Mental Health in Primary Care

Mimi Copty

Acknowledgments

The South Western Area Health Board would like to acknowledge the contributions of all of the service users, General Practitioners and Mental Health service providers who took part in this study. Their time and experience are greatly appreciated.

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Many thanks to the members of the Steering Group who gave generously of their time and expertise, and certainly contributed to the success of the project in Phase I.

Steering Committee Membership in Phase I

South Western Area Health Board

Martin Rogan - Assistant Chief Executive
Angela Walsh - Primary Care Manager, Primary Care Unit
Dr. Philip Wiehe - General Practitioner, Primary Care Unit
Dr. Bernard Murphy - Consultant Psychiatrist
John Hynes - Assistant Director of Nursing
Gerard Perry - Principal Psychologist
Michael Cummins - Development Officer, Mental Health Ireland
Noreen Murphy - Director of Public Health Nursing
Siobhan Murphy - Project Manager, Dublin South West Partnership in Primary Care

Eastern Regional Health Authority

Ciaran Browne - Research Officer, Directorate of Monitoring and Evaluation

Irish College of General Practitioners

Dr. Andree Rochfort - Director, Health in Practice Programme
Mimi Copty - Project Director, Mental Health in Primary Care

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It should be noted that the views and sentiments expressed in this report are those of the survey respondents and members of the Focus Groups and do not represent the views of the Steering Committee, the South Western Area Health Board or the Irish College of General Practitioners.

EASTERN REGIONAL HEALTH AUTHORITY

icgp

South Western Area Health Board
Bord Sláinte an Limistéir Thiar Theas

Mental Health in Primary Care

I Executive Summary

Purpose of Study

The purpose of the study is to review the current state of mental health service delivery in primary care settings in the South Western Area Health Board (SWAHB). The study examines:

- Types and levels of mental health services provided in general practice
- Referral patterns to secondary care
- Needs of GPs, mental health service providers, and service users
- Service gaps

Background

In keeping with the paradigm shift towards community and primary care, underlined by most of the new policy documents, the SWAHB supports a community care model where the majority of people s health needs, including mental health, are provided within primary care. However, in order to sustain this preferred model, a comprehensive examination of the current mental health service delivery in general practice was required.

Methodology

A combination of quantitative and qualitative techniques was employed. The views and perspectives of the three involved parties: GPs, mental health service providers (consultant psychiatrists and allied mental health professionals) and service users were examined.

Findings

The high response rate by GPs and consultant psychiatrists in the SWAHB - 64% and 77% respectively - indicate a strong level of interest in the area of mental health in primary care.

There is strong agreement among all the surveyed parties that the present system has its deficiencies and room for improvement. However, the providers seem to be more satisfied with the system than the service users. It is also evident in the report that there is a **need for**:

There is a Need for

- Specific mental health skills training among GPs
- Agreed protocols for detection, assessment, treatment, referral, follow up and discharge
- Improved communication among mental health service providers and general practitioners
- Greater information dissemination among all parties involved

The study has accomplished its aim of presenting a comprehensive picture of mental health delivery in primary care in the SWAHB based on the perceptions of providers and service users.

Recommendations

The recommendations are based on four themes that the study suggested would contribute to the desired state as perceived by the participants:

1. GP Training
2. Development of protocols
3. Collaboration among all parties
4. Information dissemination

All of the service providers in the study (GPs, consultant psychiatrists, psychologists, social workers and occupational therapists) expressed their willingness to work together to overcome the barriers in order to enhance patients quality of care.

Funding Approved for Phase II

These recommendations call for changes in the current system both to support underlying policy principles and to enhance efficiencies in the delivery of care. The SWAHB is committed to making these recommendations a reality. As a first step, the SWAHB has approved the funding for the Second Phase of the Mental Health in Primary Care project. The scope of Phase II will be to implement the recommended changes.

II Project Background

Need to Evaluate Mental Health System

In light of recent developments in the area of mental health care at local, regional, and global levels, there is a need to evaluate the delivery of mental health care in Ireland. The Inspector of Mental Hospitals Report focuses primarily on the provision of mental health care within psychiatric services. However, most Irish people receive their mental health care within the primary care setting. The evaluation should lead to a better understanding of the current system and promote developments to enhance the effectiveness and efficiency of the delivery of mental health service.

The SWAHB provides health and personal social services to approximately **581,000 people** living in:

- Dublin South City
- Dublin West
- Dublin South West
- County Kildare and West Wicklow (see Appendix 1)

Over 360 General Practitioners provide primary health care services to individuals and families in those areas. Many individuals visiting GPs experience mental health difficulties ranging from mild and transitory distress to severe, enduring and disabling mental illness.

In keeping with the paradigm shift towards community and primary care, underlined by most of the new policy documents, the SWAHB supports a community care model where the majority of people s health needs, including mental health, will be provided within primary care. Moreover, responding to mental health difficulties and disorders also requires a continuum of interventions that are available within both general practice and specialised mental health settings.

In order to sustain this preferred model, it became evident that a comprehensive examination of the current mental health service delivery in general practice was required. Despite the key role of general practitioners in the provision of mental health services in the Irish health care system historically, little is known about the extent and types of mental health services provided in primary care. Until now most of the data has been derived from research conducted in the UK. This lack of crucial information prompted the SWAHB and the Eastern Regional Health Authority (ERHA) to conduct a research project to examine:

Research Project to Examine

- Provision of mental health services in the community
- Types and levels of mental health services provided in general practice
- Referral patterns to secondary care
- Needs of GPs, mental health service providers, and service users
- Service gaps

This review was to be followed by an interim report highlighting the findings and recommending specific changes to the current mental health system.

Based on the objectives of the study and the primary role of the GPs in the study, the Irish College of General Practitioners (ICGP) joined the SWAHB in co-sponsoring this research project. Subsequently, a steering committee was established to direct the Mental Health in Primary Care Project composed of primary care and mental health service providers representing:

Steering Committee

- **The Irish College of General Practitioners**
- **The South Western Area Health Board**
- **The Eastern Regional Health Authority**

Policies that inspired the development of the Mental Health in Primary Care Project:

- **The National Health Strategy Quality and Fairness 2001** presents new opportunities in the area of mental health in keeping with its four goals:

Goals of the National Health Strategy

1. Better health for everyone
2. Fair access
3. Responsive and appropriate care delivery
4. High performance

Action 25 of the Strategy states that a new action programme for mental health will be developed. Three of its key deliverables are:

- Setting up the Mental Health Commission and implementation of the Mental Health Act 2001
- Establishing a national policy framework for the modernization of mental health services
- Promoting positive attitudes to mental health

- **The Primary Care Strategy 2001** Action 10 states that there will be greater integration between primary and secondary care. Local arrangements for referral, care pathways, shared care, access to diagnostic services, and discharge between primary care and secondary care should be in place. This National Strategy plays an important role in promoting the involvement of primary care in the identification and treatment of psychiatric conditions in general health.

- **WHO Report 2001** recommends that countries should include the integration of mental health treatment and services into the general health system, particularly into primary care. Its ten recommendations are:

Recommendations of WHO Report 2001

1. Provide treatment in Primary Care
2. Make psychotropic drugs available
3. Give care in the community
4. Educate the public
5. Involve communities, families and consumers
6. Establish national policies, programmes and legislation
7. Develop human resources
8. Link with other sectors
9. Monitor community mental health
10. Support more research

- The publication of the **Public Health Action Framework** on **Mental Health 2000** by the European Commission advocates that each member state should integrate mental health and its promotion with all public health strategies.

- **Shaping a Healthier Future - A Strategy for Effective Healthcare in 1990s** highlighted the importance of developing services for people with mental illness in appropriate settings.

- The publication of the national health policy document **Planning for the Future** (1984) led to a paradigm shift in the provision of mental health services from hospital-based to the community. It recommended that mental health services should be comprehensive; integrated with other health services; based in the community; organized in sectors close to the people being served.

In addition to these national and global policies, the SWAHB s dedication to the promotion of mental health is evident in its mental health mission statement:

SWAHB Mental Health Mission Statement

Through the provision of comprehensive, integrated, coordinated, high-quality and patient centred mental health services, the South Western Area Health Board aims to achieve the best quality of life for people experiencing mental illness. We strive to provide a seamless service to all patients, measured by ease of access, appropriateness of care and responsiveness to their needs.

Project Summary

***What** we already **know** about Mental Health in Primary Care:*

- Majority of mental health services are provided in primary care settings
- Significant percentage of primary care caseload is categorised as mental health
- Only a small percentage of patients are referred to mental health specialists
- There is a communication gap between primary care providers and specialists

***What** we would **like to know** about Mental Health in Primary Care:*

- Level and types of mental health services provided by GPs
- Current reality of the service for GPs, mental health community and patients
- Level of awareness among GPs with reference to mental health
- Level of interface between primary care and secondary care providers
- GPs need for support and training to respond to the spectrum of mental health issues in their practices

III Project Aims and Objectives

The aim of the study is to evaluate the current state of mental health service delivery in primary care in the South Western Area Health Board.

The objectives of the study are to:

1. Identify the extent of mental health services provided in primary care
2. Determine the percentage of GP caseload that falls within the category of mental disorder
3. Specify which psychiatric conditions are currently treated in a general practice setting
4. Assess GPs patterns of referral to mental health services
5. Gain a better understanding of the views of all parties involved (service users, GPs and mental health service providers) on the current state of mental health services
6. Determine barriers to the provision of optimal mental health care in general practice
7. Identify training and support needs for GPs to improve the provision of mental health services

IV Methodology

A combination of quantitative and qualitative techniques was employed to examine the views and perspectives of the three involved parties:

- GPs
- Mental health service providers
- Service users

A questionnaire was sent to all GPs and another was delivered to consultant psychiatrists in the SWAHB. The two questionnaires were followed by three focus group studies. The first group included GPs, the second service users and the third psychologists, occupational therapists and social workers.

A. Quantitative Research - Surveys

A.1. General Practitioners

The questionnaire instrument was designed based on the project s scope and objectives. It was developed in conjunction with a steering committee comprised of primary care and mental health service providers representing the Irish College of General Practitioners, the South Western Area Health Board and the Eastern Regional Health Authority.

An early version of the questionnaire was pre-piloted among GPs at the ICGP. A revised version was piloted among GPs who attended a conference on Suicide Prevention held in Dublin on September 25th, 2002 sponsored by the SWAHB.

The final version (see Appendix 2) consisted of 20 questions under three main sections:

- **GP s Patients**
- **GP s Local Mental Health Services**
- **GP s Practice**

The first two sections aimed to:

- **Assess level and types of mental health conditions treated in primary care**
- **Evaluate GPs needs to improve the delivery of mental health in their own practice**
- **Determine GPs knowledge and skill level in detecting/treating/referring mental health conditions**
- **Measure GPs attitudes and perceptions of mental health services in the SWAHB**

The third section consisted of:

- **Demographics of both practice information as well as personal characteristics which were used to interpret the results**

The questionnaire was sent to all GPs in the SWAHB. A composite list of targeted GPs was created using lists from the SWAHB Primary Care Unit as well as the ICGP database. The list of GPs contained both private practitioners as well as GPs registered under the General Medical Service (GMS) scheme who practice in the SWAHB. The list of 414 GPs was continuously revised for duplications, deaths, retirements, and changes in GPs speciality and practice location. It was later verified that only 362 GPs were active in the SWAHB.

A questionnaire letter accompanied the survey emphasising confidentiality as well as a project summary sheet highlighting the scope and aim of the project.

The questionnaire was followed by two postal reminders (two weeks apart) including the complete original packet. Completed questionnaires were returned freepost to the ICGP.

