



situation to continue, they should at a minimum satisfy themselves that psychiatrists tasked with this role are competent to discharge it. It is interesting to note that 12% of our sample had experience of attending an MHRT at which the responsible authority had professional legal representation: it may be that this will be an increasing practice in the future, and that consultant psychiatrists would broadly support such a development.

Psychiatrists acting as representatives in legal proceedings are likely to be held accountable only to the standard expected of a reasonable psychiatrist acting in that role, rather than to be competent to the standard of a legal professional. However, there is a duty on all doctors to practise only within the limits of their competence and experience (General Medical Council, 2006). Psychiatrists considering whether or not to undertake this role must be satisfied that they have the requisite knowledge of MHRT procedure and adversarial skills to discharge the responsibilities adequately. As participants in this study have recognised, this may entail specific training and the development of competencies that have not traditionally been included in psychiatric training programmes.

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Declaration of interest

C.J. is a medical member of the MHRT.

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ANNE WARD, GIOVANNI POLIZZI AND MIOMIR MILOVANOVIC

Psychological therapies provision: views from primary care

AIMS AND METHOD

Recent National Health Service (NHS) policy and guidelines support the increased provision of psychological therapies. As secondary care providers of psychological therapies, we carried out a questionnaire study of how our services were perceived by local general practitioners (GPs). All GPs in the borough of Southwark were included.

RESULTS

General practitioners value secondary care psychotherapeutic input across a spectrum of complex diagnostic groups and are interested in further training/education. They also consistently complain about long waiting times and confusion about accessing the various services.

CLINICAL IMPLICATIONS

With increasing interest in and willingness to fund the delivery of psychological therapies, there is the potential for working more effectively across the primary–secondary care divide. However, improved communication between primary and secondary care is essential if the increased commitment at government level is to be translated into a locally effective service.

The new general practitioners' (GP) contract, as well as the reorganisation of the primary care trusts and the promise of practice-based commissioning have been

influential in redefining the primary–secondary care boundary. From a psychiatric perspective, there is increasing emphasis on the preservation of secondary

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care for individuals with severe mental illness, while GPs are expected to treat the majority of psychological disturbance in primary care.

From a psychotherapies' perspective, there is evidence that members of the general public prefer talking therapies to medication (Angermeyer & Matschinger, 1996; Angermeyer & Dietrich 2006). Department of Health's and other publications recommend access to psychotherapy (Department of Health, 1999, 2001; Appleby, 2004), and the need to train psychiatrists in the psychotherapies is recognised by the Royal College of Psychiatrists (2001). The Department of Health further proposed a stepped care model of delivery which requires good communication and integration of services across primary and secondary care (Department of Health, 2004). The principles are spelled out, but the details need to be worked out on a local basis. On a practical level, access to psychotherapy services is limited by a number of factors that include, together with lack of adequate service provision (Centre for Economic Performance's Mental Health Policy Group, 2006), the referral path and the length of waiting lists. There are also reports of increased levels of stress among GPs (Royal College of General Practitioners, 2005), who have to deal in more complex ways with more difficult patients and limited funding. These factors may vary from locality to locality but they need to be taken into account in any proposed reorganisation. More recently, following the Department of Health's commitment to improving access to psychological therapies (2007), the Health Secretary has announced a £170 million boost to the provision of psychological therapies, delivered from centres that are neither primary nor secondary-care based, but which will need to be integrated with both for optimal pathways to care. Such integration presupposes good communication across primary and secondary services, something that cannot necessarily be taken for granted.

As part of our response to these initiatives, we surveyed all Southwark GPs to ascertain their views on the provision of psychological therapies by our trust (the South London and Maudsley NHS Foundation Trust) and on ways in which this might be improved. The borough of Southwark has a population of approximately 250 000, of whom 63% are White, 26% Black or Black-British, and 4% Asian or Asian-British; just under 65% are employed, and the Index of Deprivation is 17 nationally and 6 within London (1 indicates the most deprived; www.southwarkalliance.org.uk/).

Method

Initial phase

We consulted representatives of the various stakeholder groups, including the medical director of Southwark Primary Care Trust, the graduate primary care mental health workers, Southwark Psychological Therapies Committee, and various trust-based groups with an interest in primary care. We also visited a number of primary care practices to ascertain GPs' views of the issues that might be important to address.

