

GP mental health training survey Summary



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Key statistics

- GPs estimate that 4 in 10 (41 per cent) of their consultations now involve a mental health element.
- Two-thirds of GPs (66 per cent) feel that the proportion of their patients who require support with their mental health has increased in the last 12 months.
- 3 in 4 GPs (74 per cent) who completed a mental health rotation as part of their initial training did so in a hospital setting, so will have dealt with more acute cases and seen fewer people with mild-to-moderate mental health problems.
- 4 in 5 GPs (84 per cent) felt there should be a wider range of options for mental health training, such as more placements in community settings like psychological therapy services.

Who were the respondents?

Demographics

In total, there were 1,066 respondents to this survey from a fairly even spread of geographies across England and Wales. The majority of respondents were female (74 per cent), white (82 per cent) and between the ages of 35 and 54 (69 per cent). The vast majority (72 per cent) had been practising for more than 10 years and 2 per cent were GPs with an extended role in mental health.

2 in 5 (40 per cent) reported personal experience of mental health problems, and 1 in 5 (20 per cent) use or had used mental health services. This is higher than the population average who have experienced mental health problems (1 in 4), suggesting there may have been a degree of self-selection amongst the survey respondents, with a particular interest in mental health as a result of their own experiences. 47 per cent were a friend to someone with personal experience of mental health problems, and 45 per cent had a family member who had experienced mental health problems.

How respondents seek support for their own mental health

The survey asked GPs if they were to experience a mental health problem, how likely they would be to seek support from a variety of different places. 8 in 10 (84 per cent) said they would be likely or very likely to seek support from their family and friends, with only slightly fewer (77 per cent) saying they would seek support from their personal doctor. However, some people commented that many professionals they would have otherwise gone to for support they knew in a work context, and so would not feel comfortable doing so. Others were concerned that if they sought help from their GP they would then have to declare it in their appraisal, which could in turn be used to criticise their competence to work. This may have impacted the number of people who would seek support from the practice manager (only 30 per cent), or from colleagues (45 per cent).

Personally I find it difficult to find a GP to discuss my own problems with who I don't know professionally.

Only 3 per cent were likely or very likely to seek support from the General Medical Council (GMC) – an unsurprising statistic, as the GMC are the regulator. The next organisation least likely for people to seek support from is the British Medical Association (BMA) (19 per cent), despite their provision of the BMA Counselling and Doctor Advisor Service, and the Doctor Support Service for doctors under investigation.

Support for GPs' mental health is explored further in the 'What GPs need' section.

Training experience of respondents

During their training, GP Specialty Trainees (GPSTs) spend 18 months in clinical placement posts, and a further 18 months in general practice. There is a single opportunity for GPSTs to do a mental health placement within this three years, which is through a placement in psychiatry.

Of all GPs across the country who completed their training in 2017, fewer than half (46 per cent) completed a psychiatry placement. Meanwhile, over half of GPs responding to this survey (53 per cent) had completed a psychiatry rotation during their initial training, and another 2 per cent were still training and planned to complete this rotation. Again, this suggests there may have been a degree of self-selection among the respondents, with a particular interest in mental health. Of those who had completed a psychiatry placement, 3 in 4 (74 per cent) spent it in a hospital setting, in either a mental health hospital (the vast majority) or an older people's mental health unit.

4 in 5 GPs (84 per cent) who responded said they felt it would be helpful to expand training placements to a wider variety of mental health settings (eg, within a local psychological therapy service).

Further, 7 in 10 GPs (72 per cent) would like more Continuing Professional Development (CPD) training relating to mental health. Unfortunately data on the number of GPs who complete a proportion of their CPD credits in mental health are not currently collected.

What training do GPs want?

It is clear that mental health demand on GPs is increasing: two-thirds of GP respondents (66 per cent) felt that the proportion of their patients who require support with their mental health had increased in the last 12 months. It is therefore unsurprising that respondents had a wide range of perspectives on what additional mental health training they would find helpful.

