Well, the provision of specialist services has been pretty poor actually – patchy. Generally speaking, the quality of the people – you know, the professionals involved is high, generally speaking - it's just that they're not there. They either don't exist or they're on maternity leave without cover, or they're moving job - you know, there's a big turnover, or there seems to me to be a big turnover, but largely they don't exist. I've certainly complained for 15 years, 20 years about the lack of things like clinical psychologists and it's still a huge problem. So we're dealing with things because there aren't other people there to deal with them.* [GP3, ER]

While GPs see themselves as providing a frontline primary mental health care service, there is a strong opinion that rural areas are under-provided with respect to the specialist mental health services. In essence, many argue that there is no effective secondary mental health service in their areas. This section reviews the importance that GPs ascribe to each of these services, and also their views on the temporal and spatial availability of these services. Table 4 provides an overview of care services. Table 5 provides an

indication of where these services are primarily located, and Table 6 provides details of when these services are available.

Table 4: Relevance of mental health services to General Practitioners (%)

Service	CPN	Counsellor	Psychiatrist	Psychologist	Mental Health Team
Extremely important	66	10	44	12	43
Very important	33	34	32	35	33
Relatively important	4	20	20	16	14
Somewhat important	-	10	4	14	6
Not important	-	8	-	4	-
Not available	-	18	-	18	4
Total N	50	50	50	49	49

Table 5: Where mental health services are available (%)

	CPN	Counsellor	Psychiatrist	Psychologist	Mental Health Team
In practice	43	30	20	8	2
In locality	55	15	57	37	89
Inverness	2	31	22	39	7
Not available	-	34	2	16	2
Total N	50	47	50	49	45

Table 6: Availability of services (%)

	CPN	Counsellor	Psychiatrist	Psychologist *	Mental Health Team
daily	38	6	8	3	57
weekly	43	21	28	19	23
fortnightly	14	9	28	3	8
monthly	5	15	36	47	8
not available	-	49	-	28	4
Total N	42	33	33	32	26

* see discussion below

Through interviews with service users, community psychiatric nurses (CPNs) are identified as crucial for supporting people in rural and remote communities, and this finding is supported by GPs in their responses and discussions of the role of CPNs in their practices. CPNs are perceived to be extremely important in the delivery of care in

rural and remote areas, with 66 per cent (n=33) of GPs describing their role as such and 30 per cent (n=15) as very important. GPs suggest that CPNs are 'key' to the delivery of mental health services in their areas [IN39], with one respondent noting that CPNs are *'the essential component, CPNs deliver - we assist them'* [CN06]. As one GP comments, CPNs often take much of the burden of ongoing care from GPs:

> *Mental illness per se, in terms of consultation rate with us, I can't quote you figures, I don't have them with me, it's not a heavy burden on us as a GP centre, compared with 12 years ago when we didn't have community psychiatric nurses and we didn't have the Cabin*[3]*, … [we are] very aware that CPNs and mental health social workers and the Cabin really take up the main burden off us in our day to day GP work* [GP1, SL]

GPs describe the variety of roles adopted by CPNs in assisting GPs with the delivery of care to those with mental health problems. Principally, the support offered directly to the patient through home visits and counselling are felt to be of great use, as CPNs can arguably spend more time than the GP with the patient, talking through their experiences and feelings [ES10]. For this reason CPNs are important in the reviewing and monitoring of patients progress, given their more sustained contact with the patient over a longer period of time; and a number of GPs comment on the importance of CPNs as a source of advice. CPNs play an important role in the management of care in rural areas alongside their ability to liase with and provide a link for the GP to other agencies involved in the care of mental health service users, such as Social Work.

GPs are acutely aware of the pressures facing CPNs, not least the time spent travelling to reach patients at home:

> *[O]ne CPN who has a caseload bigger than her town [colleagues] and does 2,000 miles a month, now that is clearly nonsense that they don't take into account her travelling time effectively: she is often not home until 8 – 9 o'clock at night, it's criminal that the Trust has not provided resources to have a second CPN.* [GP7, NWS]

> *We know the CPNs cover a huge area, I talk about the size of my practice area but the CPNs cover Skye, Lochalsh and possibly Wester Ross as well, certainly Skye and Lochalsh, so and they can spend most of their days on the road* [GP1, SL]

Again, the geography of the area is a significant obstacle to be overcome, eating into the time available to spend with patients, which is hence to spoil one of the greatest assets of the CPN service to GPs. According to some GPs, the workload faced by CPNs is an issue not only for the CPN, but also hinders effective communication and joint working between GP and CPNs, as time spent travelling huge distances means less time to discuss and review patient care:

[3] The Cabin is a drop-in centre for people with mental health problems run by the Skye and Lochalsh Mental Health Association in Portree, Skye.