Questionnaire

The questionnaire was adapted from the Camden and Islington Primary Care Mental Health Needs Assessment tool (unpublished), developed and tested in that area as a research tool, and with the permission of the authors (details in Acknowledgements). The initial questionnaire was about general psychiatry provision, whereas ours was focused on psychological therapies (see online supplement).

Study

We advertised the study via flyers distributed through Southwark Primary Care Trust. We also obtained a list of all Southwark GPs from the Trust, as well as their practice managers. The questionnaire, with a covering letter, was sent to GPs via email and we also sent an email request to practice managers to encourage their GPs to respond. After a couple of weeks, a reminder was sent out to both doctors and practice managers. Approval for the study was given by the medical director of Southwark Primary Care Trust.

The quantitative data were analysed using SPSS version 13.0 for Windows. Qualitative responses were collated, themes extracted by repeated iteration, and the results discussed by the authors until agreement on the themes was reached.

Results

Respondents

There was a 46% response rate, with 91 of 199 GPs responding. Not all respondents answered all questions and so percentages breakdowns for individual questions are given with the number of respondents to that particular question as the denominator.

Almost two-thirds of respondents (57%) were female; 58% were under the age of 45; the median number of years since completing GP training was 10.5 (range 1–35). The median practice size was 8000 (range 1100–24 800), and roughly half (52%) of the respondents belonged to training practices.

Thirty-one GPs (34%) had some post-graduate training in psychiatry: 18 trained for 6 months in psychiatry as a senior house officer, 8 for more than 6 months at this grade, with the rest having further or different psychiatric experience. About a third had some training in working with individuals with mental health problems, including Balint groups, long and short courses and counselling training; a few had personal therapy. The actual number of GPs with experience in psychiatry may be higher, as many respondents left this section blank, presumably, but not necessarily, because they did not have experience.

Quantitative data

The quantitative data are presented in two sections: the GPs' experience of the service as it is, and their 'wish-list' for a service that is more specific to their needs.



Experience of the current service

1. WORKING WITH INDIVIDUALS WITH PSYCHOLOGICAL PROBLEMS

GPs find working with and managing individuals with psychological problems 'interesting', and they declare they want to help. However, this patient group is also felt to be challenging and – above all – time-consuming. Only 20% of GPs actively find the National Institute for Health and Clinical Excellence (NICE) guidelines helpful.

2. PRACTICE COUNSELLING SERVICES

The majority of GPs (80%) have a counsellor in the surgery, about 10% have some other kind of local access and only about 10% do not have access to any kind of counselling within the primary care setting.

3. WORKING WITH SECONDARY CARE PSYCHOLOGICAL THERAPIES SERVICES

Most GPs (83%) refer to our Trust for secondary care services, with 60% doing so more than twice a year (Table 1 & Table 2). There were several cases of dissatisfactions with the service, particularly due to difficulties in knowing whom to refer to and waiting times for assessment and treatment.

4. ACCESS TO PSYCHOLOGICAL THERAPIES SERVICES FOR DIFFERENT ETHNIC GROUPS

On the whole, GPs thought there was a need for more ethnic and voluntary counsellors, and for more multi-lingual material (Table 3).

5. VOLUNTARY SERVICES

The majority of GPs use the voluntary sector for individuals with psychological problems 'most of the time' (10%) or 'sometimes' (73%). The main factors influencing referral were local access and waiting times.

concerned, followed by referring via the community mental health team. In terms of referral via the community mental health team only, there was a highly significant difference in favour of endorsing other than this single-entry point (Binomial test: $P < 0.001$).

3. AREAS WHERE IT IS IMPORTANT TO HAVE SECONDARY CARE PSYCHOLOGICAL THERAPIES

Almost all GPs wish to have secondary care input into all the areas mentioned in the question stem: perinatal, anxiety/depression, older adults, personality difficulties, psychosomatic disorders and forensic (Table 5).

4. FURTHER TRAINING AND SUPPORT

Asked if they would like further training to help in work with individuals with psychological problems, 71% said 'yes'. Small groups were preferred to lecture or web-based formats. Almost two-thirds of respondents commented they would like help with a broad range of psychiatric diagnoses (anxiety, depression and personality disorders were most commonly cited but the spectrum included most of ICD-10 psychiatric diagnoses).