GP respondents were asked about what training they would find useful in supporting people with mental health problems, and separately for any other thoughts they might have on treating mental health in primary care. Both questions received 650 responses.

The responses to the training question can be summarised across 10 themes, as explored in the 'Content of training' section. People used the 'any other thoughts' question to highlight shortcomings in the current funding and provision of primary care and other mental health services, and the need for improved support. This broader question showed that while training is important, its lack is not the principal reason GPs are struggling to treat and support people with mental health problems. For more on this, see the 'Other support' section.

In terms of how this training would be delivered, some respondents requested online modules but the majority wanted face-to-face training. In particular, they wanted to use training opportunities to break down some of the barriers between general practice and other teams.

How training should be delivered

Some respondents gave perspectives on how training should be delivered. This often involved interactions with other teams to encourage integration, as well as online modules. Emphasis was placed on the need to backfill support while doctors were away training.

Ideas of how to integrate with different teams through training included joint sessions with colleagues such as social workers, school nurses and mental health teams, and opportunities to be trained directly by local providers about what services they offer and how they can help GPs. People talked about how often these sessions should be, and what form they should take, placing an emphasis on the importance of regularity in training and ensuring any sessions are as interactive as possible, with a seminar-style being widely favoured.

- "Opportunities to hear from local service providers about what is available locally and how best to access it."
- "Integrated sessions open to social workers and school nurses etc. would be really helpful in establishing professional relationships. At present it is very 'them and us' and GP[s] are perceived as difficult to communicate with."
- "Refresher training maybe a multidisciplinary course for GPs, mental health team members and social care?"
- "Mental health training days at least twice a year."
- "Q&A sessions, small workshops so can ask questions."

Content of training

The principal focus of the survey was on the content of what mental health training GPs would find useful. From the 650 responses received, several areas of broad consensus emerged:

1. Basic training to provide brief therapeutic interventions.
2. Medication.
3. Working with children and young people.
4. Support for GPs' own mental health and work-life balance.
5. Supporting patients with complex health and/or social issues.
6. Helping patients to engage with care.
7. Information about services available and interaction with other teams.
8. Supporting specific mental health problems.
9. Suicide assessments and management of risk.
10. Non-medical interventions.

Basic training to provide brief and therapeutic interventions

Almost 1 in 5 (18 per cent) responses to the question talked about acquiring therapeutic skills, and specifically brief interventions that could be administered within a 10-minute consultation. This was by far the most commonly requested training. The reason respondents gave for this was wanting to be able to support patients in the interim, while they were on waiting lists, as many GPs mentioned the need to 'hold' patients who were becoming more unwell while they waited for more thorough and appropriate support. Many specifically mentioned wanting to learn '10-minute CBT' skills, or how to incorporate therapeutic interventions into their consultations to add another layer to their support. Some specifically requested more training in psychological therapies.

However, offering GPs CBT training may not be the best way to support them or their patients, and avoids the bigger problems of lack of capacity, long waiting lists, and underfunding. For more on this, see below in the 'Other support' section.

- "I would like training in offering initial psychological (CBT) advice for patients with depression/anxiety while waiting for psychological therapy to start."
- "Therapeutic interventions that can be done in short periods."
- "Ways to make meaningful brief interventions."

Medication

Another topic which many GP respondents mentioned was medication. Many felt that they didn't have the knowledge they needed to effectively prescribe and manage patients' medication. They wanted updates on new drugs and their effectiveness, when and how medications could be mixed, advice on starting and stopping patients' medication, and antipsychotics.

Some doctors talked about an over-reliance on drugs within primary care, and wanted to better understand their effectiveness when contrasted with alternative interventions such as psychological therapies. For more on the restrictions of the medical model, see 'Supporting patients with complex health and/or social issues'.

- "Talks and workshops on pharmacotherapy."
- "Up-to-date use of drugs – but also most recent evidence of other interventions."
- "Training in switching antidepressants and using antidepressant combinations."