So it would be useful I think to have a little bit more contact between us and the CPNs, but they're very short of time and I would suspect that probably tied up most of the time with seeing patients [GP2, SL]

The lack of an out-of-hours CPN service is of great concern to a number of GPs who feel that this would improve mental health care in their areas. GPs also perceive there to be a problem in the absolute numbers of CPNs available to cover large geographical areas, with over a quarter of GPs identifying shortages in CPNs as hindering the provision of mental health care in their areas. GPs advocate that geography should be the key factor when determining resource allocation, rather than by per head of population measures, as is the case at present.

In their responses, 44 per cent (n=22) of GPs who responded to the question believe psychiatrists to be extremely important in assisting in the delivery of health care, with a further 32 per cent (n=16) designating them as being very important. Psychiatrists assist GPs in a variety of ways, from the review and monitoring of patients, providing medication and treatment advice to referral to other services. Their role in acute patient treatment is also thought to be of importance, particularly in ensuring admission to hospital.

GPs value psychiatrists' efforts to maintain clinics in the localities, feeling that this provided not only important opportunities for contact with the patient, but possibilities of maintaining and strengthening links with others involved in the delivery of care:

[Consultant] comes out and sees people in the surgery here on occasions which brings the psychiatrist out and gives us the opportunity because I have to come and unlock the surgery and let him in and lock up after him, it gives us the opportunity to talk over the management of people which is extremely useful. [GP2, SL]

However, the recruitment and retention of psychiatrists is felt to be a particular issue, with GPs from a number of areas (notably Lochaber, and North West Sutherland and East Highlands) pointing to recent examples of no consultant psychiatrist being available for their area, coupled to problems with the use of locums.

While GPs recognise the value of talking therapies provided by either themselves or others specifically trained, many encounter problems in securing the services of a trained counsellor. Counsellors may simply not be available at all, or may be located in Inverness, or visit so infrequently that their usefulness is undermined. As GPs comment:

… the evidence base is that talking therapies is as good as drug therapies. But if there isn't a talking therapist round the corner, I guess it's [drug] treatment my patient gets and that's just being pragmatic and using what's available. And also not being used to having these people around. [GP3, ER]

GP: *I used to feel that there was a dual role, if you like, for the chemical therapies and the talking therapies. And I felt that if you got, if somebody was depressed, if you relieved their depression then they were in a better position to*

take advantage of the talking therapies to deal with the issues that were maybe the cause of their depression.
I: *It just seems intuitively those things could work together.*
GP: *Yes, that's right. Yes, yes. And they work very well in practice because they were in the practice, they were seen in the practice and then of course when they've been seeing you and talking to the counsellor or the psychologist …* [GP8, NWS]

One practice offers a perspective on the relative benefits of using a counsellor:

She was a trained counsellor, and that input, if you look at it hard you may say well the patients didn't really benefit, they were not really that much better, but from our point of view as GPs it took the stress off us. It gave us something else to use other than a therapeutic drug therapy intervention and the patients felt the benefit of it, but I mean I know a lot of trials have shown that counselling is not better than a good chat. Yeah, fair enough, but somebody has got to have the time and the ability to direct that chat to the patient's benefit. [GP7, NWS]

As can be seen from Tables 4, 5 and 6, psychologists are seen to provide a very important service, a position reiterated by GP interviews. Yet the availability of this service is a source of concern for GPs, with eleven per cent of GPs identifying this as a continuing difficulty that they face in providing health care in their area. While almost half stated that psychologists are available on a monthly basis, almost a fifth declared that this service is not available; and a number clarified these remarks by noting that the length of waiting lists for psychologists (with figures of 12 to 18 months) means that, although on paper psychologists are available, in practice they are not:

they're very short staffed, but they're an extremely useful part of the management of a lot of mental health … I think clinical psychology for a lot of people with mental health problems is perhaps more appropriate and with longer term benefit but its a very difficult job to access clinical psychology services. [GP2, SL]

Presently there is an 11/12 month wait for patients to be seen by clinical psychologists at [a] local clinic … I have recently got an "urgent" psychology appointment for a patient that will only have to wait 7 and a half months - this is not a service [EH22]

Coupled with the need for patients to travel to Inverness, which as we have already indicated can be a financial as well as an emotional burden, means that this service's value to GPs is severely curtailed.