Similarly, when asked about situations/groups of individuals they would like help with, various diagnostic categories were cited, with 17 respondents mentioning personality disorders and others using possibly related terms such as 'entitled demanders', 'self-harmers', etc. The spectrum of anxiety disorders was included; 7 respondents mentioned depression, but again most of ICD-10 diagnoses appeared. Doctors thought that a regular face-to-face consultations or 'telephone surgeries' would be the most helpful ways to make use of a medical psychotherapist's time (Table 5).

A 'wish-list' for service improvements

1. PRIORITISATION OF FUNDING

General practitioners would be most interested in increased access to secondary care psychological therapies services, and increased availability of counselling for their patients (Table 4).

2. PREFERRED REFERRAL ROUTES

Respondents were asked about their preferred route of referral into the service, as this was being discussed within the Trust in line with the Department of Health recommendations. They could tick as many of the preferred routes as they wished. Numerically, the preferred GP option is to refer directly to the department

Qualitative data

Respondents were asked to describe three things that worked for them about secondary care psychological therapies, and three things that did not work. Over a third of GPs did not respond to these two questions, but those who did (62 and 65% respectively) provided a large number of helpful and relevant comments.

In terms of what works, the general experience seems to be that therapy is helpful and effective – if and when you can access it. The majority of complaints were about waiting times and accessibility. These emerged repeatedly, as did a sense of confusion about how to

Table 1. General practitioners' experience with secondary care psychological therapies services¹

| | Strongly agree or agree, n (%) | Neutral, n (%) | Strongly disagree or disagree, n (%) |
|--|--------------------------------|----------------|--------------------------------------|
| Very happy with these services | 16 (21.1) | 30 (39.5) | 30 (39.5) |
| Difficult to know who to refer to | 58 (71.6) | 13 (16.0) | 10 (12.3) |
| Waiting time to assessment a problem | 63 (78.8) | 10 (12.5) | 7 (8.8) |
| Waiting time to treatment a problem | 73 (91.3) | 6 (7.5) | 1 (1.3) |
| Patients are satisfied with their care | 31 (38.8) | 41 (51.3) | 8 (10.0) |
| Feedback unsatisfactory | 24 (30.4) | 29 (36.7) | 26 (32.9) |
| Good clinical outcomes | 28 (35.1) | 48 (60.0) | 4 (5.1) |

1. About 11% did not answer these questions.

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papers**Table 2. General practitioners' experience with the Trust's therapeutic modalities¹**

| Therapeutic modalities | Aware of modalities n (%) | Confident of accessing n (%) |
|--|------------------------------|---------------------------------|
| Psychodynamic | 44 (73.3) | 18 (30.0) |
| Cognitive-behavioural therapy | 72 (92.3) | 45 (63.4) |
| Family/couple | 39 (60.0) | 22 (32.8) |
| Cognitive analytic therapy | 35 (63.6) | 11 (19.6) |
| Cawley Centre ² | 28 (47.5) | 13 (21.3) |
| Interpersonal psychotherapy ² | 21 (38.9) | 6 (10.9) |

1. This was probably the least well answered question, with between 13 and 37 replies blank, depending on the modality.
2. Psychodynamically-oriented therapeutic day communities, one based in North and one in South Southwark.

access services. Respondents were also frustrated about not being able directly to access services such as cognitive-behavioural therapy, and having to refer through a community mental health team.

Discussion

The relatively poor response rate (46%) is a recognised feature of this kind of postal survey and limits the generalisability of our results. However, we were impressed with the clear messages that emerged. The data indicate a long-standing interest in the area of psychological therapies in primary care among GPs, as

well as a wish for better communication and consultation with secondary care services. Given that we had no previous group data in this area, this was encouraging. Other limitations of the study include its questionnaire basis, with all the known limitations of questionnaire studies. In particular, the survey elicited opinions on the areas queried only. However, our pre-study consultations, as well as the modified use of a questionnaire pioneered elsewhere, and the inclusion of space for comments should have gone some way towards addressing this; nevertheless, if resources had permitted, we would ideally have supplemented the study with several in-depth interviews among a subgroup of GPs.

