‘Without mental health there is no health’

There is a real difference between mental health and mental illness. Whilst both terms are often used synonymously, they are not the same Neither is mental health the mere absence of mental illness, it is a positive state of wellbeing and total health as defined by the WHO. This states that

> **Health is a state of complete physical, mental and social well-being and not merely the absence of disease or infirmity**.[1]

The report of the Expert Group in Mental Health Policy, *A Vision for Change*, was published on the 26th January 2006. *A Vision for Change* sets out an ambitious programme of reform designed to modernise our mental health services, improving service quality, setting recovery as the expected outcome and ensuring that the service users’ best interests remain at the heart of the service.

Of the 209 recommendations, 80 % have an impact on general practice; as general practitioners care for and support individual patients from their birth to their death, managing acute and chronic illnesses while promoting and maintaining patients’ mental health in their individual contexts.

Mental illness and mental distress affect a person’s self-view, health-seeking behaviour and life-style choices. People with low self-esteem and low self-efficacy feel less enabled to adopt life style changes or positive health behaviours. People with mental illness have a higher incidence of smoking, obesity, use of drugs and alcohol and poor nutrition. We know that the immune system, the endocrine system and the neurotransmitter system is integrated; evidence has shown associations between mental illness and alterations in immunity Mental illness also accompanies many chronic conditions such as cancer, COPD, arthritis, diabetes and heart disease as an associated co-morbidity.

The Health Research Board National Psychological Wellbeing and Distress Survey (NPWDS) showed that 60% of the Irish population who reported mental health problems in the last year sought help through primary care with only a small minority consulting more specialised mental health services (Tedstone Doherty et al, 2007).

Chapter 7 of ***A Vision for Change*** - *Mental Health in Primary care*, contains the main recommendations that impact on General Practice

RECOMMENDATION 7.12 states

All individuals should have access to a comprehensive range of interventions in primary care for disorders that do not require specialist mental health services.

It is estimated that23%-27% of the general population have experienced psychological distress or mental health problems. (Barry *et al.* 2009;, Blake *et al*. 2000; Tedstone Doherty *et al.* 2007) The majority of patients with mental health difficulties are GMS patients, with limited direct access from GP care to a range of therapies of proven efficacy (i.e. CBT, Psychology, etc, as recommended in this report).

Recommendation 7.2

Further research and information on the prevalence of mental health problems in primary care and the range of interventions provided in primary care is needed to effectively plan primary care services and the interface between primary care and specialist mental health services..

The ICGP has actively supported the development of Mental Health services, including the following in partnership with the HSE

1 Joint Forum of the Irish College of General Practitioners and the College of Psychiatry of Ireland

2 The Power of Words (Bibliotherapy)

3 Mental Health E learning for GPs

4 CBT training for GPs

5 Youth and adolescent mental health education package (under development)

Recommendation 7.3

All mental health service users, including those in long-stay wards, should be registered with a GP.

This recommendation is at best aspireational. When a service user is discharged from in-patient Psychiatric services (Mental Hospital) into community housing they are registered with a GP in the majority of cases. Problems have arisen when the patient is under the supervision of the mental health team with little or no communication between the GP and the mental health service on the plan of care for the individual patient. This prompts the question "who has medical responsibility for the mental health service user in the community?"

Recommendation 7.4

Appropriately trained staff should be available at the primary care level to provide programmes to prevent mental health problems and promote wellbeing

The role of Mental Health Promotion is underrated in the delivery of a comprehensive mental health serviceMental health promotion works at three levels and at each level is relevant to the whole population including individuals at risk, vulnerable groups and people with mental health problems.

Strengthening individuals – by increasing emotional resilience through interventions designed to promote self-esteem and coping skills, e.g. communicating, negotiating, relationship skills and parenting skills.

Strengthening communities – by increasing social support, social inclusion and participation, improving community safety, neighbourhood environments, promoting childcare and self-help networks, developing health and social services which support mental health, promoting mental health within schools and workplaces e.g. through anti-bullying strategies and mental health strategies.

Reducing structural barriers to mental health – through initiatives to reduce discrimination and inequalities and to promote access to education, meaningful employment, housing, services and support for those who are vulnerable.

(Department of Health 2001)

Recommendation 7.5

It is recommended that the consultation/liaison model should be adopted to ensure formal links between CMHTs and primary care.

Emerging evidence in the UK and Ireland indicates that the level of psychological distress or severity of mental health problems for which people seek help in primary care is not confined to minor difficulties. Lester (2006) suggests that in the UK over half of patients with severe and enduring mental health problems are dealt with solely by the primary care team while in Ireland a study by Gavin *et al*. (2005) estimated that 97% of general practitioners were currently treating a patient with a diagnosis of schizophrenia and 22% of these were doing so, without specialist input following an initial referral to psychiatric services. The Joint Forum ICGP/CPsychI are seeking to address this and the Cavan model (Dr Vincent Russell et al) will be studied with a view to making a recommendation to both Colleges, on shared care.

Recommendation 7.6

Mental health professionals should be available in Primary Care settings, either within community care, the primary care team, or the primary care network.

This is being implemented in a very disjointed manner, and with the reduction in staff numbers in the psychiatric services this recommendation will be very hard to achieve. Where staff with mental health expertise are in place in primary care it has been reported to be working well and the service to the patient has improved.

Recommendation7.7

Local multidisciplinary CMHTs should provide a single point of access for primary care for advice, routine and crisis referral to all mental health services (community and hospital based).

This is one of the recommendations that would be relatively easy to establish by assigning a named person or persons in the CMHT with a dedicated phone number for use by local GPs only.

This was suggested to the HSE in 2008 but little has changed in the interim.

Recommendation 7.9

A wide range of incentive schemes should be introduced to ensure mental health treatment and care can be provided in primary care.

We are now coming to the half way stage of the life time for *A Vision for Change* and yet we are still struggling to implement this Government Policy. The barriers to its implementation must be addressed.

Barriers occur at three levels; provider level, patient level and system level.

Provider level barriers include a lack of education/training on mental health in primary care; personal and professional beliefs, attitudes of both primary care and specialist practitioners, lack of access to options for care other than prescription medication and lack of communication on individual patient progress, set-backs and care plans among providers

Patient level barriers included the reluctance of individuals to engage with specialist mental health services due to associated stigma and lack of awareness of mental health services, alternative health beliefs and those who prefer to continue treatment with their primary care doctor.

System level barriers include absence of or limited access to a range of referral pathways for those not requiring specialist services; inadequate clinical and patient information systems to support practice within each setting; lack of integration of care by various providers and professionals andtime pressures in primary care. Challenges to performing detailed assessments of those presenting with mental health problems are further compounded by lack of financial support for the development of improved systems of service in the practice (such as access to allied services) in order to secure better outcomes for patients at the primary care level, for example family support, parenting skills and social worker involvement. Chronic disease management in primary care is best managed with access to a multidisciplinary team and this is no different for the management of chronic mental illness.

Conclusion

There are many examples where treatments and interventions have moved from hospitals to general practice e.g. Heartwatch and Diabetes. Similar models could readily be employed for mental health.

The majority of patients who seek help for a mental health disorder do so from their GP. GPs and the practice team are ideally placed to promote early identification and provide early intervention for individuals experiencing mental health difficulties. The GP practice has a pivotal relationship between service users, carers and other mental health service professionals. General practice can deliver high quality mental health care **if it has access to relevant adequate resources and structures.**

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