A final point regarding service provision relates to the mental health care needs of discrete groups. A number of GPs have commented on the need for the development of child and adolescent mental health services in the region and one GP observing that '*We see younger teenage groups now who are – we see true depression in teenagers which I was not aware of previously'* [GP3, ER]; and:

> *[There] [a]bsolutely needs to be much greater recognition of child and adolescent mental health problems as the starting point for many adults and resources required to provide an adequate mental health service for young people which at present is grossly deficient.* [WR 25]

To summarise, while rural GPs see specialist services as being important in the delivery of care to those with mental health problems, they believe that they are under-provided in terms of availability. The recruitment and retention of staff have been highlighted as particularly important issues in relation to psychiatrists and psychologists. The vital role played by CPNs in the delivery of care is acknowledged alongside a shortage in CPN availability, and the limits to what CPNs can realistically achieve given the geography within which they operate. Again, the geography of the Highlands is central in GPs' interpretations of service provision in their area. Indeed, GPs are well aware that problems of specialist services travelling to remote and rural areas or of patients travelling to Inverness present a significant challenge in the delivery of care. GPs are not unaware of the problems facing those planning services for an area such as Highlands. They do, though, believe that it is unacceptable that patient care should be compromised because of *where* patients live. They therefore question the equity of the current provision:

> *[The state] does not fulfil that responsibility, does not give equity of access to the people in remote areas … they talk about it, but when it comes down to it, it is acceptable for my patient to travel 2½ hours to Inverness, and maybe has to share a car on the way back which takes them via Ullapool … Beauly and everywhere else, maybe leaving home at 8 in the morning and not getting back until 8 at night for a 1 hour appointment in Inverness. That has happened regularly.* [GP7, NWS]

In a later section we briefly review GP views on alternative service futures, noting what would enable them to fulfil their role in improved ways.

Social and cultural aspects of care

GPs are aware not only of the impact of physical and service environments on the provision of effective mental health services in their practices, but also comment on the importance of the social, economic and cultural environments. Rural deprivation is perceived to be a significant factor in the mental health of the population, with GPs pointing to 'fuel poverty' and seasonal unemployment as affecting the mental health of their practices:

> *Lower fuel prices would be less of a burden for those paying more fuel tax than income tax. Poverty, especially fuel poverty is a significant factor in the mental health of the area.* [EH33]

> *I mean I was told when I interviewed for the job that there was a high, a fairly high incidence of mental illness, and certainly … that was relating to the social circumstances, lots of unemployment, particularly seasonal unemployment. The dark nights, whether it's classical or seasonal affective disorder, but certainly*

the dark nights, people, it does depress people. Maybe just because in winter they're out of a job. And because there's a lot of alcohol. [GP8, NWS]

Oh yes, they're absolutely scraping a living here … Yeah, if they [people with mental health problems] could get employment elsewhere in a more urban-type atmosphere, more facilities, I think their mental health would be better because their finances are better. And their habit of socialising through the bar perhaps would be less than for some of them. There'd be more things to do. Absolutely. [GP5, NWS]

The final two quotes both end on the significance of alcohol as a means of socialising in rural communities. The complex relationship between alcohol and mental health present GPs with challenges as they seek to diagnose and care for people with mental health problems.

Apart from economic influences, the Highlands contains distinctive social relationships. The nature of rural places means that while people may be physically distant, they are nonetheless perceived to be socially proximate, a situation impacting on the social and professional lives of service providers as noted earlier. The visible nature of Highland rural lives is felt to be of particular relevance for service providers and those with mental health problems, since daily lives are routinely surveyed and subject to community gossip, the social practice through which rural lives are made more visible. Fifteen per cent (n=7) of GPs recognised that issues over confidentiality and the lack of anonymity was one of the difficulties in delivering care. Interviews with GPs reiterated the role of gossip in rural areas, recognising that this could be a force for good or ill:

I don't think they talk about ... people who have mental health problems stand out in a small community and I don't think there is any inhibition about talking about other people's mental health problems … you know so and so has ... [GP6, NWS]

You know, everybody's aware of other people with problems and have their own opinions as to what they should do and what we should do! [GP5, NWS]

I: *So there's an issue that people maybe aren't feeling sort of very obviously supported but people are sort of keeping an eye out on people, there's a level of positive surveillance if you like*
GP: *Yes, very much so, and in the smaller the community the better the kind of surveillance, which of course quickly strays into sheer nosiness and lends itself to gossip and that comes up as being malicious gossip* [GP1, SL]

Of those who responded (n=40) two thirds (n=27) believe that stigma still exists around mental health issues in their practice area, with a further 12 per cent believing that people feared mental health problems. The following direct extract from a GP Questionnaire neatly summarises many of the issues raised by users and service providers alike in the study areas:

There are stigmas surrounding mental illness based on lack of understanding, collective sub-consciousness of Victorian images of insanity and locked doors

and the desire for family privacy on matters of difficulty, whether emotional or financial, that is common in rural communities in which anonymity is not an option. [WR25]

However, despite such high figures, many GPs believe that, although stigma does still exist, it is reducing significantly and is much less of an issue than in the past. GPs have related to us many instances of tolerance and understanding from the local community through a variety of 'caring acts'. From Table 7 the importance of close networks of family and friends, as well as the wider community, are deemed to be important in the care and support of individuals with mental health problems.

Table 7: The importance of local communities in the caring for those with mental health problems (%)

	Family	Friends	Church	Local community groups
Extremely important	63	41	10	7
Very important	31	39	14	4
Relatively important	4	16	33	30
Somewhat important	2	4	31	35
Not important	-	-	12	14
Total N	49	47	49	43

A quarter (n=10) of GPs believe their communities to be tolerant of those with mental health problems while 30 per cent (n=12) believe communities to be understanding towards this group. In other words tolerance and stigma are reckoned to co-exist within communities. GPs suggest that community tolerance for mental health problems is in part determined by whether the patient is designated an incomer or a local:

I think the community is accepting that somebody has had a problem, less so if it was a major psychotic illness like schizophrenia or manic depression on an outsider. If it was a local person – one of our manic depressives is a local and people accept it – "Oh that's just Mr x, that's what he's like", they get on with it and accept them, on the whole he is fairly stable on that. There's never been a great problem. Incomers who come in with their problems, they would not be assimilated back very well. If they come in and they develop a problem but they have established themselves in the community - we have one schizophrenic who developed his problems after he had established himself in a fishing community here - he has been accepted back quite well, you know it's not been a major problem, but if he had come in as a schizophrenic wanting to move to the Highlands I don't think he would have ... I think they have driven him out by default you know. [GP7, NWS]

A third of GPs who responded (n=33) believe community experiences of mental health issues are of importance in influencing attitudes. Other influences on attitudes include the media such as television and radio (39%, n=13). Interestingly, just under a third believed what they term 'traditional values' has an influence on attitudes towards mental health, although this is not described in any detail. A small number of GPs (n=5, 15% of respondents) comment that religion is an influence on attitudes in the Highlands, a point also suggested by users of services:

> *I have been a GP for 18 years …[in various rural and urban practices]. I have found a problem here that I have not encountered before in that some "religious folk" talk of depression as being a sin! This greatly hampers patients progress and understanding of their condition. There can be a culture of 'covering' with mental disorders … often not acknowledged by the families affected.* [EH22]

> *There is a stigma especially in the older age group – often tied to religious beliefs.* [WR09]

> *I'm sure the church must have had some role over time – 'the devil within', people who have God in their life won't have these problems etc.* [WR25]

Significantly, almost three fifths (58%, n=24) of GPs feel that local attitudes toward mental health affect people's willingness to access services, while 10 per cent (n=4) are unsure. Following from this, 60 per cent of those who responded (n=35) believe that there is a need to raise community awareness of mental health issues in their area. Awareness of the stigma of mental health problems, coupled with awareness of the visible nature of rural lives and distinctive cultural beliefs has meant that GPs are sensitive to the issues of delivering care in remote and rural practices:

> *I think its almost, its not even distinctive Highland, this is different from the Western Isles which are different again from Shetland or Orkneys, but its certainly, … there tends to be a feeling, and it is only a feeling that there's a barrier, that they're not comfortable talking about personal issues with you, and I think that's a thing you find far more with people who are local than [with] people who have come in, but there is just this feeling sometimes that local are reticent, slightly enclosed, slightly difficult about opening up to people.* [GP2, SL]

> *One of the things about working in an area like this is to some extent to try and fit in and not come with your own ideas and say this is this and that is that, this is what's got to be done. You have actually got to step back for a while and see how things work before …* [GP6, NWS]

In summary, GPs are therefore not only aware of the impacts of the physical geography in which their practices are situated, but are also sensitive to the social and cultural frameworks in which they are working within, recognising how both aspects shape access to mental health services.

