The NHS GP Health Service: providing mental health support

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GPs with mental ill health will rarely admit their emotional vulnerabilities to colleagues and therefore find it difficult to access existing local mental health services. This article discusses the NHS GP Health Service, a new England-wide service that offers confidential help for GPs experiencing mental health issues.

If you are a doctor who finds him or herself in poor mental health, to whom do you turn? Until now, there has been a tendency for GPs to try to manage their own mental health problems rather than risk loss of anonymity via consultation and treatment. However, the new GP Health Service, an initiative commissioned and funded to the tune of £19.5 million over five years by NHS England via the General Practice Forward View, seeks to change all that. Launched at the end of January 2017, it is billed as a free and confidential service for GPs and GP trainees who are suffering with a mental health concern, including stress, depression and addiction.

According to the evidence, such support is much needed. A British Medical Journal report in 2012 found that 46% of the 564 doctors surveyed had high levels of emotional exhaustion, while an analysis of more than 2200 GPs in 2015 by Pulse magazine showed rising levels of burnout. Up to 20% of UK doctors become depressed at some point in their career and doctors are at higher risk of suicide than the general population.

Mental health support
Mental health support has already been offered to doctors and dentists living in the London area for the past nine years through the NHS Practitioner Health Programme, operated by the Hurley Group, the biggest NHS GP partnership in London. Following a period of open tender, NHS England also awarded the contract of the nationwide rollout to the Hurley group, with many of the same personnel, including medical director Dr Clare Gerada (previously chair of the RCGP 2010–2013), clinical director Richard Jones and chief executive officer Lucy Warner at the helm.

Though the service is to be headquartered in London at the Riverside Medical Centre, Wandsworth, the idea is that GPs will be able to access local services in 13 different areas throughout the country. “We’re currently building a team of experienced clinicians and therapists working from locations across England able to offer assessment and ongoing treatment,” says Lucy Warner.
Fear and stigma still a big issue

Key to the success of a scheme such as the GP Health Service is that doctors can self-refer and not tell anybody they are seeking help. In spite—perhaps even because—of their role, many doctors still see stress or depression as a weakness, and there is a recognised need to reduce the stigma attached to mental ill health. This, indeed, is the precise aim of a new campaign called “&me”, launched by the Doctors’ Support Network this February, which encourages senior, currently well, healthcare professionals to informally identify as having experienced a mental health condition.

“The stigma is there with mental health in a way it wouldn’t be if you were, say, a doctor with diabetes,” observes Lucy Warner. “It’s difficult for GPs to say they have depression or that they feel absolutely anxious about doing their job just now, as they feel it will impact the confidence their colleagues have in them and affect their career prospects.”

Perhaps more than anything, most GPs with mental health issues want to be assured that if they seek help, they won’t have to discuss their problems with a health professional they know. “Lots of doctors have a range of roles and can run into people in a variety of ways, so that is why they are unlikely to access mental health services though the normal local routes. This is where the GP Health Service can help,” Ms Warner explains.

How will the service work?

When GPs decide they want to refer themselves to the service, they can do so via phone or email, details of which are on the website at gphealth.nhs.uk. After completing a few basic registration forms, there is an initial assessment on the phone to understand what the issues are, and the GP is then given access to an app that allows booking of a face-to-face assessment with a clinician and any ongoing therapeutic appointments. It’s here that the important issue of anonymity can be respected, says Ms Warner. “They go into the app and put their postcode in and then they can select a clinician or therapist close by or further away if they prefer, and make sure they’re not breaching their confidentiality by linking to someone they know.” A flowchart giving an overview of how the service is to be delivered to the patient is shown in Figure 1.

Many doctors worry that if they admit to suicidal thoughts, alcohol abuse or addictions they may be considered unfit to practice and be reported to the GMC for investigation. But a written agreement between the two organisations allows the GP Health Service to see and treat GP patients without informing the GMC in the vast majority of cases.

“The exceptions to this could include where patient safety is at risk, where a practitioner is not complying with assessment or treatment, or where even though currently abstinent from illicit drugs, there is a serious risk of relapse,” notes Ms Warner. If such a situation were to occur, the service would support the GP to self-refer to the GMC or, in rare cases, contact the GMC directly, but with the GP’s knowledge.

Clinical perfectionism – a doctor’s curse?