As a consequence of our survey we are in a better position to understand the state of provision of psychological therapies in primary care. The results point to a high level of in-house counselling provision among respondents, as well as to a substantial experience and training in psychological issues among local GPs. The respondents also expressed an interest in further training to enable more local delivery of psychotherapy. They also acknowledged the need for secondary care provision for personality problems, anxiety and depression, traditionally the remit of NHS psychotherapy departments. It should be noted that there is a significant disparity between GP diagnosis of personality disorder and that of a research rating, and that the GPs' ratings may be strongly associated with adverse perceptions of the individuals' consultation behaviours (Moran *et al*, 2001). Thus these individuals may not make it to our secondary care facilities, but GPs may benefit particularly from consultation about the patients or from discussing them in a Balint group.

Table 3. Access to psychological therapies services for different ethnic groups¹

| | Strongly agree or agree, n (%) | Neutral, n (%) | Strongly disagree or disagree, n (%) |
|--|--------------------------------|----------------|--------------------------------------|
| Access is the same as for other groups | 36 (43.4) | 16 (19.3) | 31 (37.3) |
| Not aware of any special services | 55 (66.3) | 14 (16.9) | 14 (16.9) |
| Need for more ethnic counsellors | 58 (69.0) | 23 (27.4) | 3 (3.6) |
| Need for more voluntary services | 50 (60.3) | 28 (33.7) | 5 (6.0) |
| Need for more multilingual material | 62 (74.7) | 19 (22.9) | 2 (2.4) |

1. Question 19; there were at most eight non-respondents to each part of the question.

Table 4. Prioritisation of funding¹

| | Endorsing 1 or 2 n (%) | Endorsing 3 n (%) | Endorsing 4 or 5 n (%) |
|--|---------------------------|----------------------|---------------------------|
| Increased general practitioner consultation time with patients with psychological problems | 32 (38.1) | 12 (14.3) | 40 (47.6) |
| Increased availability of counselling for patients in your practice | 46 (53.5) | 23 (26.7) | 17 (19.8) |
| Increased availability of self-help materials, including CD-ROMs or web-based materials | 11 (12.8) | 22 (25.6) | 53 (61.6) |
| Increased access to South London & Maudsley psychotherapy and psychology services | 61 (68.6) | 12 (13.5) | 16 (17.9) |

1. Question 5; with limited funding for improvement of psychological services for individuals in the practice, general practitioners were asked to order their preferences (between 2 and 7 values missing for each part of the question; 1=highest; 5=lowest)

**Table 5. Doctors' views on psychological therapies and consultation with a medical psychotherapist**

| | Strongly agree or agree, n (%) | Neutral, n (%) | Strongly disagree or disagree, n (%) |
|---|-----------------------------------|----------------|---|
| Areas where it is important to have secondary care psychological therapies ¹ | | | |
| Psychosomatic disorders | 68 (80.9) | 13 (15.5) | 3 (3.6) |
| Personality difficulties | 72 (84.7) | 12 (14.1) | 1 (1.2) |
| Anxiety/depression | 74 (87.1) | 9 (10.6) | 2 (2.4) |
| Forensic disorders | 67 (78.8) | 15 (17.6) | 3 (3.5) |
| Older adults | 72 (84.7) | 11 (12.9) | 2 (2.4) |
| Perinatal (women and babies) | 77 (90.5) | 8 (9.4) | 0 |
| Input from a medical psychotherapist ² | | | |
| Regular face-to-face consultations | 52 (61.9) | 19 (22.6) | 13 (15.5) |
| Telephone surgeries | 59 (69.4) | 19 (22.4) | 6 (8.3) |
| Staff support groups | 36 (42.3) | 38 (44.7) | 11 (13.0) |
| Balint groups (facilitated work-discussion) | 30 (35.7) | 33 (39.3) | 21 (25) |

1. Question 15; six general practitioners did not respond to each query, but only two did not respond to any part of the question.

2. Question 18; there were at most seven non-respondents to each suggestion.

The formal incidence of personality disorder in a sample of London GP practices (Moran & Mann, 2002) was estimated at 21%, with a 4% prevalence of cluster B personality disorder; the latter was described by the authors as low, but that 4% of patients may nevertheless occupy a good deal of GP time as there was associated high psychiatric morbidity as well as multiple social problems. There is growing evidence for the efficacy of psychotherapy in this group (Bateman & Fonagy, 1999; Giesen-Bloo *et al*, 2006; Clerkin *et al*, 2007; Gabbard, 2007; Oldham, 2007).