Alternative service futures

Inevitably, GP solutions to the everyday realities of providing a service in the Highlands have at their heart a need for more resources, both human and financial. Underlying such responses is a belief that the unique geography of the Highlands must be taken into consideration during the planning and allocation of resources, with clear attention paid to GPs' predominant position in providing such care in rural and remote localities:

> *Better regional planning and greater recognition of the special needs of remote and rural communities and acceptance of the greater cost in providing an equitable service to such areas. Better recognition and support of primary care role- possibly of CPNs who are primary care based.* [WR25]

Or, as one GP states, *'They should have designed the service to fit the needs of the area and not trying to force the area to fit the design of the service'* [GP7, NWS]. One way of tackling the resource issue is to change the way in which resources are allocated, with GPs suggesting that geography (land area, road distances to be travelled) should be a factor as well as population size. One GP notes that the idea of a notional list could be employed to calculate resources, in this example numbers of CPNs available for an area:

> *So they multiply my actual list by various factors, including the mileage. One of the biggest things is mileage. So they actually ... so I get a notional list of something like 3000 based on a complicated calculation. And really that's what they should do for CPN services. So if you have a CPN for every, you know, 3000 patients, no it would be more than that wouldn't it, a CPN for say 10,000 patients in Inverness or Edinburgh or Glasgow, then you should factor up the same calculation and say right in Sutherland we should have 3, 4, however many CPNs it takes to get up to that norm.* [GP8, NWS]

GPs offer a variety of ways of channelling these resources in responding to the difficulties of provision, reflecting in part their own needs in their areas when dealing with both acute and chronic users of services.

Reflecting the concern with the lack of locally based services, 40 per cent (n=11) of GPs feel that a local-based service is required in order to alleviate the problems faced in the delivery of mental health care. This would not only improve provision but would have a positive impact on changing attitudes towards mental health in these communities, as the following GPs suggest:

> *It comes back to this coordinating co-locating services, and if Portree surgery had a psychologist working alongside them people would see psychology and psychiatry perhaps as being part of the mainstream, rather than seeing it as being something that has to be brushed under the carpet. You know, you don't say to your friends "Look I went to see a psychiatrist today because.." … [I]f you bring it all under one roof, then perhaps you can get away from stigmatisation and the misapprehensions, the whole problem about what people think of mental health, and how they handle mental disease and so on, but*

that's manpower, it's planning, it's all of these issues, it's money really,[GP2, SL]

Well identified community mental health team has helped to raise awareness of issues and reduce stigma. [NA08]

These comments link in with how policy and practice can play an important role in changing attitudes towards mental health through providing services in the community. It is interesting to note that the GP NA08 is based within Nairn and Ardersier LHCC, which does have a well-developed locality based mental health service, in contrast to GP2, based on Skye.

GP3 provides an alternative argument, however suggesting that a 'core of expertise' centred around Inverness should be available from which the Highlands can draw upon:

I think that services – specialist services should be concentrated in Inverness and that way, you get a core of expertise all in the same place and patients can travel. Patients in the Highlands are used to travelling for services ... So I – so there's a perception that it's difficult for patients to see the specialist. It's a perception and I think the benefits of centralising the specialist service outweigh the disadvantages. [GP3, ER]

Unsurprisingly, many GPs suggest that more CPNs be made available (45%, n=14). A number of GPs suggest that practices could be re-imbursed for employing practice-based CPNs.

Support services are also deemed to be of importance such as day hospitals, supported employment, drop-ins – again locally based – and support workers to assist those with long term mental health problems. Following from GPs' desire for more talking therapies (see earlier), and from users' own preferences, 26 per cent (n=8) feel that a better psychology service is required alongside 10 per cent (n=3) who require more counsellors to be available. In relation to addressing acute patient needs just over 20 per cent (n=8) of GPs suggest that a place of safety is required in their locality alongside rapid response to such situation by the secondary mental health services, while a number suggested that out of hours CPNs would be advantageous (35%, n=11).