Working with children and young people

Children and young people were mentioned in a large number of responses (15 per cent), and were the most frequently referenced group on which doctors wanted training. Other groups for which GPs wanted more training included older people, women in the perinatal period, people who had drug or alcohol dependency, and victims of domestic abuse.

CAMHS is a mythical beast only available during a solar eclipse.

Many GPs felt that there had been a large increase in the number of children and young people presenting with mental health problems in primary care; some doctors cited that this is now the majority of their work. Many do not feel confident in providing for the different needs of young people, and wanted to know both how to engage with young patients, and how to alter treatment methods for them. Many specifically mentioned adolescents as a group they were unsure how to support and who fell through the gap between child and adult services. Some felt frustrated by having referrals to CAMHS and EIP teams blocked; some suggested it would be helpful to have in-house training from CAMHS to support young patients while they were on waiting lists.

- "Our training in adolescent mental health is pitiful and the amount presenting to us rising yearly, with little support from an underfunded and crumbling CAMHS service."
- "Understanding [the] role of schools and how much input they can provide to help, improving liaison with schools."
- "Better guidance from CAMHS as to what referrals they will accept (thus far 100% of my referrals have been rejected whether or not they meet the online criteria)."

Support for GPs' own mental health and work-life balance

Many GPs asked for training on how to manage their own mental health, but most asked for support rather than training. Respondents cited burn-out, high levels of stress, toxic work environments, and working beyond the limits of their competencies as common triggers for mental health struggles. They also referenced the part played by the pressures of modern general practice and the increasing complexity of their workloads, leaving many feeling incapable of doing their job effectively.

Further, stigma and discrimination were cited as frequent among health practitioners,

and many people commented that this impacted their confidence in seeking help for mental health problems. Respondents asked for practical training, such as mental health management techniques, resilience training and awareness-raising among practice staff. Respondents also emphasised that as well as initial and ongoing training in this, systems need to be in place so that doctors have access to regular, confidential and easy-to-access support. Importantly, there needs to be backfill cover to allow GPs time to attend such appointments for support.

You cannot as a GP see 30 to 40 patients daily for decades, hearing all those tales of trauma plus seeing horrific things, without it causing an impact.

- “Realistic management for real life general practice. Some training simply doesn’t take account of the time frame, pressures and complexities.”
- “I have at times seen a psychotherapist for extended periods for both supervision and for my mental health. This was fantastic and positive.”
- “Sessions to help with GP mental health would be amazing- access to free sessions, with backfill cover, even just 5 sessions a year to have access to if needed would be a big help.”

Supporting patients with complex health and/or social issues

Although social issues were not mentioned frequently in the question on training needs, they were core to the broader free-text answers. A number of GPs mentioned their struggles to support patients, many of whom were experiencing social issues such as financial, housing, or benefits problems, or isolation and loneliness. Many felt overwhelmed by trying to manage the complexity of patients’ problems, and disempowered by finding there was often nothing they could do to help. Lots of GPs found that administering a medical model of support to people was not helpful, when social issues were at the root of many of their mental health problems. This was all set against the backdrop of what respondents felt was a worsening social climate, with more and more people experiencing financial, housing and other issues.

I often feel so impotent in what I can do to help patients. Psychosocial issues have such a large predominance in many presentations but as a GP there is not much I can do.

- “The increase in unemployment, benefit crackdown, homelessness and drug use has also significantly affected the mental health of my patients.”
- “I think we are fighting a losing battle in trying to treat mental health on a case by case basis only without looking at a lot of these wider issues which affect nearly everyone, and leaves everyone vulnerable to a mental health crisis following adverse life events.”

- “Most of the mental health problems I encounter are not amenable to the conventional medical model. Factors such as housing, poverty, employment, education, family cohesion etc are more relevant than medical.”