A.2. Consultant Psychiatrists

The questionnaire instrument was designed to complement the areas covered in the GP questionnaire to ensure comparability of perspectives in the analysis stage. The steering committee which reviewed and approved the tool consisted of several mental health providers:

- One psychiatrist
- Two psychologists
- Several psychiatric nurses

The questionnaire was then piloted at the ICGP. The final version consisted of nine multiple-choice questions (see Appendix 3). These sections aimed to:

- Assess psychiatrists views of GPs and their practices in treating/referring mental health patients
- Measure the psychiatrists attitudes and perceptions towards the delivery of mental health services in primary care

The postal survey was sent out to thirty consultant psychiatrists in the SWAHB. A complete list of the consultant psychiatrists was obtained from the SWAHB psychiatric services.

A questionnaire letter accompanied the survey as well as a project summary sheet highlighting the scope and aim of the project. A freepost card was also provided to prevent issuing unnecessary reminders. The questionnaire was followed by telephone calls. Completed questionnaires were returned freepost to the ICGP within a period of five weeks.

B. Qualitative Research - Focus Groups

B.1. General Practitioners

Participants

Over 70% of the surveyed GPs had indicated that they were interested in taking part in future studies such as focus groups. However, setting up the focus group meetings proved to be a challenging task. Several telephone calls were made to interested GPs to request their participation in a 2-hour focus group meeting.

Five GPs were identified and selected to participate. The participants were inner city and urban doctors who have been in practice for a minimum of ten years. The group consisted of two women and three men. The majority of the group had mixed practices of both private and GMS patients; one member had mostly private patients and another had mostly GMS patients.

Open-ended questions were used as topic guides. Probing questioning techniques were used to facilitate discussion flow and to encourage participation by all members in a manner that reflected their perceptions, attitudes and feelings.

The group was assisted by a GP acting as a facilitator and a minute-taker who also helped with the facilitation. The discussion was recorded, and confidentiality was assured. The focus group meeting was held at the ICGP in Dublin.

B.2. Psychologists/Social Workers/Occupational Therapists

Participants

Eight allied mental health service providers (5 women and 3 men) were recruited to take part in the focus group from the various SWAHB catchment areas.

- Two clinical psychologists
- Four social workers
- One counsellor with a nursing background
- One occupational therapist

They worked in a variety of settings including community clinics, day hospitals, general hospitals and psychiatric hospitals. Some had direct patient care; others were in line management. Half of the participants also had work experience in the UK.

The facilitator was a clinical psychologist who has also been on the Mental Health in Primary Care project s steering committee. The note-taker also assisted in the facilitation. The discussion was recorded. The meeting took place at the ICGP in Dublin.

B.3. Service Users

Participants

Eight individuals (5 women and 3 men) took part in this study. They had a wide range of mental health problems including depression, anxiety (panic attacks, and phobias), schizophrenia, and bipolar affective disorder.

These individuals have been in the mental health system from 3 to 15 years and have been treated in a variety of settings and locations including psychiatric inpatient units, day hospitals, psychiatric outpatient clinics, psychologist/therapist offices and GP surgeries.

They were recruited through multiple channels including mental health voluntary agencies, SWAHB Day Hospitals and Club Houses, and referrals from therapists and social workers.

The main criterion in their selection was that they had experiences in both general practice as well as community psychiatric services during the course of their diagnosis and treatment. The participants resided in the South Western Area Health Board catchment areas.

A male and female facilitator assisted with the study in order to ensure that both genders in the group felt comfortable. One of the facilitators had over 20 years of experience in both the clinical and administrative aspects of mental health. The second facilitator had 23 years of experience in public health nursing and management. A note-taker who also assisted with the facilitation was present.

Open-ended questions were used to guide the group. The facilitators checked with the participants on the clarity of each question prior to discussion. The discussion was recorded. The meeting took place at the ICGP in Dublin.

V. Findings

A. QUANTITATIVE RESEARCH FINDINGS

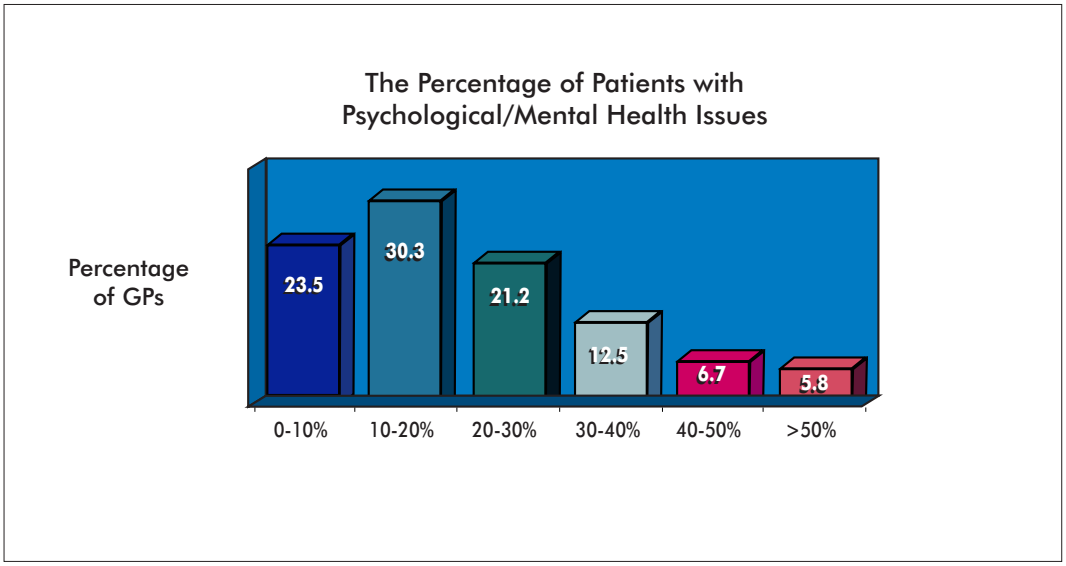
A.1 GP Survey Results

- A total response rate of **64%** was achieved (n=231) 8 weeks after sending the first mailing.
- The data is represented under each main heading in figures, tables or charts.
- Percentages used in the findings refer to valid percentages, which means that percentages are calculated from **those who responded** to each question rather than the whole data set.
- Differences among respondents with statistical significance of at least **p<0.05** were noted.

GP s PATIENTS

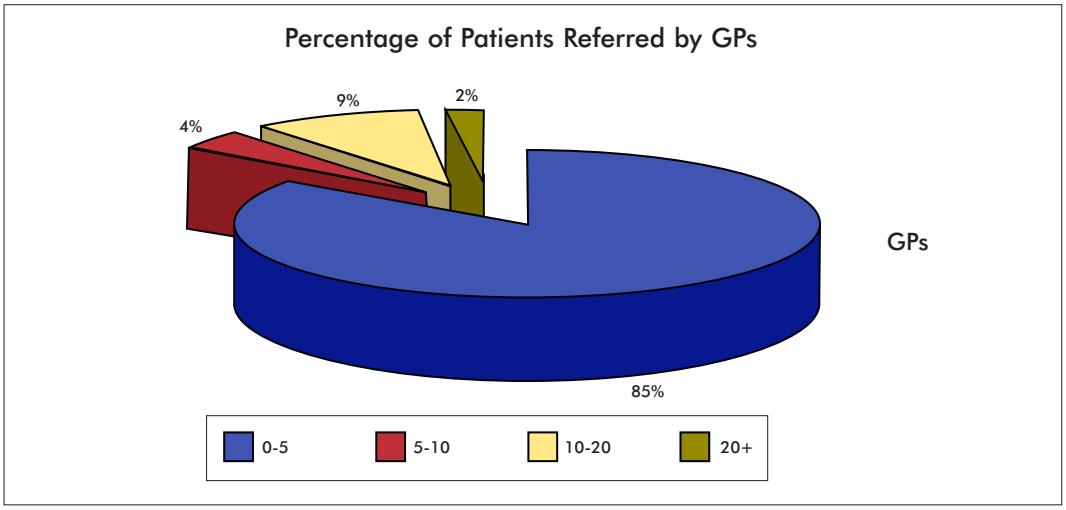
Percentage of Patients with Mental Health Issues

- Approximately a third reported that between 10% and 20% of their caseload have some mental or psychological issues
- Approximately a quarter stated that fewer than 10% of their patient population have mental health problems
- A total of 76.5% indicated that more than 10% of their patients have mental health issues



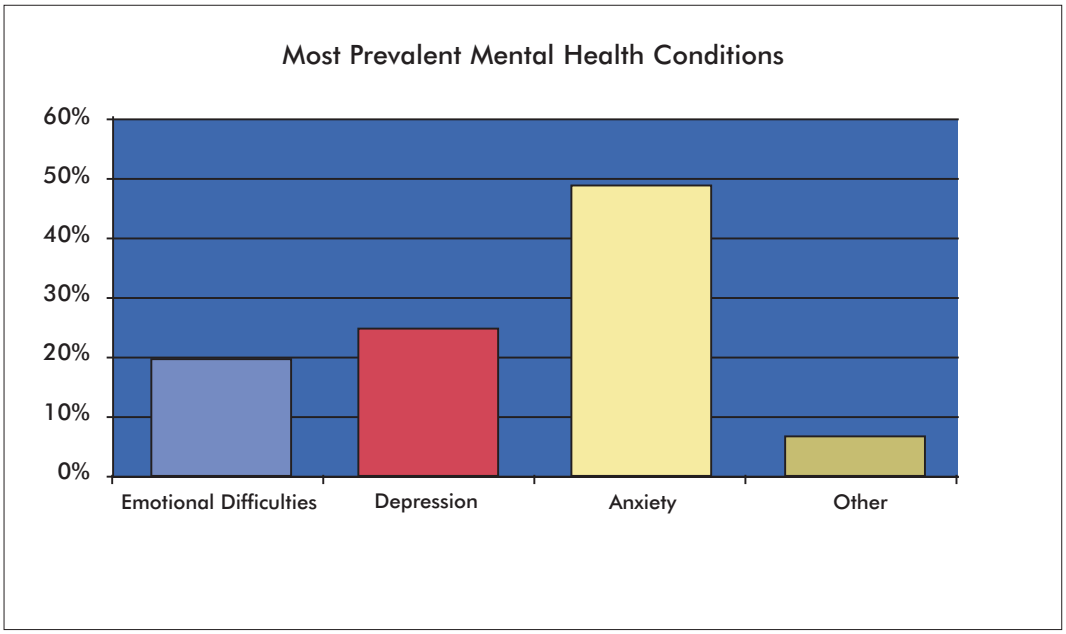
Percentage of Mental Health Patients Referred to a Mental Health Specialist

- 85% of GPs indicated that they referred fewer than 5% of their patients to mental health specialists



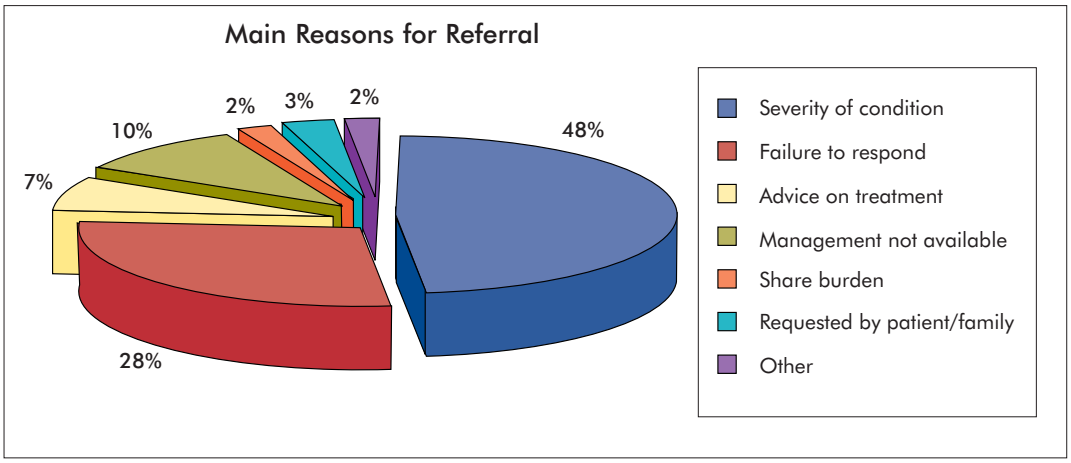
Most Prevalent Mental Health Conditions in Patient Population as Ranked by GPs