GPs are keen to have access to advice, even by telephone, with one suggesting that a weekly phone in clinic to secondary mental health care providers would be useful. Additional training and learning from regular contact with others involved in mental health care delivery is also felt to be of importance in addressing issues. In response to a question about training, a significant finding is that of those who responded (n=46), 72 per cent (n=33) would like additional training in mental health. Clearly, given GPs' perception that they principally provide mental health care in their areas, this desire for additional training is understandable. Many, however, feel that, while they would welcome such training, given time constraints such an opportunity could be impractical.

GPs are seeking to care for their patients within their local communities and are looking to the specialist mental health services to enable them to do this. As one GP comments:

> *Often resources … allocated to specific clinical areas e.g. mental health or whatever, get allocated to those who do that specialist task - missing the generalist (GP and district nurses) who often make the most difference.* [LB15]

Views from the fringes

Throughout this paper, GPs' awareness of the impact of the physical and social environments in which their practices are situated has been highlighted. In this final section we consider GPs' views on the implementation of the Mental Health Framework. In their responses, GPs utilise a variety of spatial scales to make sense of their current situation. Of those GPs who responded (n=33), 60 per cent believe that the Mental Health Framework had had *no* impact on their delivery of care. Nonetheless, a few do believe that some changes are apparent, with a quarter (24%, n=8) of respondents believing that it has improved long term care and a further quarter stating that there has been improved inter-agency working. Seventy per cent (n=26) nonetheless see no change in their role in the future with respect to this policy.

The low level of GP involvement in the Mental Health Framework implementation meetings appears to be due to structural practices that effectively block the efforts of GPs to get involved. Primarily this involves the lack of appreciation of the distances involved for many rural GPs, and also the lack of support given to GPs to attend such meetings:

> *[T]he difficulty is, if you're single-handed, you can't check on these things so it's unusual if you get consulted, fairly uncommon for people to involve you in policy decisions. Local heath care co-ops should take on a role, I think, in co-ordinating delivery of planning, delivery of health services funding and delivery, but again you see it's the difficulty in getting off from your work, to get away to meetings; providing times when they clash with surgeries; or when you can't be away from the area you practise because you can't get time off and therefore single-handed people are people who have very limited time off, I think, [and] find it difficult to have an input into decisions on planning and service delivery.* [GP2, SL]

> *Have been invited to implementation group meetings, but no back fill available so unable to participate as clinical commitment ongoing. Backfill [is needed] to keep up to date and allow us to become fully involved* [ES07]

GP2 goes on to suggest ways in which these difficulties could be overcome:

> *I suspect that meetings could be held at more appropriate times, consultation could be done by telephone, by letter, … there are ways around that, you don't have to be isolated purely because you can't get to meetings, I mean if it was thought necessary, you could have teleconferencing … there's a whole range of ways that you can include people in decision making, so yes, there are ways around it, yes.* [GP2, SL]

The Framework itself is understood as not being produced with rural areas in mind, and as a result this produces tensions in the implementation of the framework:

Part of it is – when you think of the geographical bit – population distribution – most of the plans come from London and or Edinburgh, and they're city based plans and you simply cannot apply these to scattered – you cannot do it. But that's the Framework that you're supposed to work in. That is a problem and the service is under-served and that's the big problem. Funding, as I understand it, is changing for the worse for us because it's heading more towards per head funding and less from need funding. [GP3, ER]

GPs draw upon 'urban' constructions of the rural idyll as a means of understanding why their predicament does not appear to be understood or addressed by policy makers, who are invariably located in the central belt of Scotland:

I have spoken to the Director of Primary Care at the time, and various other people - I have spoken to Sam Galbraith when he was a minister, and your feedback very much was "oh but you are in such a lovely area surely that makes up for all these disadvantages". There is this huge mind set in the Central Belt on government, even in Inverness, that the disadvantages are made up for [by] the fact that you "live in a lovely area, it's beautiful to come and see it". [GP7, NWS]

