Primary care provision for mental health

Samantha Murton

Introduction
The treatment of mental illness in New Zealand has seen a steady transition from institutionalised to community-based care, from the mental institutions of the late 19th century to the service-based facilities we see today.

While this change in attitude towards mental illness is to be celebrated, it does not come without its challenges, and general practice (GP) clinics nationally have been finding these hard to overcome, particularly in rural and low socio-economic areas.

But these challenges are not insurmountable, and, as a body, we welcome more opportunities to reduce the escalation of common mental health problems to a scale that requires hospital or specialist residential care.

First port of call
A survey was conducted by The Royal New Zealand College of General Practitioners (the College) in 2019 to obtain a snapshot of the volume of mental health and addiction consults a GP performs on a typical day.

It found that 31% of all patient interactions included a mental health component, with around half of those resulting in a prescription for medication, and 20% requiring a referral to specialist services.¹

These patients present with a wide range of mental illness, from mild mental distress to being psychoticly unwell.

For each case, we have to identify the needs of that individual and then work out how and when those needs can be met.

Making decisions about what treatment paths to follow can be hard when tertiary services are overwhelmed, and a shortage of psychiatrists means that only 3% of those with serious mental health problems can be seen.

An extensive Ministry of Health survey in 2006 estimated that 4.7% of the adult population has severe mental health needs. At the time, Mental Health and Addiction (MHA) services for these types of patients saw just 2% of the population.² By 2016, this figure had grown to 3.6% of the population, while funding was set to cover just 3%.²

Many GPs report a vicious cycle of emergency referral and short-term hospitalisation before a lack of District Health Board (DHB) resources sees the patient released back into GP care.

Obviously, this is no solution. It also leaves no room for those who are experiencing a mild to moderate level of mental distress to receive help. They just aren’t ill enough.

The figures also indicate that there are a significant number of people struggling with severe mental health conditions who are not receiving the treatment they need.

Community support services are key
But patient needs are not always medical. Often the mental distress being experienced is in some way caused by or amplified by the socio-economic challenges the patient is facing.

If these patients can be supported and helped within the primary health care sector together with community service providers, it will make a huge difference to individuals as well as easing the burden on the acute service provision.

This is especially the case for young people, Māori, Pasifika, rainbow, and rural communities where early intervention can have a dramatic impact on patient outcomes.

My own experience with mental health issues in teenagers is that patients are generally experiencing mild to moderate anxiety and distress, and are in need of support for a relatively short period of time in their lives.

This support enables them to work through their mental struggles and build a foundation for understanding how to deal with what they are experiencing, which stands them in good stead for the rest of their lives.

One of the main aspects of being a GP are the journeys you go on with your patients, where you learn about them as an individual, about what wellness looks like for them, and share in their triumphs and challenges we see today.

At my own clinic, the Capital Care Health Centre in Wellington, many GPs report a vicious cycle of emergency referral and short-term hospitalisation before a lack of District Health Board (DHB) resources sees the patient released back into GP care.

To be able to extend that experience to all my patients dealing with mental illness would be amazing, not just for them but for myself as a GP too.

So the Government announcement in the 2019 Wellbeing Budget that $455 million NZD is being allocated to a frontline services programme is to be welcomed and celebrated.³ An additional $40 million NZD goes to suicide prevention services; and the issue of homelessness, a major contributing factor for many mental health patients, is also being addressed.³

These new services are being rolled out over the next five years and aim to put trained mental health workers into clinics, so patients can receive immediate support and advice once a GP has identified a mental health or addiction issue.

This is not a new idea, as there are already some excellent service models in operation that are delivering results.

At my own clinic, the Capital Care Health Centre in Wellington, our self-funded social worker is having a real impact in improving the lives of patients as a whole, which in turn makes a difference in the level of mental distress they deal with on a daily basis.

This lower risk profile then means that other cost effective community services such as counselling and lifestyle support become available to those who previously may have fallen in the gap between what primary sector care can do, and what tertiary care is able to provide.
Frontline funding focus

What will be key to the success of this vision of “wellbeing” is ensuring that provision focuses on the highest area of need within specific communities.