- Anxiety disorder (49%) ranked first
- Depression (24%) ranked second
- Emotional difficulties (20%) ranked third
- Other (7%) including eating disorder, psychotic disorder, and substance abuse ranked fourth



Main Reasons for Referral

- Severity of condition (48%) ranked as the main reason for referral
- Failure to respond to treatment (28%) ranked second
- Management not available in General Practice (10%) ranked third



Mental Health Conditions Treatable in General Practice, with Adequate Support

- Anxiety disorders (80%)
- Emotional difficulties (72%)
- Depression (69%)
- Eating disorders (38%)
- Substance abuse (35%)
- Psychotic disorders (18%)

Support Services Needed to Treat Conditions Not Currently Managed in General Practice

- The majority of GPs (81.5%) indicated that they would like to have access to counsellors or psychologists
- Only 5% would like to have support from psychiatrists
- Others desired access to community psychiatric nurses

GP s LOCAL MENTAL HEALTH SERVICES

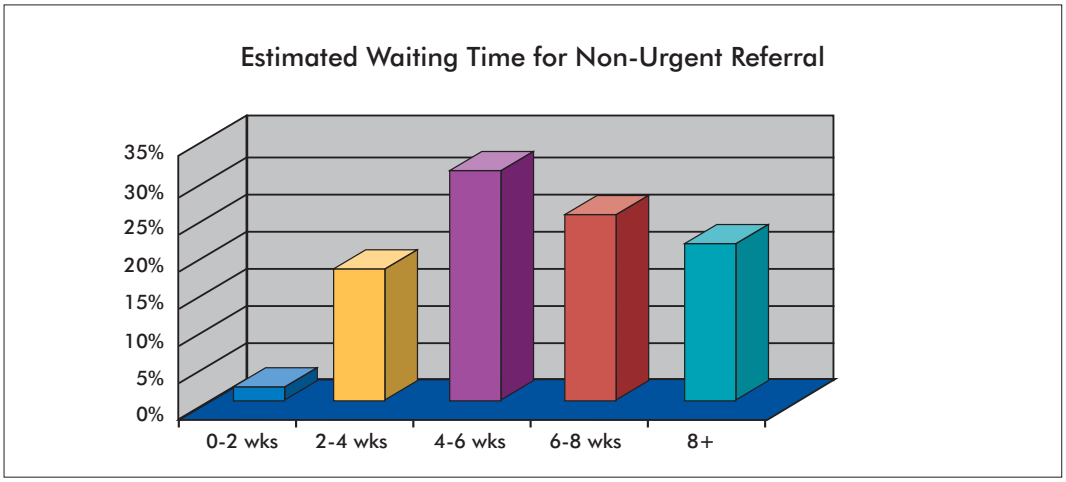
Contact to Arrange for a Non-Urgent Mental Health Assessment

- 44.3% of GPs refered to the Mental Health Team
- 42% refered directly to local psychiatrist

Non-Urgent Referral to	N	%
Mental Health Team	100	44.3
Psychiatrist	95	42.0
Hospital	21	9.3
Other (Unspecified)	10	4.4

Current Waiting Time for a Non-Urgent Referral for Mental Health Assessment

- 31.8% estimated a waiting time of between four and six weeks
- 25% believed that it took 6-8 weeks for a non-urgent referral
- A total of 79.8% estimated a waiting time of at least four weeks



Contact For an Urgent Mental Health Assessment

- 47% of GPs referred their patients to the local psychiatrist in urgent cases
- 29.5% of GPs referred patients through the local community psychiatric team

Urgent Referral to	N	%
Psychiatrist	105	47.0
Mental Health Team	66	29.5
Hospital	49	22.0
Other	4	1.5

Initial Point of Contact for Child and Adolescent Mental Health Services

- 56% of GPs stated that they contacted child clinics or family clinics in their area
- 27% referred directly to psychiatrists
- 17% referred to hospitals

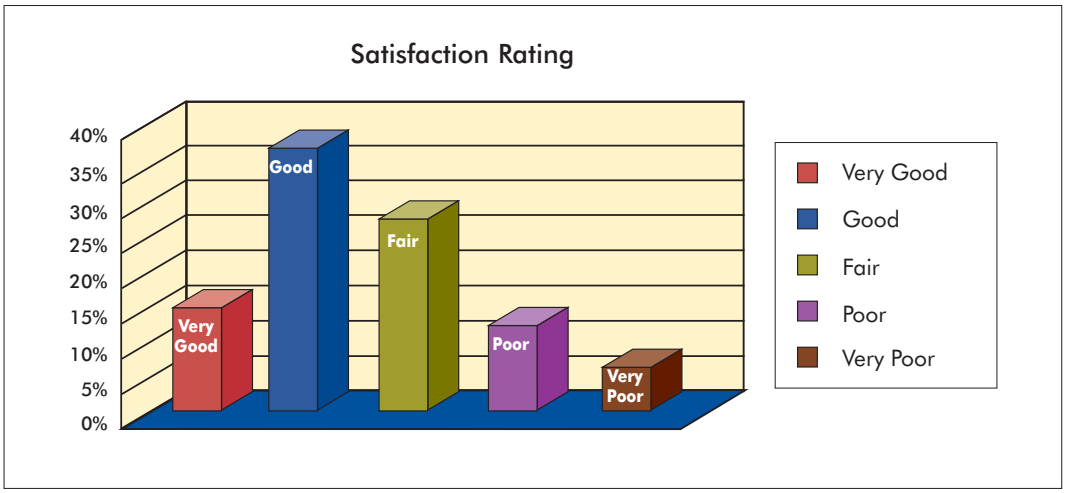
Mode of Communication Used When Referring Patients

- 65.9% of respondents used letters for referrals
- 23.8% used facsimile as a mode of communication

Mode of Communication	N	%
Letter	147	65.9
Facsimile	53	23.8
Telephone	21	9.4
Other	2	0.9

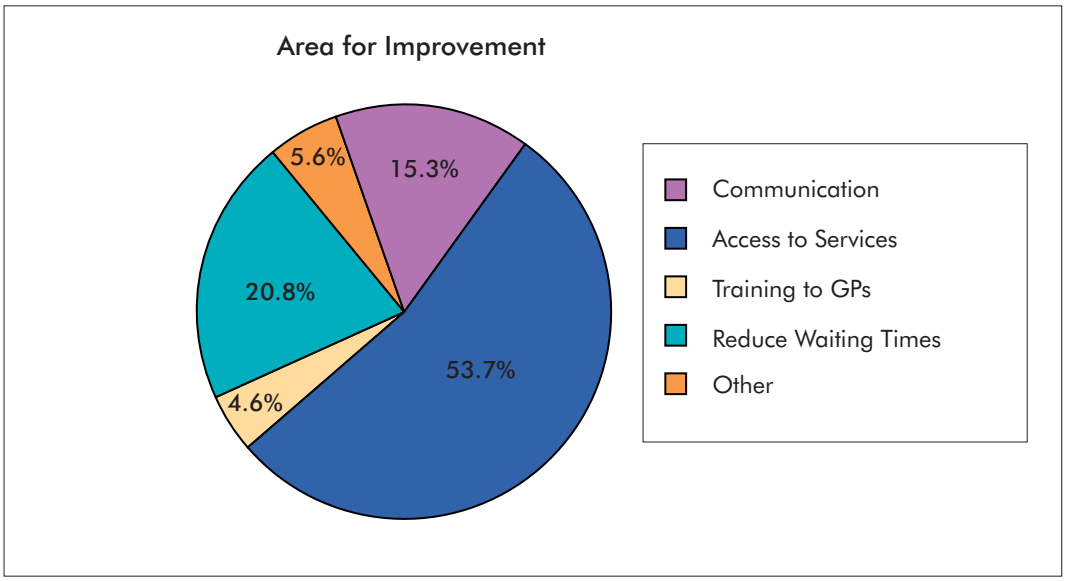
GPs Satisfaction Level with the Mental Health Services in Their Area

- 14.9% regarded them as very good
- 37.2% judged them to be good
- 27.9% thought them fair
- The remainder felt they were poor or very poor



Areas for Improvement in Mental Health Services in Primary Care

- 53.7% of GPs requested improved access to services
- 20.8% indicated that they would like to see a reduction in waiting time
- 15.3% sought improvement in communication

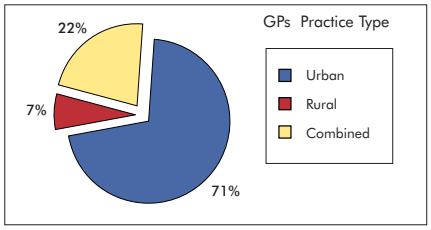


GP s DEMOGRAPHICS

Practice Characteristics

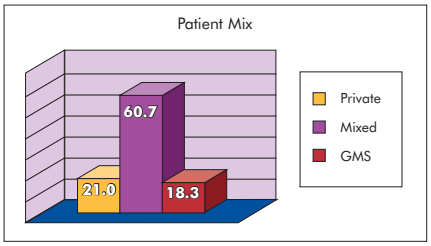
Practice type

- 71% of GPs have URBAN practices
- 7% of GPs have RURAL practices
- 22% of GPs have COMBINED practice



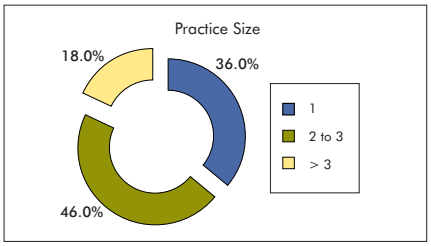
Patient Mix

- 60.7% of GPs have both Private and GMS patients
- 21% of GPs have mostly Private patients
- 18.3% of GPs have mostly GMS patients



Number of GPs in Practices

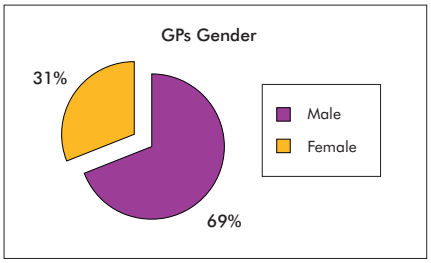
- 46% of practices contained two or three doctors
- 36% were run by sole practitioners
- 18% were in practices where there were three or more doctors



Personal Characteristics

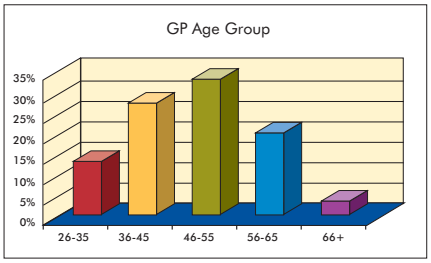
Gender

- 69% of GPs were male and 31% were female



Age group

- 34% of GPs were between 46 - 55
- 28% were between 36 - 45
- 20% were between 56 - 65
- 14% were between 26-35
- 4% were above 66