Some GPs asked for specific training in this area, for example suggesting psychological skills training to help manage more complex consultations with patients, or requesting more support to help patients with non-medical issues such as benefits. Others recognised that while giving this support to patients was not their role, it would be helpful to have increased access to external services which could provide this function, such as a quick route into organisations like Citizens Advice. Some GPs mentioned the practical support their practices had received from wellbeing navigators, who help with benefits issues, refer to third sector organisations or simply spend time talking to vulnerable patients to free up GPs to deal with medical issues.

I think there should be a dedicated mental health practitioner in every practice and also social worker and drug/alcohol counsellor. GPs do not have sufficient time to thoroughly assess or support patients.

Helping patients to engage with care

GPs requested training in methods to enable patients to better engage with services and self-care. Some mentioned specific methods they would like training in, such as motivational interviewing, and support to set small goals with patients to keep them engaged. They cited the frequent problem of patients disengaging from care if they were unwell. Some also wanted training on how to help patients manage their mental health problems while they waited for further support.

Issues highlighted repeatedly were with effective communication, how to inspire motivation in disengaged patients, methods to help practitioners to build trust with patients, and how to engage patients in a conversation about self-care. Many simply wanted to be able to give patients tools to go away and use themselves, rather than just referring them to a service with a lengthy waiting list with no support in the interim.

- “Training from experienced GPs and mental health professionals on how best to support patients who have difficulty accessing or engaging with mental health services, or who do not quite meet the referral criteria.”
- “Motivational tools/apps to encourage patients to exercise/self-care.”
- “Being able to offer more relaxation and distraction techniques to patients awaiting an assessment.”

Information about services available and interactions with teams

Lots of doctors talked about wanting more training on what other local services are available to support patients, so they could make informed referrals. For example, some didn't feel knowledgeable about what different types of therapy were available locally, and which were best for different mental health problems, as well as who to contact within their local mental health teams.

GPs identified a lack of integration between primary care services and other providers, which they were keen to break down through more joint-working. Some people wanted training in how to work with teams such as social workers, school nurses, and mental health teams, as well as more opportunities to build relationships with them. Many wanted sessions with providers to give them a chance to hear about what they did, what services were available through them, and how they could best help patients to access them. Several respondents mentioned that they felt there was a lack of knowledge and understanding from both sides about individual roles and remits.

- "In-house training with local providers as part of a team."
- "Integrated sessions open to social workers and school nurses etc would be really helpful in establishing professional relationships. At present it is very 'them and us' and GPs are perceived as difficult to communicate with."
- "Better working relationships with the voluntary sector and community organisations - we need better ways to work together."

Supporting specific mental health problems

Doctors mentioned some specific mental health problems in which they would like more training. Most frequently mentioned was depression and anxiety, followed by personality disorders and eating disorders. Doctors also mentioned wanting training on how to support people with:

- Learning disabilities, dementia, ADHD and autism in relation to mental health
- Self-harm
- Psychosis
- The Mental Health Act
- PTSD
- Somatic disorders
- Personality disorders.

GPs frequently mentioned depression and anxiety, particularly with regards to medication. Many wanted more information about antidepressants, such as how they can be mixed with other drugs and how they can be stopped and started (for more on this, see 'Medication' under 'What GPs need'). Doctors also wanted more information on how to support people experiencing treatment-resistant depression. Personality disorder was mentioned particularly in relation to what services are available to patients and managing some of the more difficult aspects of the condition.

- "Managing low mood, anxiety, knowing when to refer."
- "Supporting those with Borderline PD more practically."

- “Diagnosing psychosis and how to ask about it/deal with patients. When to invoke the MHA.”

Suicide assessments and management of risk

Many GPs told us they feel personally responsible for their patients’ welfare. Managing the risk of further harm to their patients with mental health problems, and how to assess this particularly in relation to suicidal patients, was something that concerned many and was mentioned frequently by respondents. Several people had experienced people with mental health problems coming into the practice in crisis, and wanted support with how to deal with these emergency situations, especially if the local crisis team were too busy to see them. Several highlighted the importance of reception and other non-clinical staff also receiving the appropriate support to help these people, as they are often the first point of contact in crisis situations.

