Irish College of General Practitioners

Submission of the Irish College of General Practitioners to the Oireachtas Joint Committee on the Future of Mental Health Care regarding the use of medication and talk therapies in relation to mental health

Improving care for people with mental health care needs

Essential for health system transformation and sustainable health care

February 2018

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Opening statement

The Irish College General Practitioners (ICGP) is the professional body for general practice in Ireland. The College's primary aim is to serve the patient and the general practitioner by encouraging and maintaining the highest standards of general medical practice. It is the representative organisation on education, training and standards in general practice.

The College is the recognised body for the accreditation of specialist training in general practice in Ireland and is recognised by the Medical Council as the representative academic body for the specialty of general practice.

There are 3,724 members and associates in the college, comprising over 85% of practising GPs in the Republic of Ireland. There are 205 members in Northern Ireland, the United Kingdom, Canada and other overseas locations, and 690 GP trainees.

Introduction

ICGP representatives:

- Dr John O'Brien — ICGP Vice President and Incoming ICGP President.
- Dr Brian Osborne — Assistant Director, Postgraduate Resource Centre (PRC), ICGP, with special responsibility for mental health.
- Dr Brendan O'Shea — Director, Postgraduate Resource Centre (PRC), ICGP.

General practice teams deliver continuing personal medical care, provided by generalist healthcare professionals, including GPs, practice nurses, and a growing strand of practice based allied health professionals in the fields of psychology, counselling and family therapy.

When well supported and adequately resourced, GP teams can engage systematically in activities known to prevent and care for a range of mental health issues and medical conditions. This is achieved through the use of brief interventions in relation to alcohol and tobacco use, lifestyle interventions in the context of exercise and stress management as well as delivering ongoing community based care.

Elsewhere in the primary care domain, the Counselling in Primary Care Service (CIPC) provides off - site counselling for people who are significantly stressed, but this only applies for people who are eligible under the Primary Care Reimbursement Scheme (PCRS) or Medical Card Scheme. GPs refer to voluntary and/or 'private' counselling services, and specific services (e.g. local addiction counselling) vary depending on local circumstances, and crucially, on the ability of the individual to pay. The ICGP is of the view that there is a major lack of capacity in this area of service provision. On a system wide basis, the volume of service provided by the CIPC is inadequate, and a majority of the population are ineligible for CIPC services. The contribution of voluntary agencies is increasingly evident and important to GPs and people who use these services.

When a person attends general practice with a mental health issue, several approaches are explored. The GP will engage in initial evaluation and diagnosis. People mostly present with mild to moderate anxiety and depression. In many instances, an opportunity for reflection, shared formulation of the issues, lifestyle advice, a cognitive approach grounded in a pre-existing understanding of the individual and their particular circumstances, signposting to relevant additional resources, and follow up at the practice level will enable many people to resolve the problems they experience. This is

particularly so when the reflection is undertaken with a GP who has a deep and long term knowledge of the individual, their circumstances and their past medical history.

Prevention, earlier diagnosis and management in relation to problem use of alcohol and recreational drugs, or the presence of signs and symptoms of a range of psychiatric conditions including postpartum depression, self-harming, addictions, adjustment reaction to life events, abnormal grief reaction, obsessive compulsive disorder, borderline personality disorder, chronic anxiety disorder, or clinically significant depression will result in a more formal practice based approach, the management of which will reflect the circumstances of the practice, and the needs of the individual.

The earliest diagnosis of severe spectrum or complex psychiatric diagnoses is also undertaken by GPs, including psychoses, bipolar affective disorder and high risk suicidality. These activities are undertaken across the full spectrum of people who attend, including those from deprived and affluent backgrounds, and the young and old. At the severe/persistent end of the spectrum of clinical presentations, treatment will extend to pharmacotherapy, and or referral to psychiatry.

When practices are operating in a dearth of resourcing, opportunities and time to engage with the people and families concerned are fewer. Less can be done in terms of prevention and earlier intervention, with increased pressure on GPs to treat people pharmacologically, and to refer, regarding which, many GPs are unhappy. Payment is a known additional barrier to optimal treatment for many citizens. It is a major cause of dissatisfaction where pressure of work is such that GPs are unable to spend adequate time with people attending them with significant mental health issues. Onward referral to secondary care is challenging for people.