Postgraduate training in mental health such as counselling and/or psychotherapy

- 68% of GPs indicated that they had no specific training in mental health
- 32% had training consisting of between three to nine months on the job and/or during their hospital rotation
- Much of the GPs experience and training was received abroad

Psychiatric Training	N	%
Yes	72	32
No	135	68

Interest in future studies

- 71% of GPs indicated that they were interested in future studies in the area of mental health

Other Results

- Significantly **more female GPs** referred patients to psychiatric services (Chi-Square= 25.87; $p < 0.001$)
- No significant differences were found in referral patterns between
  - urban and rural GPs
  - GPs with psychiatric training and GPs with no psychiatric training
  - GP age groups
  - practice sizes; sole practitioners and group practices
  - GPs with mostly private patients and GPs with mostly GMS patients

A.2. Consultant Psychiatrist Survey Results

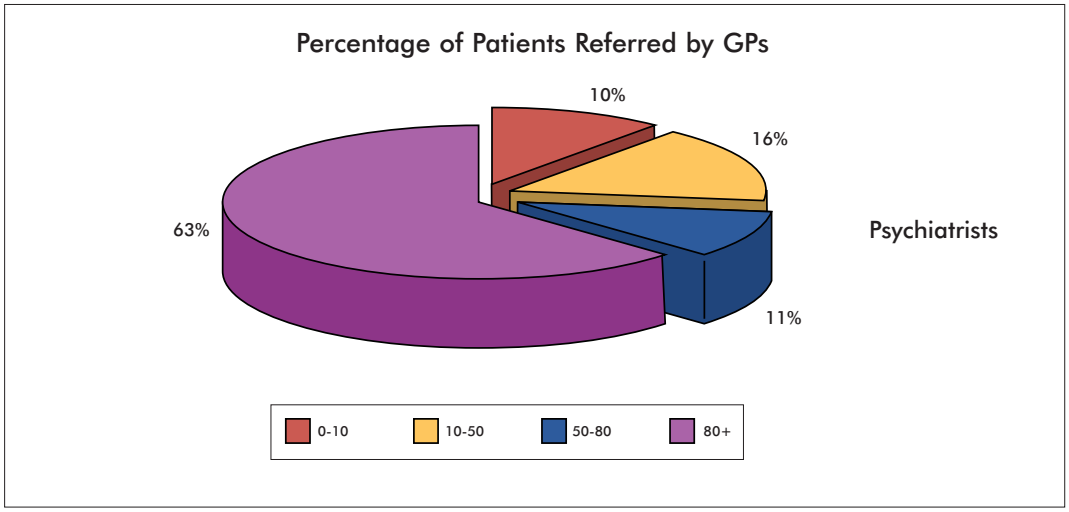
- A response rate of 77% occurred 4 weeks after sending out the questionnaires.
- The data is represented under each main heading in figures, tables or charts.
- Percentages used in the findings refer to valid percentages, which means that percentages are calculated from **those who responded** to each question rather than the whole data set.

Number of Patients Seen Weekly by Consultant Psychiatrists

- 57% saw over fifty patients per week
- 43% saw less than fifty patients per week

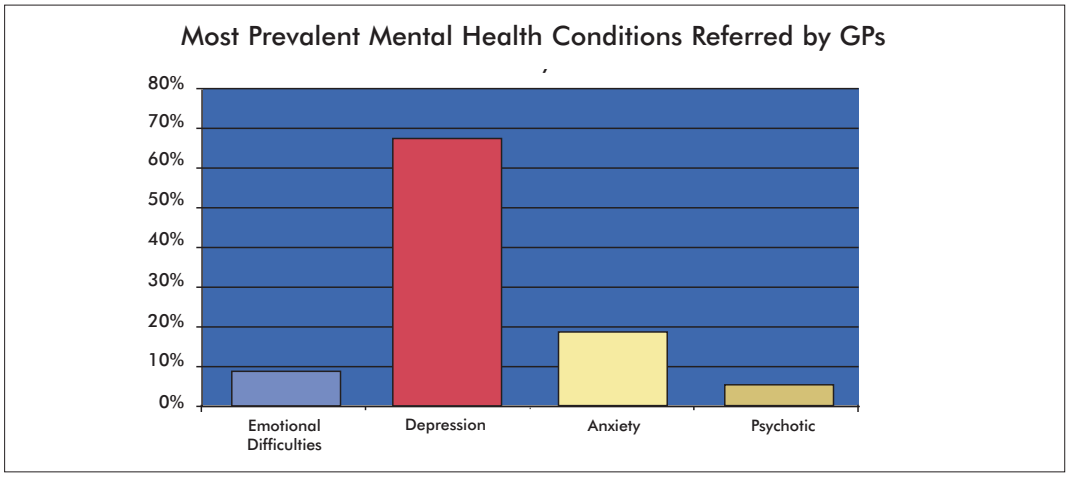
Percentage of Patient Population Referred by GPs

- Over half of the psychiatrists (63%) indicated at least 80% of their patients were referred to them by GPs



Most Prevalent Mental Health Conditions Referred by GPs

- Depression (67%) ranked first
- Anxiety disorders (19%) ranked second
- Emotional problems (9%) ranked third
- Psychotic disorders (5%) ranked fourth



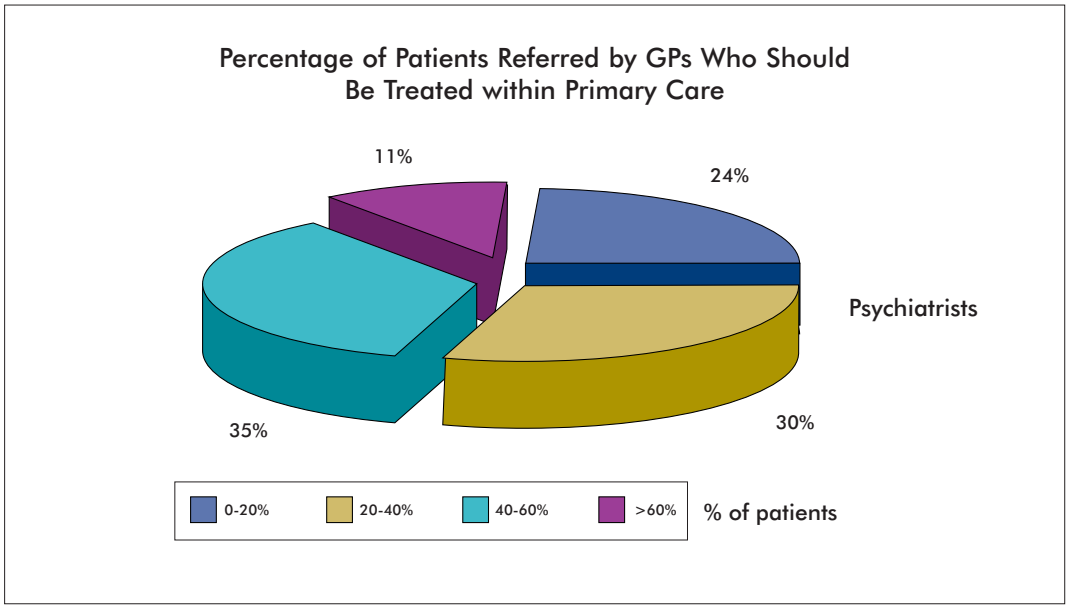
Mental Health Conditions Currently Referred, that Could be Treated Within General Practice if given Adequate Support

- 74% stated that all three conditions
  - depression
  - anxiety
  - emotional problems

  should be treated within primary care

Percentage of Patients Referred by GPs who Should be Treated Within Primary Care

- 35% of psychiatrists felt that between 40% and 60% of patients should be treated within primary care
- 30% thought that between 20% and 40% of patients should be treated in primary care
- A total of 46% of psychiatrists felt that at least 40% of the referred patients should be dealt with in primary care

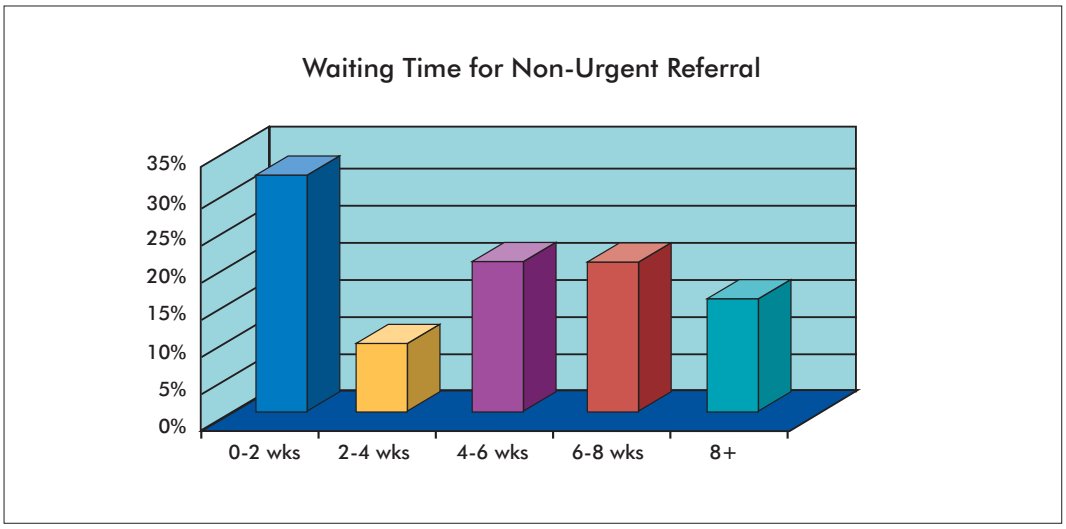


Barriers Perceived when Discharging Patients back to Primary Care

- 59% ranked provision of free medication as the most common barrier
- 32% considered patient reluctance, patient expectation, and patient condition (such as suicidal risk and dangerousness) as barriers
- 9% listed lack of referral structure, lack of social support and lack of time and experience among GPs as barriers

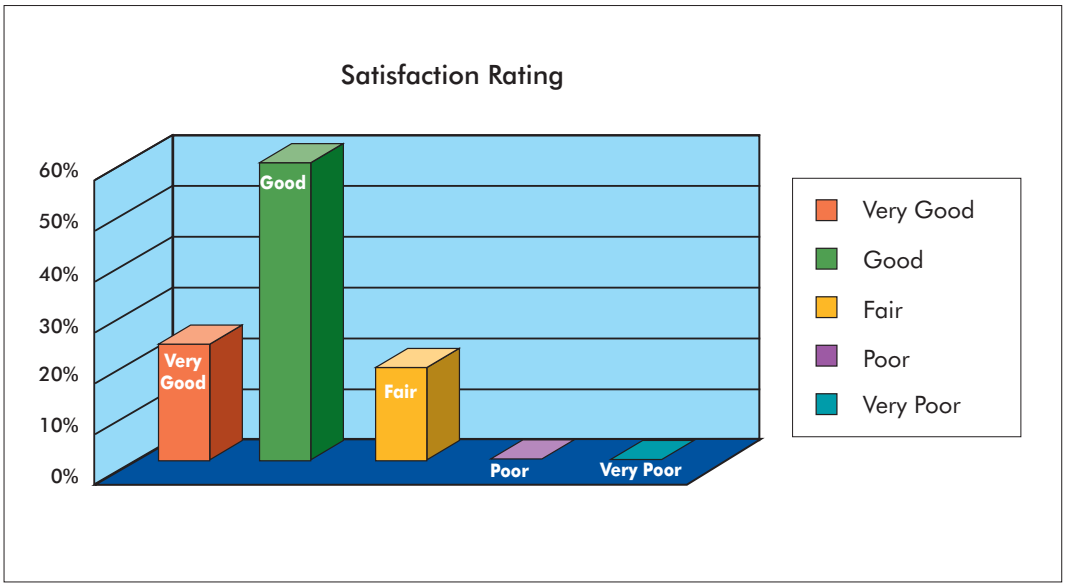
Current Waiting Time for a Non-Urgent Mental Health Assessment Referral