- “Actually managing suicidal risk, not just assessment.”
- “Help with management of Mental Health emergencies presenting in general practice.”
- “Locally, mental health services have been decimated with a loss of the crisis team so it’s now a struggle to get people seen even when they are acutely psychotic or suicidal.”

Non-medicinal interventions

As already discussed, some GPs expressed a frustration at the inadequacy of the medical model to solve the root causes of people’s mental health problems, often based in social issues. As such, some people said they wanted more information on non-medicinal interventions. This is related to the desire for more information on local services provided by voluntary and community sector organisations.

- “What the patients really need, such as counselling/CBT/DBT and other talking therapies, as well as art/music therapy, are not readily available.”
- “Evidence base for different non-pharmacological therapies.”
- “There should be information leaflets explaining watchful waiting/exercise/diet/ and the role of CBT as first line therapy for anxiety. There should be wallet sized cards with contact numbers for patients with suicidal thoughts with numbers of samaritans/papyrus/local crisis team etc. that GPs can provide.”

The element that is missing from this is funding. We can all become a bit better at diagnosis and treatment but unless resources and access to Secondary Care is improved, especially for children and adolescents then, we are fighting a losing battle.

Other support

Although there is clear value in assessing current GP training and where this can be expanded and improved, upskilling already overstretched GPs and so further broadening their responsibilities is a short-term solution to a longer-term problem. For example, many GPs asked for more training in CBT to support their patients as they wait for mental health services. The lack of services and support available and resulting long waiting lists are the root of the issue, and expanding GPs' responsibility to also administer therapeutic interventions helps neither practitioner nor patient, and fails to address the larger and more urgent problem.

Here, in-house support can help. Some GPs talked about how much it had helped them to have a mental health specialist or counsellor in the practice to which they could refer people while they waited for other services. All this needs to be supported by increased funding to primary care services to allow for additional resource.

- “Be very, very careful about suggesting or deciding [to train] GPs to be counsellors or therapists. Yes, we have skills & can support – but we need more skilled mental health practitioners to (a.) deal with the volume of people & (b.) deliver more specialist care.”
- “Unfortunately, patients are having to wait up to 18 months for psychological therapy in my region. There is also a shortage of psychiatrists and mental health services are extremely stretched. [...] Improving availability of psychological intervention can be a first step to significantly help ease the pressures.”

In the broader, free-text question, doctors expressed great frustration at how overworked the system was, and the extent to which they were working at the very limits of their capacity. Several GPs felt they were working in situations of heightened risk with increasing regularity, and emphasised the impact that was having on their own mental health.

- “We do not have enough support as GP to look after our vulnerable mental health patients. Mental health services are a farce.”
- “We are often working towards the limit of what is appropriate / safe in a primary care setting, especially when dealing with complex / specialist psychiatric medication and when looking after patients who pose a risk to themselves.”
- “It’s like trying to stop a flood with only a child’s seaside bucket at times. On some days nearly every patient is coming in with stress, anxiety, depression, substance abuse issues and more.

IAPT is overwhelmed and so are we as GPs. It’s rare that CMHT will see a patient referred with anxiety or depression, they will redirect into IAPT who don’t have the capacity to see them. [...] More and more patients are being discharged to primary care by CMHT on complex medication regimens, adding to our work load. It’s frustrating to not be able to help as much as I want to.”

Ten minutes is simply not long enough, leading to extra pressure for the GP seeing many patients with mental health issues.

Additional to a lack of support and funding, respondents also cited not having enough time to speak to patients. Some people asked for training on this, but on the whole it was asserted that it is simply impossible to get patients to open up enough to help them in 10-minute appointments. Many respondents suggested that longer appointments for people with mental health problems would be a big help.