Of course, we would like to see an equity of service across the country which disregards the rural/urban divide and the ethnic make-up of the population. An overall increase in service provision should be part of the plan. But there is also scope for Primary Health Organisations (PHOs) and iwi health providers to access funding for targeted programmes that address the needs of the local community.

This focused approach is particularly effective for Māori and Pasifika communities, where a sense of connectedness may be missing, and where culturally aware services can have more of an impact than the Western model of “one size fits all”.

The findings of the Waitangi Tribunal Health Services and Outcomes Kaupapa Inquiry (Wai 2575) provide iwi health providers and kaupapa Māori services with a lot of scope when submitting Request for Proposals (RFPs) to the Ministry of Health. This is a real opportunity to enable Māori to provide for Māori, giving these communities autonomy over how they care for themselves in a way that makes sense to them.

Putting mental health services at the frontline means that the changes we have seen in GP practices nationwide over the last decade will continue further into the realm of interprofessional teams, bringing specialised skillsets from different areas together to give patients the effective services they need.

It is a exciting time to be a GP as we will be able to access more immediate treatment for our patients, be able to spend more of the journey by their side, and do away with the frustrations of referrals and time-delays.

It is also a recognition of sorts that the issues GPs are being asked to deal with when patients walk through their door have increased in both size and scope. The frustration doctors feel when they are required to advocate for so many individuals to access treatment and care that is in short supply is palpable, and it has been taking its toll.

GP burnout on the downturn?

The 2018 General Practice Workforce Survey, conducted on behalf of the College, found that 26% of respondents rated themselves high on the burnout scale. This follows the trend of steady increase from the 22% reported in 2016.

It is notable, however, that respondents reporting burnout are significantly more likely to be aged between 50 and 64 years of age, a practice owner or partner, and working full-time.

These are also most often doctors who are struggling with a heavy workload because of the historical shortage of new GPs coming into the profession. Rural doctors can be particularly prone to burnout due to the isolated nature of their practices and the fact they are often the only GP in town.

Decisions made by DHBs about what services will be delivered in or out of hospital can lead to a lack of autonomy, and more and more services being devolved to general practices adds to stress levels.

Difficulty of succession planning also puts older GPs under huge pressure to continue practicing because if there is no one to step in, who will care for the people they have spent a lifetime looking after?

However, the evolution of what a general practice looks like and an increase in the number of training positions available for new doctors means that these factors are being worked on, and I would hope to see a falling trend in these burn-out figures soon.

Becoming a GP

To become a GP you need determination, passion, and resilience. It’s a totally different realm for new graduates, and initially you feel that you are being reminded of how little you know every 15 minutes.

But the College’s specialist GP Education Programme (GPEP) provides the support and teaching that trainees on this huge learning curve need when finding their feet and developing confidence in their skills and decision-making. The low drop-out rate we have is testament to the effectiveness of the programme and there are rising numbers of young graduates achieving their Fellowship status.

Once a young GP has established themselves into a practice team, the wealth of choice and opportunity open to them is extensive. Individuals can follow their personal interest for things like minor surgery, rural medicine, mental illness, governance, or a plethora of other things. Working hours can be flexible, or even part-time, leaving time for family or passions aside from medicine.

The future of general practice

Bringing mental health services into the primary sector reflects the beginning of a change in how mental health is perceived, where we no longer treat mental health problems, but instead focus on mental wellness.

Society has experienced changes in the way people connect, an increase in material wealth, technological advances, and improvements in personal comfort and safety. We have also seen widening gaps in equity across the socio-economic strata, particularly for cultural and ethnic minorities. The pace of these changes has been frenetic and unrelenting, and the periods of stability required for society to rebalance itself have been missing.

This speed of change has been identified as a huge factor in the increased incidence of mental illness (described by many as an epidemic) across the developed world, and it is fair to say that medical professionals have borne the brunt of the onslaught.

But a new emphasis on mental wellbeing, on providing community-based services that address the social aspects of mental illness, as well as the individual experience, means that we are perhaps on the right path to recognising that it is by meeting community needs we can stem the tide and, ultimately, provide more positive outcomes for our patients.

References


About the author

Dr Samantha (Sam) Murton, MBChB, FRNZGP (Dist), PGDipGP, FAcadMed, is the President of the Royal New Zealand College of General Practitioners.

Correspondence

Dr Samantha Murton: samantha.murton@otago.ac.nz