- 33% believed that waiting time did not exceed two weeks
- 19% believed that both 4-6 weeks and 6-8 weeks were standard



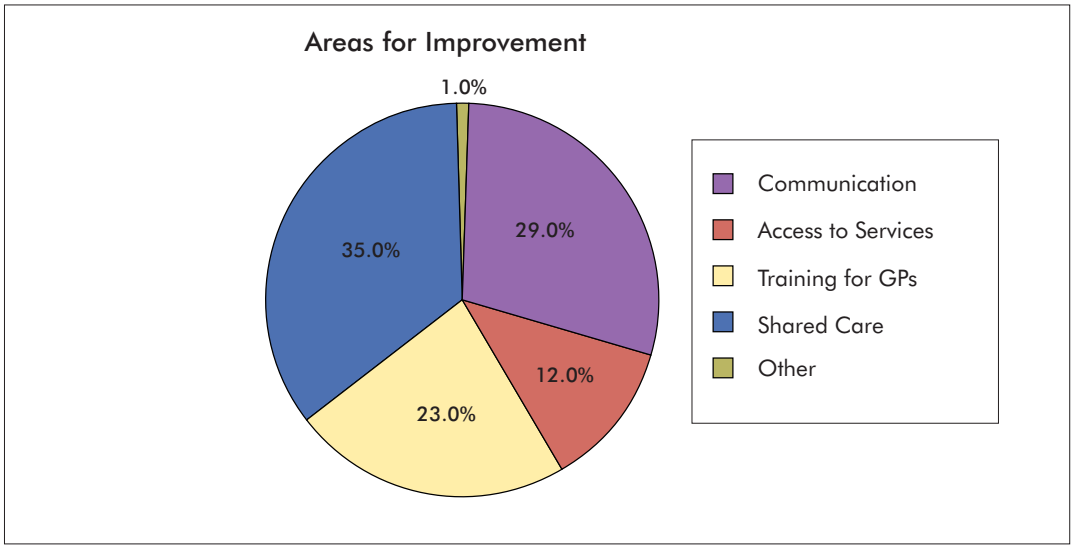
Satisfaction Level with the Mental Health Services Provided by GPs

- 59% of psychiatrists thought they were good
- 23% judged them to be very good
- 18% felt they were only fair



Areas for Improvement in the Delivery of Mental Health Services in Primary Care

- 35% ranked *shared care* as the primary area for improvement
- 29% ranked *communication* between general practice and secondary care as the second area for improvement
- 23% ranked *training for GPs* as third



Comparisons between GPs and Consultant Psychiatrists

- There was a general consensus that both GPs and psychiatrists were satisfied with the mental health service:
  - 52% of the GPs indicated that their local mental health service was good or very good
  - 82% of the psychiatrists rated the service as either good or very good
- Both agreed that there was a compelling need to improve communication channels between general practice and primary care. Psychiatrists and GPs ranked communication second and third respectively as an area for improvement.
- There seemed to be a significant difference in their estimate of waiting time for non-urgent mental health assessment/referral:
  - 32% of GPs believed it took 4-6 weeks for referral
  - 33% of psychiatrists believed it took 0-2 weeks

B. Qualitative Research Findings

B.1. GP Focus Group Results

The findings of the study were based on a set of questions asked during the interview. The discussion focused on:

- Management of patients in general practice
- Referral criteria and patterns
- Barriers encountered
- Perception and views of the current system
- Needs and requirements for improving the service

Statements made by participants of the focus group are shown in quotations.

Management of Patients Mental Health Needs

Management in Consultation

The group indicated that patients mental health needs are managed in the same way as any other health needs during consultation. Some of the GPs stated that the majority of patients mental health needs are handled in general practice.

> *"We manage mental health needs of our patients in the way that we do most of our work in general practice, that is in consultation."*

> *"Mental and psychological health matters are dealt with in thousands every week in consultations in GPs' surgeries."*

Private Versus GMS

There was an overall implication that a patient s health needs are managed differently depending on the patient s category, private or GMS:

> *"I think how we treat and how we manage our patients depends on three matters:*
>
> - *Whether they have a medical card*
> - *Whether they have access to private psychiatric care if this becomes important*
> - *Whether they have the finances to provide for themselves other resources like counselling."*

Factors for Referrals

Patients referral to community psychiatric services was impacted by several factors:

(1) Severity of condition or failure to respond to medication:

> *"Only if somebody is very severely depressed and not responding to medication, or suicidal, or if you feel you're not getting anywhere with them. But that would be very infrequent. Most people need counselling, or psychotherapy - clinical psychologists rather than psychiatrists."*

(2) Patients characteristics:

Frequent attenders, patients who have emotional/psychological issues rather than physical problems, are considered the most difficult group to deal with. GPs stated that they occasionally referred those individuals in order to get some relief.

> *"Frequent attenders comprise most of my psychiatric caseload that I look after in the community. They always seem to be very dependent on me."*

> *"A lot of them you would have to describe as somaticisers - people who turn*

psychological distress into pain, headache and so on. We have to be very careful that they don't have a genuine physical illness."

GPs also indicated that clear-cut psychiatric conditions such as depression and psychotic disorders were much easier to manage.

"To be honest, real psychiatric conditions are easy to manage. Someone with depression is very easy to manage."

Emotional conditions were the most difficult to deal with.

"Emotional cases who have all sorts of other things going on - family rows - they are difficult to manage."

"Anxiety, panic attacks, these kinds of patients are more numerous than you might think."

(3) Requests by patients and pressure by patients families were also factors in referral.

"Sometimes you're just bullied into referring."

Barriers and Issues in Treatment of Mental Health

There was a general agreement among the group that **lack of time** was a major barrier in treating mental health issues.

GPs outlined several factors that contributed to this problem:

Limited Time a Major Barrier

1) **Very busy practices and the increasing demands by patients, especially those with medical cards**
2) **Lack of support within the practice; some have solo practices and great difficulty in recruiting GPs, especially to inner-city practices**
3) **No direct access to counselling services that might ease some of the pressure**

"I think time is the biggest barrier. We just don't have enough time."

"We're all busy and we can't give them the time they need."

"Everybody wants to talk about his problems."

"It's difficult to get young doctors now, especially into big GMS practices in the inner city."

Skills Deficit a Major Barrier

The group admitted that **lack of specific skills in detecting, diagnosing and treating mental health conditions** was a major barrier.

Some of these skills were:

- **Interviewing techniques**
- **Counselling skills**
- **Cognitive behavioural therapy (CBT)**
- **Other psychotherapy skills**

"Some of the people just have such chaotic lives and to actually be able to help them through is just so time-consuming, and the skills to help them are not something we're taught in medical school. Some of the skills that would help people with mental health problems, such as cognitive behavioural therapy and so on, I don't think most GP's have those skills."

Patients with Complex Needs

Some of the GPs expressed the view that patients characteristics were also a problem. These included:

- **Dual diagnosis problems**
- **Substance abuse**
- **Social issues such as homelessness**

GPs admitted **not knowing** how to deal with those patients because their needs did not fall within their scope of work.

> *"In the area I work in, many of the people with mental health problems are also homeless. Perhaps forty per cent or more homeless people have mental health problems. Having contact with those people is difficult both for them and for us. Many of them aren't even registered with a GP and wouldn't necessarily come to one if they were."*

Sectorization and Service Structure

There was **some dissatisfaction** with the current structure of the psychiatric services in SWAHB. The sectorization of mental health into catchment areas limited GPs choices in referral and treatment. GPs acknowledged that at times they did not know where to refer their patients. Moreover, GPs described the current system of referring patients according to their address as irrational, confusing and frustrating. GPs admitted advising patients to use relatives addresses or previous home addresses to get them referred to the appropriate facility.

> *"The most important part of psychiatric history is address."*

> *"You have to get them to give fraudulent addresses, which is ridiculous. They have to fictitiously go back to live with their parents or something."*

> *"The Grand Canal separates Tallaght from St. James' Hospital. The perverse thing is people can see St. James' from their front window but are banned from visiting it."*

One GP expressed his frustration by claiming that it is best if you are homeless without an address.

> Maybe all patients should just say they re homeless.

Free Medication in Psychiatric Clinics

Another structural issue that exists in the ERHA including the SWAHB catchment areas was the provision of free medication in community psychiatric clinics. Patients tend to go to the psychiatric public clinics to get their free medication, whereas if they go to their GPs they have to pay out-of-pocket for their own medication unless they are GMS members. This issue impacts upon patients continuity of care and reduces the willingness of chronic patients to be discharged back to primary care.

Essential Needs and Requirements for the Provision of Better Service in the Community

Direct Access to Counselling

There was a widespread interest in having direct access to counselling services. However, there were multiple suggestions within the group on how to channel these services. Some recommended having a clinical psychologist onsite while others saw the benefit of having a practice-based nurse with counselling skills. The group agreed that this would only be feasible if the health board pays for these services. One GP stated that these services did not have to be practice-based and could be area-based and accessed through direct referrals.

> *"At the moment I'm referring to a psychiatrist, not because I particularly want the psychiatrist to see them, but because psychiatrists are the only gatekeepers in this area."*

GP Training

There was a general consensus that training among GPs was crucial to enhance the provision of mental health care. GP training courses on counselling, brief intervention, cognitive behavioural therapy and problem solving skills were considered helpful to GPs. Owing to time constraints, they recommended that they would benefit from concise, short training courses.

"A course on cognitive stuff, short, sharp, very focused."

Better Information Dissemination

Better information dissemination was also crucial for the provision of better service. Many expressed interest in finding out more about voluntary agencies in their area. They also desired access to leaflets on self-help and support services for their patients.
Information on the various psychiatric services within the SWAHB was also requested. Colour-coded maps of catchment areas coupled with a comprehensive listing of all the psychiatric facilities would be helpful when referring patients.

There was widespread support among GPs for the improvement of channels of communication between general practice and psychiatric services.

Enhanced Communication with Secondary Care

- They suggested improving the correspondence/communication process with psychiatric services by recommending a minimum of one letter per six months, or letters prompted by changes in medication or dosage.
- GPs proposed the standardization of the correspondence between the two services such as referrals, follow-up letters, and discharge plans.
- Some of the GPs agreed that a shared care or an integration model with psychiatry would be beneficial to all parties involved.

"I have had people attend the psychiatric services for twenty years and have only one letter from 1985 in the chart."

"Because all we want to know is diagnosis and what treatment they're on."

GPs Desired State

GPs would like:

- More freedom in referring patients
- Direct access to clinical psychologists and community psychiatric nurses
- Better communication with psychiatrists and establishment of links with the Mental Health Team
- Development of protocols and procedures for referrals, follow up and discharge plans
- More information on the SWAHB catchment areas and psychiatric services
- Better information on voluntary agencies and support groups

B.2. Psychologists/Social Workers/Occupational Therapists Focus Group

The findings of the study were based on a set of questions used to guide the group during the interview. The discussion focused on:

- Perception and views of the current system
- Barriers and issues in the mental health system
- Needs and requirements for improving the service

Statements made by the participants are shown in quotations.

Management of Mental Health in the Community

The Worried Well Versus Severe Cases

There was a general agreement among the group that certain patient profiles, the worried well , should continue to be treated within primary care, while patients with more severe mental difficulties should be seen in secondary care.