When perfectionism is taken to an extreme level, it can interfere with the ability to work, study or maintain relationships. Whether clinical perfectionism—which is often associated with eating disorders, obsessive compulsive disorder and depression—is more common in the medical profession compared with the general population isn’t known for sure but GP Health Service chief executive officer Lucy Warner says: “We certainly do see it a lot, for example younger doctors who have done very well through medical school and training and then the very first time they make a mistake—no harm done—they absolutely catastrophise it. Or in a practice that has a CQC inspection, there could be a really minor issue like a policy being out of date and yet the doctor feels like an absolute failure.” Treatment for clinical perfectionism usually involves cognitive behavioural intervention, which is one of a range of therapies that doctors can access via the GP Health Service.
More to be done
But while all agree that the introduction of the service is highly laudable, the BMA thinks still more must be done for GPs suffering burnout due to an ever-increasing workload. “It’s an important step forward that will help GPs, but we do need more action from government,” says BMA GP committee chair, Dr Chaand Nagpaul. “This must include the implementation of a comprehensive occupational health service for GPs and their staff, which currently does not exist as it does for other members of the NHS workforce.”

The RCGP adds that while the service is “an incredibly welcome development” – they contributed to the development of the service specification along with the BMA, GMC and others – there are big geographical gaps. “We now need to see similar schemes – as part of wider commitments to increase investment in general practice and build GP numbers – in Scotland, Wales and Northern Ireland,” notes RCGP chair professor Helen Stokes-Lampard.

But for those who can access it, the service can be a literal lifeline. As one doctor who got help from the Practitioner Health Programme (the London precursor to the GP Health Service) explains anonymously to Prescriber: “It was an extremely valuable service when I was in a crisis and after. I managed to get back to work and I believe I am still alive thanks to the help I received. Everyone from the admin team, my psychiatrist and psychologist have been so kind and I felt I had a safe place to turn to.”

With our doctors being emotionally supported in this way, this can only be better for patient care.

References

Declaration of interests
None to declare.

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POEMs

Dexamethasone may reduce sore throat symptoms in adults at 48 hours

Clinical question:
Are oral steroids effective in the treatment of acute sore throat in adults?

Bottom line:
A single dose of oral dexamethasone is no more effective than placebo in resolving acute sore throat symptoms at 24 hours in adults who do not receive immediate antibiotic therapy. However, among a multitude of exploratory secondary outcomes, the authors found that dexamethasone compared with placebo did increase the proportion of patients with symptom resolution at 48 hours (number needed to treat (NNT) = 12; 95% CI 7–146). (LOE = 1b)

Reference:


Synopsis:
These investigators identified adults, 18 years or older, who presented to primary care offices in England with acute symptoms of sore throat and odynophagia for which the treating clinician did not prescribe immediate antibiotic therapy. Exclusion criteria included the recent use of inhaled or oral corticosteroids, recent adenotonsillectomy, recent use of antibiotics, or a clear alternative diagnosis such as pneumonia. Eligible participants (n=565) randomly received (concealed allocation assignment) a single dose of dexamethasone (10mg) or matching placebo. Treating clinicians could decide to offer no antibiotics (n=349) or a delayed antibiotic (n=227). Patients unaware of group assignment self-assessed outcomes including the primary outcome of complete resolution of sore throat symptoms at 24 hours. Secondary exploratory outcomes included complete resolution of sore throat at 48 hours, duration of moderately bad symptoms, time to onset of pain relief and time to complete resolution of symptoms, consumption of delayed antibiotic prescription, time missed from work or education, attendance at or telephone contact with any healthcare facility because of the sore throat, and use of over-the-counter medications and/or other prescription medications in the first seven days.

Complete follow-up occurred for 94% of participants at one month. Using intention-to-treat analysis, no significant difference occurred among the steroid group and the placebo group in achieving complete resolution of symptoms at 24 hours. Results were similar between patients who were and were not offered a delayed antibiotic prescription. At 48 hours, significantly more participants who received dexamethasone reported complete resolution of symptoms compared with those who received the placebo (35.4% vs 27.1% respectively; NNT=12; 95% CI 7–146). Neither severity of sore throat at baseline nor a positive throat culture for Streptococcus bacteria on throat swab were related to group differences. No significant differences occurred between the treatment group and the placebo group in other secondary outcomes or serious adverse events.