In our study, we were particularly interested in the endorsement of secondary care psychotherapy provision for older adults, mothers and babies, and those with psychosomatic disorders. These are both common and chronic conditions not specifically catered for in a generic psychotherapy service. In the case of somatoform disorders, for example, evidence points to their long-term nature, their ubiquity and severity, and that they often lead to high numbers of investigations and hospital admissions, and dependence on state benefits (Bass *et al*, 2001).

Some of the difficulties raised by GPs about our services can be responded to in the shorter or medium term. Thus, inadequate understanding of the different therapies, requests for consultation, and better feedback could be addressed by relatively simple changes to our current practice. We have since developed a website where information about different therapeutic modalities can be found, as well as how to access these services. We are also mindful of the need to speak directly to GPs about referrals whenever appropriate. Admittedly, it takes time, an increasingly scarce resource. However, as this study was carried out with no additional resources, it may be so that with commitment the proposed changes are possible to implement. Response to other feedback would have involved a more laborious reorganisation and longer-term strategic change, something the Southwark directorate in our Trust was in any case committed to, and our survey was greeted with a good deal of interest by both clinicians and managers. Since carrying out the

study, however, financial considerations intervened in the form of a £4 million 'disinvestment' by the Southwark Primary Care Trust in secondary mental healthcare services, owing to budgetary pressures and in particular by demands from the acute care services. Thus, the Southwark Directorate within our Trust was forced to undertake a more rapid reorganisation of its psychological therapies services than planned. Many of these changes are in the direction requested by GPs, so that there is now a more coherent provision across the borough, with more clearly defined routes to treatment and a continued pressure to keep waiting lists manageable. However, these changes mostly apply to the provision of cognitive-behavioural therapy, with psychodynamic and other non-cognitive-behavioural therapy psychotherapies now effectively a specialist provision, rather than an integral part of service provision. This is almost certainly part of a national trend, whereby the pendulum has swung fairly dramatically from the more psychoanalytically-based therapies towards cognitive-behavioural therapy. Still, this is unlikely to be the final position, as the more complex and chronic patient population re-emerge and different/combined therapeutic approaches are needed. The expected (due to be published in December 2008) NICE guidelines on personality disorders will be helpful in this respect as they are likely to endorse this.

Despite these drawbacks, the experience of carrying out such a study was rewarding for us in terms of better understanding of and improved relationships with GP colleagues, a necessary ingredient to any 'improving access' initiative, wherever the increased monies are eventually located. We recommend the exercise in other locations if resources permit. Our experience also suggests that, although the NICE guidelines on depression and anxiety are useful, it is important from the GP's perspective to consider a broader population of complex psychiatric patients for whom a psychotherapeutically-informed approach may be needed such as individuals with somatoform disorders, young mothers, or



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offenders. Our respondents clearly appreciated being consulted, and expressed a wish for further training and support not just for the patients directly but for themselves in dealing with the vast bulk of psychological distress that stays within primary care.

Declaration of interest

None.

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STEVE ONYETT, KAREN LINDE, GYLES GLOVER, SIOBHAN FLOYD, STEVEN BRADLEY AND HUGH MIDDLETON

Implementation of crisis resolution/home treatment teams in England: national survey 2005–2006[†]

AIMS AND METHOD

To describe implementation of crisis resolution/home treatment (CRHT) teams in England, examine obstacles to implementation and priorities for development. We conducted an online survey followed by a telephone or face-to-face interview among 243 teams.

RESULTS

Considerable progress has been made

in implementation with a subset of teams demonstrating strong fidelity to the Department of Health's guidance, particularly in urban settings. However, only 40% of teams described themselves as fully established. Many teams reported a high assessment load, understaffing, limited multidisciplinary input and patchy fulfilment of their gate-keeping role.

CLINICAL IMPLICATIONS

Successful implementation of the CRHT teams as alternatives to hospital admission requires resources for home treatment out of hours, effective systems working among local services, stronger local understanding and advocacy of the teams' role.

[†]See original paper pp. 378–379, this issue.