> *"I don't use terms like the 'worried well', but patients like that can take up a lot of GP's time. If the GP refers clients for counselling who do NOT have severe enduring mental health problem, then our severe enduring schizophrenic and bipolar affected disorder clients - who need our services to stay out of hospital - might miss out."*

Best to Refer Via Local Mental Health Team

The group supported the current referral structure for GMS patients. They admitted that they are not equipped to receive direct referrals from GPs. Moreover, some believed that direct referrals by GPs might lead to confusion. Thus, they recommended that it is best to refer patients via the current referral model, the local Mental Health Team.

> *"It's easiest to refer to a psychiatric service because at least that has a psychiatrist who makes all those decisions that we're talking about, counselling, therapy, and social work. So they have a vague sense that they really shouldn't be sending a person to psychiatry, and they just wish that there was some other alternative."*

When asked about preparations needed to discharge patients from psychiatric services back to primary care, there was a strong support among the group that needs-led assessment of patients was an important aspect in patient s discharge. Moreover, the discharge plan should be prepared from the onset of the referral. This plan should include a comprehensive assessment that is prepared jointly by the GP and the multidisciplinary Mental Health Team. The patient and the patient s family should be involved in the process.

> *"We need to do a lot of education and we need to revamp how we are working. We need comprehensive assessment in terms of the multidisciplinary approach and it must be needs-led."*

Discharge Protocols Needed

Development of discharge protocols between Psychiatry and GPs was seen as a crucial step. There should be agreed acceptance of patients between GPs and local Mental Health Teams. Correspondence/letters between providers should be a common practice.

> *"I think registrars and doctors need to have a protocol for relationship with the GPs. There should be a meeting, whether it's every three months or four months, to discuss the quality of discharge letters and other information, and to ensure all of this is audited so that the GP is getting the right information. Also, those clients who attend both are getting extra value from a GP and then they're getting medication from outpatients. In my experience this can be very confusing."*

Patient Information Provision

In preparing patients for their discharge from psychiatric services, they should be given a lot of information about other support groups and voluntary agencies that exist in the community.

> *"We need to give the patient a lot of information about other support services that are out there in the community, apart from the GP, that might assist them if a problem arises. We need to try to ensure that, their discharge plan is prepared jointly, that we are working collaboratively with patients and that they get a copy of some discharge plan."*

Barriers and Issues in Treatment of Mental Health

Psychosocial Approach Preferred

There was a general consensus that the biological/pharmacological view of mental health poses a barrier to the treatment of mental health. The importance of the psychosocial approach to treatment of mental health is often undervalued. Accordingly, the definition of the mental health concept by the medical world is very limited.

> *"One major barrier that people in social work might experience is the notion that mental health is a more limited concept to people in medicine. Social work and psychology have a wider and more encompassing concept of what mental health involves. It is a barrier to encounter a view that is very biological or pharmacological and perhaps is less appreciative of psycho-social factors which play a very important part in whether an individual is well or ill."*

The group felt that their contribution as allied mental health professionals is unappreciated. There was also a general sense of lack of clarity of the parameters of mental health services including what constitutes the core business of those in the allied mental health professions.

> *"There is a kind of a debate going on about our core business, particularly in the community mental health service and the Mental Health Teams. There's some uncertainty about it."*

Shortage of Time

There was agreement that **lack of time** was a major issue in the delivery of mental health services. Many blamed time pressure for their failure to take direct referrals from GPs. Staff shortage and under-representation of the allied mental health service providers on the multidisciplinary teams also contributed to this problem.

> *"The non-medical professions are very under-represented in the multidisciplinary teams…. the workload is too big…. one therapist or one social worker for a sector of forty thousand population… it's not realistic."*

Lack of Communication and Cooperation

There was a widespread belief that lack of communication and cooperation among the medical providers and allied mental health service providers was a main barrier in the delivery of care. Lack of formal links between them and GPs was also a significant barrier.

> *"The concept of mental health between different professions often means that you have groupings among the professionals."*

There was a widespread belief that patients sense of prejudice, stigma and fear prevented them from seeking help from the psychiatric services.

Referral Criteria Needed

Many considered the absence of referral criteria among GPs as a hindrance to their practice. Some suggested the importance of refining the process of need assessment and case management among GPs. They admitted that, due to lack of standardization of the various mental health disciplines and approaches, it is best if GPs continue to go through the present referral channel, the local Mental Health Team, for any counselling referrals. This would alleviate the level of uncertainty in referrals to psychology services.

"I think each counselling service has a responsibility to inform the GP that we're here, that we're a resource within the community."

Essential Needs and Requirements for the Provision of Better Service in the Community

The group pointed out the need to address the shortage of resources in the SWAHB including the lack of human resources with a range of skill-mix. They would like to see the SWAHB invest in additional resources within the community in terms of facilities such as day centres and day hospitals, and in human resources such as skilled professionals who can provide particular interventions.

GPs Need More Skills and Information

The group stressed the importance of GPs education on types of counselling services available in their community mental health services in order for the GPs to make appropriate counselling referrals. The group recommended training on basic counselling skills and problem-solving skills among GPs and frontline staff in GP practices. Moreover, there was support of the necessity to improve detection and screening skills among GPs.

"The first thing the GP needs to know is whether there's a counselling service because often that's questionable. I think the GP needs to know what's available and what isn't available and what should be available perhaps."

"It is important to know that the person is qualified and is affiliated to a reputable organization. With regard to discipline approach, you don't always know what approach is best."

Multidisciplinary Approach Needed with better Communication

The group proposed a multidisciplinary approach among the Mental Health Teams with input from both the medical staff as well as the allied mental health service providers. This would improve the channels of communication within the Mental Health Team. Moreover, they recommended improving the channels of communication between general practice and psychology services.

"One essential thing, I think, is that team working happens in the multi-disciplinary teams. Real team working needs to happen where there is recognition of the different roles that each professional plays and a real understanding of that and a real respect for each other."

The group encouraged links with the voluntary agencies in the community in an effort to empower patients.

Mental Health Service Providers Desired State

Mental health service providers would like:

- Increased training for GPs
- Shared care model approach
- Enhanced communication with GPs
- Better links with voluntary agencies
- Additional facilities and human resourses

B.3. Service Users Focus Group Results

The findings of the study were based on topic questions asked during the interview. The discussion focused on:

- Perception and views of the current system
- Barriers and issues in the mental health system
- Needs and requirements for improving the service

Statements made by the participants are shown in quotations.

Patients Experience with their General Practitioners

Most patients found it difficult to discuss their emotions with their GP for the following reasons:

Discomfort

1) They did not feel comfortable discussing their mental health needs. Some stated that they did not feel any empathy or understanding from their GP.

"I don't bring up my mental health problems at all with my GP, I was only down with him about three weeks ago and I never even mentioned…"

"They don't try to even understand."

Lack of Time

2) They felt pressured for time during consultation.

"It's easy to talk to my doctor but she only has fifteen minutes."

3) Some felt that their GPs were not qualified since their training was not in psychiatry. Thus they only discussed physical problems and not mental health concerns.

GPs Not Qualified

"They're not qualified as psychiatrists so you feel you're getting nowhere."

"Well I'd probably go to my GP now if there was something physically wrong with me."

"GPs are not trained for psychiatric illness but just for general practice. You don't know who to be going to."

GPs Not Detecting

When asked about their GP s ability to pick up on emotional/mental health issues during their consultation, some responded that their GP was not able to detect their mental health condition. One service user in the group who had suffered from schizophrenia for years stated that his GP was not able to detect his condition and that he was not appropriately diagnosed until he was referred to the psychiatric services.

"I was never out sick and then leading up to my breakdown, I felt like the GP should have recognised something because all of a sudden am going to my GP every second week. I mean if he could, he should have spotted something I thought, someone should have spotted something."

"It's very hard to talk about, but I thought he should have been more trained than me. I'm going to him for help and I think if I'd have gotten that bit of help before the final breakdown. I thought there could have been more done, you know."

Some attributed the lack of their GP s detection skills to the presumption that GPs are not trained to listen or pick up on emotional problems.

"Well I have a GP but I mean they just prescribe, they're not listening to what I'm saying that I'm not well myself and they're just writing out the tablets and I take the tablets and I'm not well."

"You have to tell them how you're feeling and it doesn't kind of register with them because they're not trained as say, the psychiatrist, I don't know."

GP Gender Irrelevant

When asked if the gender of their GP made a difference in their opening up and discussing emotional issues, their answer was no.

Patients Experience with the Mental Health Service Providers

Some of the service users indicated that they had to press to get referred to the psychiatric services.

Actively Seeking Referral

"It's not like you can go up to a psychiatrist's door and say 'Doctor I want to see you today'…. it's like you have to make an appointment to have a nervous breakdown."

One participant claimed that it took six weeks to see a psychiatrist after being referred by their GP.

"The GP to the psychiatrist, about six weeks."

Anonymity Preferred

Patients pointed out that they were aware of the stigma against mental health patients among the public. They claimed that this stigma is increased by the segregation of psychiatric clinics from primary care clinics, psychiatric hospitals and general hospitals. Patients felt that they should have a choice over the referral clinic. They complained that the current system promotes stigma.

"It would be good to have a choice in what clinic you can go to, you know. I live across the road from the clinic… and anybody that you work with, everybody that you communicate with in the community, they're all looking at you going into this clinic."

"I think getting rid of all those mental institutions is one good step, putting them into the general hospitals, so that you're not isolated."

Some also stated that they had no choice about the psychiatrist to whom they were referred.

"If you happen to get on well, that's great, but if you don't, well that's unfortunate but you're stuck…"

Need for Improved Facilities

The group discussed the current structure of the mental health services. The service users described the poor conditions of the psychiatric clinics, the unfriendly atmosphere, the long waiting times, short consultations and constant changes in providers.

"The first three minutes of five minutes consisted of being asked the same questions that you were asked the previous visits."

"Do you feel like committing suicide, blah, blah, blah…"

"There's your prescription, off you go"

"If you get the five minutes, it's a luxury."

"I remember my very first visit to that clinic like it was only yesterday, and talking about committing suicide, I felt like committing suicide when I came out of the place…"

Waiting Time

When asked about comparing their waiting time for a psychiatric visit to any other medical specialty visit, the service users admitted that when it comes to waiting time to see a specialist *"it's bad everywhere."* The service users highly recommended the honouring of the appointment system.

Reluctant to Complain

Many group members perceived their mental health service provider to have a negative attitude, which prevented them from discussing their mental health needs. They also felt they could not complain about the bad service they received as they had a sense of fear.

> *"You see, when you're suffering from depression or panic attacks or both you become very dependent on the psychiatrist."*

> *"I never raise a disappointment; I always had the fear of annoying them or discommoding them."*

Counselling Services

When they were asked about services provided by the allied mental health service providers, some of the group members praised their counsellors. They listened to them and gave them ample time to talk about their problems.

> *"My counsellor would listen and respond to me when it was necessary, rather than me listening to her telling me what's wrong with me. I felt that was a big factor in me getting to where I am."*

Lack of Continuity of Care

When asked to compare their experience in general practice to that in psychiatric services, the group felt there was no interface between GPs and community psychiatric care. They stated that they were not treated in an integrated manner. Some GPs never asked about their mental health status during subsequent consultations after their referral to the psychiatric services.

> *"It would suit me if my GP asked; 'How's your head?'"*

> *"I found at the beginning my GP did ask about my mental health state. I found then as soon as he passed me over to the psychiatrist he didn't want to know about my emotional state. He wanted to know about my health, my physical health all right, but nothing about my emotional or mental health."*

They claimed that continuity of care was lacking, as no sign of follow up existed between the two services. Communication between primary and secondary care seemed to be poor.

> *"It's six months since I've seen my psychiatrist and I'm waiting on her to send a letter to my GP and he hasn't received it yet."*

Voluntary Agencies

When asked about their experiences with the voluntary agencies and support groups in the community, only a few seemed to be familiar with them. Some of the participants claimed that they never saw any leaflets or information on voluntary agencies and support groups in their GP s surgery.