There's the thing about government ministers coming on the television and talking about the health service, schools and then saying, you know, they're talking about schools and hospitals and decisions are made which affect us which we don't have a hand in. High level decisions are made by people who do not understand the issues on the periphery. That's really a question of raising the profile of the people who work in rural areas, so that they're seen as being a valid reference point when decisions are being made, at the moment we're looked upon as, ***I feel … we're looked upon as having a cushy job in a beautiful place, and not too much work to do and you know, …*** *I mean, it's probably the same for rural nurses and rural everything else, there aren't many people out here and you know, you see, changing something completely, you see maps that say Vodafone covers 99% of the UK's population, well it does, but there are vast areas out here that aren't covered at all … So yes, the government covers 99% of the population, they forget the sort of fringe is a large area that's not covered effectively, they've not thought about [it].* [GP2, SL, our emphasis]

GP2's observation that the fringes are forgotten is not isolated to the national scale, but is echoed elsewhere. The perception that there is a definite east-west coast divide within the Highland region is apparent:

I couldn't say it clearer than that, the west coast has always been the neglected, poor relation, and if anything happens the money is taken from us and fed to the east, and [I] can cite countless examples of that under the old Caithness and Sutherland NHS Trust. … The resources got pulled from us left, right and centre. We wanted more a central Trust where the spread of resource would be diluted a bit, so that maybe so much didn't get pulled from us, and I think we

did benefit from that. I mean we have seen it. But I mean we have seen it for years, before my time people have complained of exactly the same: we're the poor relation, we've not got a big population. [GP7, NWS]

There hence is a sense then that GPs feel on the margins in relation to influencing policy development and its implementation on the ground.

Other Issues

This section will briefly list other issues that were raised within questionnaire and interview responses. A number of GPs perceive that people from outwith the Highlands with mental health problems appear to be attracted to the Highlands with a number coming in search of peace and solitude and a desire for the rural idyll. This leaves rural GPs with difficulties in attempting to deal with the needs of an unknown patient who may require emergency assessment and admission to hospital [LB12; LB01]. Such situations place additional pressures on rural GPs, accentuating the problems around access to emergency services and support detailed throughout this report. GPs also touch upon the issue of suicide in remote and rural areas, noting the propensity of individuals to travel to the Highlands in order to commit suicide from other parts of the country, with one GP describing this phenomena as 'suicide tourism' [GP6, NWS].

Conclusion

This report has attempted to highlight the roles, challenges, views and concerns of GPs with regard to the provision, management and delivery of mental health care in the Highlands. GPs are the frontline of mental health care and as such they fulfil a variety of roles and face a number of challenges relating to the particular social, economic, cultural and physical environments in which they operate. The physical geography of the Highlands impacts on the delivery of services, due to distances to be travelled by both users and service providers and many believe that the geography of the area should be taken into account when planning and allocating resources. Many GPs believe that their areas are under-provided for in relation to specialist mental health services. As a result they are the main care givers in their localities and more resources could also be diverted to enable GPs to fulfil this role.

Appendix 1

GP Questionnaire
Social Geographies of Rural Mental Health: Experiencing Inclusion and Exclusion

Instructions:

The focus of the questionnaire is on individuals with severe and enduring mental health problems aged between 16 – 65.
Dementia is not part of this study.
If there are questions where you would like to give a longer response, please attach additional sheets, marking clearly to which questions you are responding.
PLEASE RETURN IN SELF-ADDRESSED ENVELOPE PROVIDED BY FRIDAY, 22nd NOVEMBER

Background Information

(Please PRINT responses)

This section is about you and your practice. We realise that we may be able to access quantitative data on Qs 3, 4, 8 and 9, but if you have that data to hand, that would be much appreciated.

Q1 Where is your practice? e.g. Thurso, Inverness _____

_____

Q2 How would you describe the area that your practice serves? Please tick

Urban ❑ Rural ❑

Mixed urban rural ❑ Remote ❑

Additional comments_____

_____

_____

Q3 How many GPs are there in your practice?_____

Q4 Roughly how large is your practice list (number of patients approx.)?

Own practice list_____

Total practice list_____

Q5 How many years have you worked in your current practice?_____

Q6 Do you have any specialist training/particular interest in mental health? Please detail_____

_____

_____

_____

Q7 Would you like more training in mental health? Yes/No

Q8 What proportion (or number if available) of patients in your practice do you identify as having severe and enduring mental health problems?