- “10-minute appts are simply not long enough to do anything other than prescribe antidepressants, even when I don’t feel that they are the best options, we don’t have the time or the skills to offer anything else.”
- “10-minute slots barely give time to establish a proper agenda let alone deal with the physical, social and psychological stuff that arises.”
- “There is a limit to what can be achieved in 10-minute slots in patients with mental health issues, and patients frequently burst into tears or hyperventilate during the consultation, especially on initial presentation, meaning that much of the consultation is spent trying to soothe and calm the patient enough to answer questions in order to be able to make an assessment and an initial management plan.

Some doctors talked specifically about the benefits they had experienced by having more staff support in the surgery, onto whom they could refer patients. A few people drew attention to the fact that some GPs naturally made patients feel comfortable opening up and discussing their mental health. This led to some GPs having a greater caseload of people with mental health problems, spending more time with these people, and resulting criticism for running behind. Other mental health practitioners helped to share the caseload.

Some practices had practitioners who helped patients with particular areas of their life, such as with their relationships or housing. This helped to address some of the underlying causes of their mental health problem, rather than patching it up for the short-term with medication.

- “I think there should be a dedicated mental health practitioner in every practice and also social worker and drug/alcohol counsellor. GPs do not have sufficient time to thoroughly assess or support patients.”
- “We have found practical support from wellbeing navigators invaluable. They help with benefits issues, refer to third sector organisations or simply spend time talking to vulnerable patients. This is skills and time GPs don’t have.”
- “I think we need to move towards employing mental health practitioners in primary care: they will have skills the average GP doesn’t, have more time, and be unable to prescribe antidepressants (which I believe are overprescribed as a quick answer to complex problems).”

Key learnings

We need to fully utilise new primary care roles

First and foremost, the fact that GPs have identified these areas as problematic and potentially lacking from their current training does not mean that adding all of these areas into GP training is the most effective solution. The potential of new roles to

incorporate these different aspects of primary care support should be explored as much as possible; this mitigates the risk of creating an additional workload for GPs who are already overstretched and overworked. Some examples are:

- Continuing the roll-out of mental health therapists co-located within GP practices providing therapeutic interventions to patients
- Practice team members, such as nurses and potentially reception staff, providing information about other available services and support (especially dealing with social issues such as housing and finance problems)
- Make better use of pharmacists within primary care to provide advice to patients on managing medications, their impacts and side-effects.

The GP curriculum and CPD offer need to be reviewed and expanded

Alongside consideration of the potential of new roles, there should be a review of current GP training in order to incorporate appropriate issues identified within this survey, such as more regular medication updates; training on managing challenging patients and patients who are less engaged with their care and services; training on resilience and self-care to help GPs manage workplace pressures; and providing GPs with information about other available local services in order to facilitate effective onward referrals. Further, mental health needs to feature more prominently and widely in the range of CPD options available to GPs to ensure continuous learning post-qualification (and updates where relevant).

GPs' own mental health needs to better supported

Practices, training providers and commissioners, and national bodies such as NHS England need to give special consideration to GPs' own mental health and how this can be better supported through training, practice systems, and more formalised support systems at a national level such as the GP Health Service. There should be investigation into current awareness levels of the GP Health Service, GPs' experiences of using the service, and potential routes to improve the service going forward. This should be considered alongside routes to expand current support systems to the whole of the primary care workforce, to ensure that the entire practice team is getting the support it needs to provide effective mental health support to patients.

Workforce and funding need urgent consideration

All previous points need to be considered alongside the urgent issues of workforce and funding. We know that, even in high-risk roles such as those within the emergency services, factors such as excessive workload and long hours are greater triggers for mental health problems than the content of the work itself. Therefore, we can reasonably assume the same of GPs, and that GPs' mental health cannot be effectively supported without also addressing the culture of long hours and excessive workloads in which they operate. NHS England, Government, the Royal College of GPs and the General Medical Council should together address current primary care pressures and how these can be alleviated as much as possible, using opportunities such as the NHS Long Term Plan to do so.