Needs and Requirements to Improve Services in the Community

More Patient Choice

There was general support among the group for more patient choice in treatment. Many preferred counselling or therapy to medication. Some had a sense of helplessness as they did not have much input into their own care.

Some of the group recommended an interdisciplinary approach as a way to bridge the communication gap between GPs and mental health service providers. One service user had first hand experience with this approach.

> *"Our team meets once a week, which I think is a brilliant. They all meet on a Friday and and discuss their patients so that everyone knows where everyone is."*

More Training, Awareness and Time

There was widespread support among the group for provision of training of GPs on detecting/assessing mental illness. They stated that mental health awareness must be improved among GPs. The majority of the group also requested more time with their GP. One service user found a partial solution for increasing the consultation time with his GP.

> *"I know that pharmaceutical reps have to do their job but is it possible they could maybe do it out of hours instead of on patient time?"*

Day Hospitals

Some of the participants praised the Day Hospitals in the SWAHB. They found them to be very beneficial. However, some asked for improvement in the patients activities. They asked to include more stimulating activities.

> *"You're just sitting around all day, not doing anything, playing cards.....playing cards was supposed to cure you....playing bingo."*

Service Users Desired State

Service Users would like:

- More time with their GP and mental health professional
- More say in their treatment
- Choice over where to be referred
- More training for their GPs in the area of mental health
- Additional rehabilitation facilities
- Improved psychiatric clinics/facilities

VI Discussion and Recommendations

A. Study Limitations

It was difficult to recruit individuals to participate in the focus group studies. Only five GPs took part in the focus group, including men and women in both private and GMS practices. These GPs selected themselves to be part of the study as a result of special interest in mental health, which might have biased the study. However their responses were compared to the findings in the questionnaire, and seemed to be consistent with the overall results.

Recruiting GPs from rural areas was particularly difficult, due to their small numbers and remote location in the SWAHB. Timing of the study during the summer holiday made it even more difficult to conduct. Thus no rural GP focus group took place. However, this should not affect the study, as the questionnaire did not indicate any significant difference between urban and rural GPs in terms of referral patterns and practices.

It was also difficult to recruit consultant psychiatrists to take part in the focus groups. This may have been due to the timing of the study coinciding with the summer holidays or the providers demanding schedule. However, the questionnaire sent to them provided adequate information about their views of the present mental health system.

The service users were selected via different channels. It should be taken into consideration that people who are willing to be part of a study, without any financial incentives and on their own time, must have strong feelings and biases about the issues compared to those of the general public. In spite of this, many of their views and experiences were reinforced by the providers in the study.

B. Discussion

The study has accomplished its goal of presenting a comprehensive picture of mental health delivery in primary care in the SWAHB. In general, one can conclude that many of the findings are consistent with previous studies conducted outside the Republic.

The discussion is based on the three key players:

- GPs
- Mental health service providers
- Service Users

Their views and perceptions of the current reality, their aspirations and vision, as presented in the questionnaires and focus groups, form the basis for discussion.

Management of Mental Health in the Community

The high response rate by GPs and consultant psychiatrists in the SWAHB - 64% and 77% respectively - indicates a strong level of interest in the area of mental health in primary care. Moreover, over **half of GPs (52%) seem to be satisfied** with the current system rating the mental health service in their area as good or very good.

The GPs mental health caseload, treatment of certain psychiatric conditions and referral patterns seemed consistent with previous literature (Gask and Croft 2000; Goldberg and Huxley 1992; Goldberg 1991; Orleans et al. 1985). The small percentage (5%) of referral to psychiatric services was consistent with normative UK data stating that fewer than 10% of the patients are usually referred to mental health specialists (WHO 2001; Gask and Croft 2000).

In the study, the **most prevalent conditions** treated in primary care were:

- Anxiety
- Depression
- Emotional difficulties

Other studies had showed that anxiety and depression are the most common conditions in primary care (WHO 2001; Cape et al. 2000; Geller 1999; Tyrer et al. 1993; Orleans et al. 1985).

When the main **reasons for referring** patients were examined in the questionnaire,

- Severity of condition
- Failure to respond
- Management not available in general practice

were ranked as **the top three**. An Irish study supports some of these findings (Maguire et al 1995). In the focus group, GPs reported that in addition to severity of the condition, they referred patients due to lack of expertise or skills, and in response to requests by patient and family.

GPs seemed familiar with the referral process in the SWAHB, where 44.3% of them reported that they referred patients via the Mental Health Team. Around 42% referred directly to psychiatrists who tend to be part of the Mental Health Team. Only 13.7% indicated that they refer patients to hospitals or other facilities for non-urgent assessment.

GPs seemed to be comfortable in managing their patients mental health needs. However, GPs stated that they were more comfortable treating straightforward mental health cases. Difficulties were faced in treating complex cases with uncertain diagnosis and complex cases with social issues. GPs acknowledged that treating mental health cases involved a range of specialised skills (e.g. CBT) and often required more time than was available for the consultation. They also highlighted the need for counselling services to be available to assist with mental health issues especially with the complex cases.

The most common mode of communication between primary care and secondary care providers was **letter format**. This is consistent with previous studies where the majority of providers send a referral letter (Tanielian et al. 2000).

The demographics of GPs surveyed seemed to be consistent with national demographics, **more than a third (36%) of GPs are sole practitioners** (Deloitte and Touche 2001). The percentage is lower than that reported in the ICGP national survey study which found more than half (51%) of GPs operated as sole practitioners (ICGP 1997). This indicates a shift towards group practices among GPs.

When it came to gender, **69% of GPs were male and 31% female.** This is consistent with 1997 ICGP national survey indicating 70% male GPs and 30% female GPs. As evident in the questionnaire, the GP s practice characteristics did not seem to play a role in determining treatment and referral behaviour. However, GP s gender showed variation in referral where female GPs referred more than male GPs.

Overall psychiatrists perception of GPs treatment of mental health was positive. Over 80% of the psychiatrists ranked mental health services provided by GPs as good or very good. They indicated that the majority of their referrals (80%) come directly from GPs. This underscores the understanding of the GPs of the referral process in the SWAHB.

However, almost half of the psychiatrists (46%) felt that over 40% of all mental health conditions referred to them could be treated within primary care. The majority of the psychiatrists (74%) stated that depression, anxiety and emotional problems should be treated within general practice.

There also seemed to be an unwritten rule between the GPs and the mental health service providers:

- **GPs should deal with the less severe mental health conditions (mild depression, anxiety disorders, and emotional problems).**
- **Psychiatrists should treat the more severe conditions.**

However, when it came to the allied mental health professionals, the boundaries did not seem as clear. There was a consensus that the core of their business was **not clear** and even their role as professionals was **not well defined**, especially to the medical professions. GPs also admitted their **lack of understanding** of the role of the various allied mental health professions.

The service users perceived the provision of mental health services in the SWAHB as inadequate. They pointed out a number of inadequacies, shortages and obstacles in the current system. Some of these deficiencies and barriers were also presented by the providers themselves. These included:

- **Lack of communication between providers, and between providers and service users**
- **Current structure of the referral system to psychiatric services**
- **Absence of continuity of care**
- **Insufficient time given to patients by providers**
- **Deficiency of training among GPs**

Moreover, the service users indicated their preference in seeking mental health providers for their mental health needs and general practitioners for their physical needs. Their overall experience with the allied mental health providers was positive. Counsellors seem to give them what psychiatrists and GPs cannot - time to talk about their problems and needs.

C. Recommendations

The recommendations are based on four themes that evolved during the different components of the study that would contribute to the desired state as perceived by the participants. These are:

- GP Training
- **Development of Protocols**
- **Collaboration among all Parties**
- **Infomation Dissemination**

GP Training

It was clear from all parties involved in the study that **mental health training is lacking among GPs.** The objective of the training should be to provide appropriate skills and techniques needed for the assessment, detection, treatment and referral of mental health conditions.

Mental health awareness and training, needed for the treatment and management of mental health, begins in medical school. However, **a large percentage of GPs (68%) did not seem to have any mental health training** during their postgraduate training. Despite this, the majority of the mental health conditions (over 95%) are being treated within primary care.

For the practising GPs training needs, the ICGP should examine what local and regional sources of training and support are available to primary care professionals. The training resources can include both courses on specific skills, such as counselling skills, interviewing techniques, and cognitive techniques, or skills-based training packages such as videos and CD-ROM.

Based on this review, **an information chart should be developed** of all training resources for GPs. The SWAHB will work in conjunction with the ICGP in facilitating the training of GPs on those skills. The ICGP can also incorporate mental health skills-based training in its existing modules.

Moreover, based on the complexity and variety of skills needed in the assessment and treatment of mental health, **a mental health educational programme** with different modules covering skills and knowledge base is needed in general practice. In designing this educational programme, it is crucial to look at relevant training programmes and modules created in other countries, especially in the UK (due to the similarity in the delivery of mental health services in primary care) and consequently tailor them to the needs of the Irish health care system.

CME credits should be offered to all of the GPs who take part in the training. Other channels of GP training might include accredited short courses on specific mental health skills or psychiatric conditions, distance-learning modules, training packages such as audiotapes, videos, and CD-ROM.

WHO suggests the development of specific primary mental health skills within the practice such as:

- **Structured problem solving**
- **Motivational interviewing**
- **Cognitive skills**
- **Teaching controlled breathing**
- **Teaching relaxation skills**
- **Managing self-harm behaviours** and many others

Funding might be an issue in the design and implementation of these educational programs and learning techniques. It should be noted that due to population changes, the SWAHB receives the lowest per capita funding for mental health services in Ireland. The ICGP together with the Health Board should look at ways of funding these courses in order to encourage GPs attendance and involvement in these programs. Some of these training resources are developed by voluntary agencies in the community. It would make financial sense to collaborate with these agencies in developing some of these training programs.

Development of Protocols and Pathways of Care

There is an urgent need for protocols for:

- **Detection**
- **Assessment**
- **Treatment**
- **Referral**
- **Interface between primary care and secondary care**
- **Discharge**
- **Communication with the patient**

The study showed that GPs depended on their own judgement as to whether to treat or refer a patient. However, there seemed to be an unwritten protocol in that GPs refer the more serious cases to secondary care such as:

- Severe depression
- Schizophrenia

GPs and mental health service providers should be involved in developing appropriate protocols for the delivery of mental health in the community. This would ensure that these protocols are relevant and acceptable to both parties.

Protocols should be disease specific i.e. a protocol for anxiety disorder would differ from a protocol for schizophrenia (Bruce 2001). Examining and adopting some of the UK psychiatric protocols should be considered by the SWAHB as an interim measure, prior to the production of protocols tailored to the Irish mental health care system. The research evidence sugggests that protocols and guidelines are more likely to be effective if they are locally developed and owned (Gask and Croft 2000).