Diagnoses	Own Practice	Total Practice
Clinical depression		
Shizophrenia		
Bi-polar		
Other (please specify)		

Q9 Is underdiagnosis a problem in your area? Please comment_____

_____

_____

Mental health care in the Highlands

This section is about your role in delivering care to people with severe and enduring mental health problems.

Q1 How would you describe your role in caring for those with severe and enduring mental health problems in your practice?

Q2 Which of these roles do you perform in the care of individuals with severe and enduring mental health problems? Please indicate whether you provide the roles listed below and how important you see these activities in caring for this client group.

Roles	Provision of service		Very important	Important	Unimportant
	Yes	No			
Counselling					
Administering drugs					
Prescribing drugs					
Psychological therapies					
Talking/listening to patient					
Other (please specify)					

Q3 What are the particular difficulties that GPs encounter in providing effective mental health care in rural/remote areas?

Q4 How might these difficulties be alleviated?

Q5 How important are the following secondary care services in assisting your delivery of care to clients with severe and enduring mental health problems? Please tick

	Extremely Important	Very Important	Relatively Important	Somewhat Important	Not Important	Not Available
CPN	❑	❑	❑	❑	❑	❑
Counselling services	❑	❑	❑	❑	❑	❑
Psychiatrist	❑	❑	❑	❑	❑	❑
Psychologist	❑	❑	❑	❑	❑	❑
Mental health team	❑	❑	❑	❑	❑	❑
Other (Please specify)						
_____	❑	❑	❑	❑	❑	❑
_____	❑	❑	❑	❑	❑	❑

Q6 When and where does your practice have access to these secondary support services? Please tick

Service	Location of service			When available			
	In practice	In locality	Inverness	Daily	Weekly	Fortnightly	Monthly
CPN							
Counsellor							
Psychiatrist							
Psychologist							
Mental health team							
Other (please specify)							

Q7 In what ways does the CPN service assist you in the delivery of mental health care in your area?

Q8 In what ways does the psychiatrist assist you in the delivery of mental health care in your area?

Q9 Listed below are other services involved in the care of people with severe and enduring mental health problems. How useful are these services in the delivery of care for individuals with severe and enduring mental health problems in your area? Please tick

	Extremely Important	Very Important	Relatively Important	Somewhat Important	Not Important	Not Available
Statutory						
Mental health officer	❑	❑	❑	❑	❑	❑
Social work	❑	❑	❑	❑	❑	❑
Day centres						
Support workers	❑	❑	❑	❑	❑	❑
Voluntary sector						
Drop ins	❑	❑	❑	❑	❑	❑
Outreach workers	❑	❑	❑	❑	❑	❑
Other						
Training and guidance(TAG)	❑	❑	❑	❑	❑	❑
Other (please specify)						
_____	❑	❑	❑	❑	❑	❑
_____	❑	❑	❑	❑	❑	❑

Please add any additional comments on any aspects of these services that you find particularly useful

_____

_____

_____

_____

_____

_____

Q10 How important are local communities in the care of those with severe and enduring mental health problems in your area? Please tick

Community Group	Extremely Important	Very Important	Relatively Important	Somewhat Important	Not Important
Families	❑	❑	❑	❑	❑
Friends	❑	❑	❑	❑	❑
Church	❑	❑	❑	❑	❑
Local community groups	❑	❑	❑	❑	❑
Other please specify	❑	❑	❑	❑	❑

Mental health awareness in the Highlands

We are interested in awareness of and attitudes toward mental health issues in your locality.

Q1 To the best of your knowledge, how do you think mental health problems are understood in your locality? For example is this a locality where there is a stigma surrounding mental health problems?

Q2 Who or what influences these perceptions in your locality?

Q3 Do local attitudes toward mental health problems affect people's willingness to access services in your locality?

Q4 Is there a need to raise community awareness of mental health issues in your locality? How could this be best achieved?

Policy environment and future service provision

We are aware of the implementation of the Mental Health Framework throughout the Highland Region, and in Scotland more generally, and are interested in your opinions and experience of implementation.

Q1 What has been the impact of the implementation, if any, of the Mental Health Framework on your delivery and practice and management of care?

Q2 What changes in your role do you foresee with regard to the delivery and management of mental health care in the Highlands in the future

Q3 What would you identify as the key resources required to assist GPs in the delivery of effective mental health care in rural areas?

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THANK YOU