Collaboration among GPs and Mental Health Providers

Cooperation between primary and secondary care was highly recommended by all of the participants in the study. There was a strong support that the quality of patient care would only improve with collaboration among all involved parties from the onset of care. There was no agreement on what shape or form this shared care would take. However, both providers and patients agreed that a shared care model could achieve the following:

- Improve communication channels between all parties
- Improve the quality of services
- Ensure continuity of care and coordination of care
- Alleviate any mistrust between the GPs and the mental health service providers

There are various collaboration models, which differ in the level of direct patient contact (Gask and Croft 2000; Gask et al. 1997):

1. Attaching mental health professionals to the primary care team by employing counsellors, community psychiatric nurses, psychologists in the practice
2. Relocated outpatient clinics in psychiatry (also known as Shifted outpatient clinics in the UK) whereby mental health professionals relocate their practice to a primary care setting and informal discussions take place between psychiatrists and GPs about patients
3. Triage system where referrals are screened by a community psychiatric nurse
4. Consultation-liaison scheme where there is regular face-to-face contact between the psychiatrist and GP, and cases are discussed before referral
5. Link workers where a liaison, such as a community psychiatric nurse is assigned to liaise with practices to set communication channels and practice-based education

Shared care is not a new concept to psychiatric services in Ireland (Phelan 1995; Carey et al. 1994). In Cavan/Monaghan s mental health service, there is a successful multidisciplinary shared care approach. The emphasis is on the centrality of patient s needs and rights, which includes the involvement of GPs and the various Mental Health Team members. Shared care is now commonly used with other chronic disease management programmes in Ireland, such as diabetes.

GPs should meet with mental health service providers in the SWAHB to discuss what collaboration model would be most feasible and of benefit to all of the stakeholders. Their selection criteria should consider the demography and epidemiology of the population in the SWAHB, available resources and expertise in the region, and the guiding principles of the National Health Strategy and Primary Care Strategy.

Information Dissemination

Information dissemination was highlighted in all of the focus groups as an area that requires enhancement.

The SWAHB should update its list of GPs who provide services to its population. Using the revised GP list, the SWAHB should send GPs updated, comprehensive lists of the psychiatric services, including personnel and facilities in each catchment area. Coloured maps of the SWAHB catchment areas should be included.

The voluntary agencies should establish efficient channels for disseminating information to general practice. The SWAHB should work with the various local agencies and support groups in developing a comprehensive directory of their services. Moreover, Mental Health Alliance, the umbrella of a number of mental health voluntary agencies in Ireland, must work with each of its agencies to develop effective outreach strategies in the community. This also applies to other umbrella groups in the Eastern Region such as the Disability Federation of Ireland. These strategies should be tested and continuously monitored for effectiveness.

The psychology services need to make themselves known to GPs. Many GPs admitted their lack of knowledge of the locations of psychology services in their community. This is probably of more importance to private patients who do not have to go through the Mental Health Team and can be referred directly to allied mental health professionals.

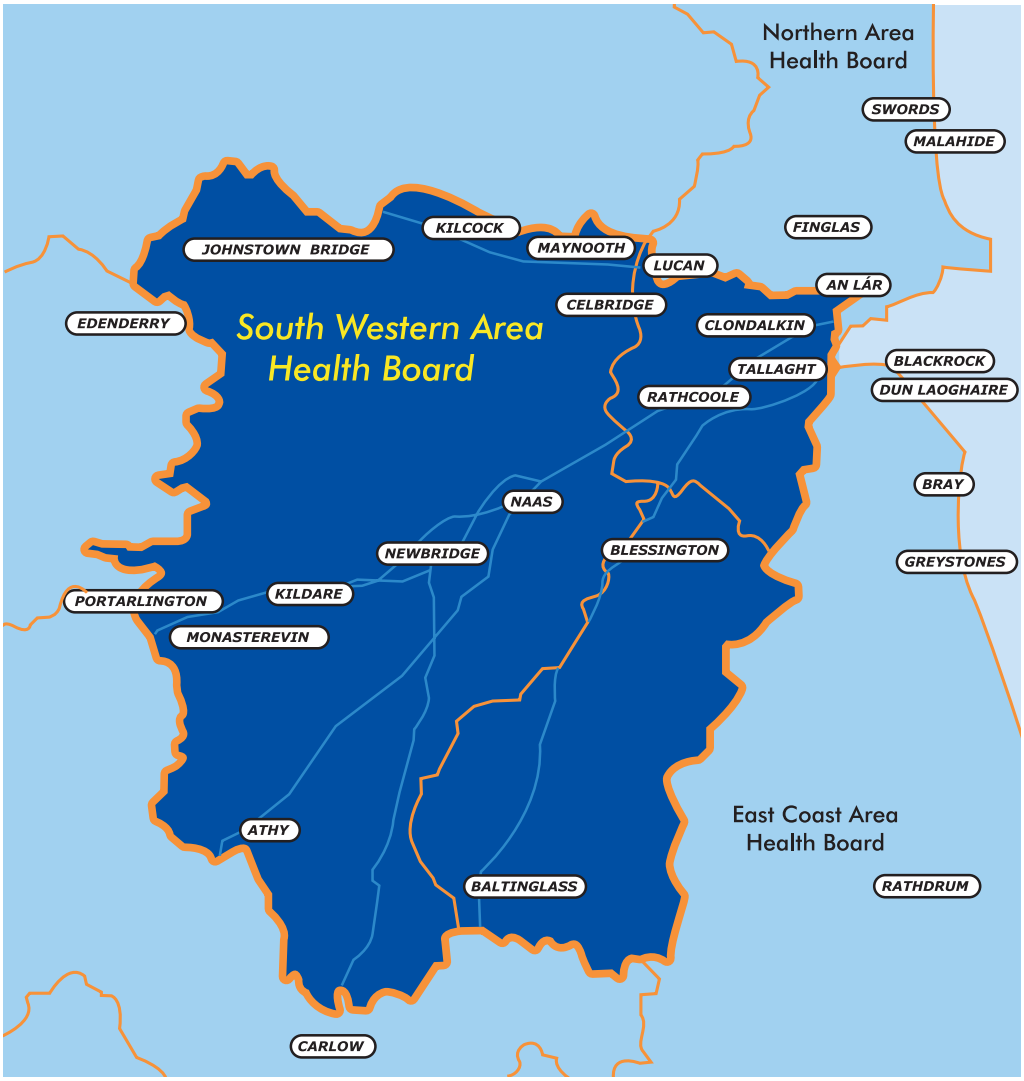
There was also an ambiguity about the roles of the various providers within the allied mental health professions. Psychology services should reach out to GPs in the community and educate them on the various disciplines, and approaches in psychology and on the types of licensure and accreditation requirements for each discipline.

GPs should make available to their patients information leaflets, posters, audiotapes or videos of their specific psychiatric conditions. Information on voluntary agencies and self-help groups should be accessible in the GP surgery.

In conclusion, the recommendations in this report call for changes in the current system to both support underlying policy principles and enhance efficiencies in the delivery of care. The SWAHB is committed to making these recommendations a reality. As a first step, the SWAHB has approved funding the Second Phase of the Mental Health in Primary Care project. The scope of Phase II will be to implement the recommended changes.

VII Appendices

Appendix 1: Map of South Western Area Health Board



Appendix 2: GP Questionnaire

YOUR PATIENTS

Please estimate the percentage of your patients that have psychological or mental health issues ☐ %

Approximate the percentage of your patients referred to a mental health specialist ☐ %

Please rank in numerical order the most prevalent mental health conditions in your patient population (Number 1 being the most common condition):

Anxiety Disorders ☐ Depression ☐ Eating Disorders ☐ Emotional Difficulties ☐

Psychotic Disorders ☐ Substance Abuse ☐ Other Specify: _____

Please rank the main reasons for referral (Number 1 being the most common reason):

Advice on treatment ☐ Requested by patient and/or family ☐

Failure to respond to treatment ☐ Severity of Condition ☐

Management not available in general practice ☐ Share burden of Care ☐

Other, Please Specify: _____

Which mental health condition(s), if any, that you currently refer for, do you feel could be treated within your practice if given adequate support? (Please tick as appropriate)

Anxiety Disorders ☐ Depression ☐ Eating Disorders ☐ Emotional Difficulties ☐

Psychotic Disorders ☐ Substance Abuse ☐ Other Specify: _____

Based on the previous question, please specify what type of support services, if any, would you need to treat these mental health condition (s) in your practice?

_____

YOUR LOCAL MENTAL HEALTH SERVICES

Who do you usually contact to arrange for a non-urgent mental health assessment?

Local Mental Health Team ☐ Local Psychiatrist ☐ Local Hospital ☐

Other, Specify: _____

What is the current waiting time for a non-urgent referral for mental health assessment?

0-2 weeks ☐ 2-4 weeks 4-6 weeks ☐ 6-8 weeks ☐ over 8 weeks ☐

Who do you contact for an urgent mental health assessment?

Local Mental Health Team ☐ Local Psychiatrist ☐ Local Hospital ☐

Other, Specify: _____

Indicate your initial point of contact for child and adolescent mental health services: _____

What mode of communication do you use when referring patients?

Facsimile ☐ Letter ☐ Telephone ☐ Other, Specify: _____

How do you rate your satisfaction level with the mental health services in your area?

Very Good ☐ Good ☐ Fair ☐ Poor ☐ Very Poor ☐

If you were to improve one area in the delivery of mental health services in primary care, this would be:

Improve communication with mental health providers ☐

Improve access to mental services/facilities ☐

Provide mental health training to GPs within the practice ☐

Reduce waiting times to for psychiatric care ☐

Other Please specify: _____

YOUR PRACTICE

Is your practice: Urban ☐ Rural ☐ Combined Urban-Rural ☐

Mostly Private ☐ Mixed (Private/GMS) ☐ Mostly GMS ☐

Including yourself, how many GPs are in the practice? _____ Your gender is: Male ☐ Female ☐

Indicate in which age group you belong:

26-35 ☐ 36-45 ☐ 46-55 ☐ 56-65 ☐ 66 Plus ☐

Have you had any postgraduate training in mental health such as counselling, or psychotherapy?

No ☐ Yes ☐ If yes, please specify: _____

FOLLOW-UP STUDY: This survey will be followed by other studies to assess the area of mental health in primary care. We would appreciate your future participation. If you are interested in taking part in future studies such as focus groups or would like to get the results of this study, please provide your contact information.

Name:_____

Practice Address:_____

_____Tel.:_____

Best time(s) to call: _____am/pm

Please return completed questionnaire by Monday 23rd December 2002 in the freepost envelope provided to The ICGP, 4-5 Lincoln Place, Dublin 2 - Thank you!

Appendix 3: Consultant Psychiatrists Questionnaire

1. Please estimate the number of patients that you see per week: ☐

2. What percentage of your patient population are referred to you by GPs? ☐ %

3. Please rank in numerical order the most prevalent mental health conditions that are referred to you by GPs: (Number 1 being the most common condition)

   Anxiety Disorders ☐ Depression ☐ Eating Disorders ☐ Emotional Difficulties ☐

   Psychotic Disorders ☐ Substance Abuse ☐ Other Specify: _____

4. Which mental health condition(s), if any, that are currently referred to you, do you feel could be treated within general practice if given adequate support? (Please tick as appropriate)

   Anxiety Disorders ☐ Depression ☐ Eating Disorders ☐ Emotional Difficulties ☐

   Psychotic Disorders ☐ Substance Abuse ☐ Other Specify: _____

5. What percentage of patients referred to you by GPs, do you feel should be ideally treated within primary care? _____

6. What barrier(s), if any, do you perceive when discharging patients back to primary care?
   _____

7. What is the current waiting time for a non-urgent mental health assessment referral?

   0-2 weeks ☐ 2-4 weeks ☐ 4-6 weeks ☐ 6-8 weeks ☐ over 8 weeks ☐

8. How do you rate your satisfaction level with the mental health services provided by GPs in your area?

   Very Good ☐ Good ☐ Fair ☐ Poor ☐ Very Poor ☐

9. Please rank areas in the delivery of mental health services in primary care that you would like to see some improvement: (Number 1 being the most common condition)

   Improve communication between primary and secondary care ☐ Improve access to mental services/facilities ☐

   Provide training to GPs in the area of mental health ☐ Shared care between GPs and mental health providers ☐

Other Specify: _____

Comments: _____

Name: _____

Practice/Hospital Address: _____

_____

Thank you

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