The impact of FEMPI cuts and sustained failure to deliver a contract for general practice has caused many professionally important activities in general practice to come under pressure as a result of competing and conflicting pressures of higher professional values set against relentless business pressures. This conflict is a major deterrent to younger general practitioners establishing in practice, and a cause of burnout among older colleagues, contributing directly to medical emigration, and leaving people without essential services. Our health system would appear to value machines, hospitals, and drugs over talk therapy, time to care and social support.

Being able to manage problems in the general practice setting has the added advantage of markedly reduced or absence of stigma. GPs and the people who attend them for care of mental health issues both prefer to avoid the use of pharmacotherapy where possible; while it is quicker and easier to prescribe medication, in many instances it is neither best nor the first thing to do.

Resourcing

Clear and honest communication around resourcing for mental healthcare is essential. It is the view of the ICGP that there is an absolute requirement to increase capacity in GP led healthcare within the Irish health system.

Three important observations are particularly relevant in this context.

Firstly, the **numbers of GPs and practice nurses per capita** in the Irish health system are low by international standards. Numbers of GPs per 100,000 population in Ireland are in the order of 64[1], compared to 90-100 in Canada, Scotland and England. There are approximately 3,700 GPs and 1,800 practice nurses working in our system, and these numbers need to be urgently increased towards 5,000 of each, as we plan for a population of 5 million in the intermediate term.

Secondly, the proportion of total health spending on primary care in Ireland is strikingly low by comparison with developed economies including Canada, Australia, Scandinavian Health Systems and

the NHS in the UK. In these health systems, circa 8-11% of total health spending is directed into primary care, whereas in Ireland the proportion is in the order of 4%.

Thirdly, the overall health spend on healthcare in Ireland is in the order of €22 billion, and the per capita spend here is high by international standards. It is the view of the ICGP that within the Irish health system, we are historically spending excessively on hospital based care, on administrative overheads, on technological medicine, on specialised care, and on pharmacological therapies, and that conversely, we are spending too little on primary care, and on holistic talking therapies.

General practice is changing. Irish general practice is leading the Irish health system in the use of electronic medical records. Despite low levels of funding for primary care, most Irish citizens can access a GP on demand, within 1-2 days, and most Irish people still believe that they 'have' their 'own' GP, and they have an appreciation of personal care. The ICGP however is of the view that better and higher volumes of care could be provided by increasing capacity in GP led care. Recruitment and retention of more GPs would enable higher volumes and better quality of care in communities, including mental health, enabling better prevention, earlier diagnosis and better community based care.

Irish general practices are slowly getting bigger, as the proportion of single handed GPs (now at 18%)[2] is reducing, and more GPs work in practices with 3, 4 or more GPs. These larger practices could very usefully incorporate an on-site strand of talk therapy, delivered by GPs and with the support of practice nurses and visiting allied professionals. Trend setting practices are actively exploring the use of relevant innovative care including telemedicine, mental health and exercise apps, and social prescribing.

Some difficult realities

While turnover on general practice teams is low, with good continuity of care, we are aware of the challenges facing public psychiatry care, where high levels of turnover are understood to be a problem. This creates special difficulties in psychiatry, where communication and continuity are particularly important.

Clinical Case Scenario

Mary is depressed.

Mary is attending her GP. She frets in a busy waiting room. She sits with an agitated man who explains he has diabetes, a mother and a baby with a cough, a gentleman with "man flu", and two other women, one of whom is clearly pregnant. Mary is anxious, but it helps that she is attending her own GP, hers since she was a child. She likes her GP because she feels known and listened to, and her GP is careful.

Mary explains she is tired all the time and gets headaches. Her GP listens as she describes that the headaches occur most days, she feels exhausted, can't do things with the children, and feels guilty all the time. The GP asks what she thinks might be going on. She isn't fully sure, but on reflection, they both agree that things are not that good in her relationship. She has three children under 10, she works outside the home, and also visits her mother with whom she has a complicated relationship, who is ill, and needs her attention. She knows she has increased the amount she is drinking, but finds the only nights she gets a few hours of decent sleep are when she's had 2 or 3 glasses of wine, which is now happening 4 or 5 nights per week.

She's worried she has a serious illness, maybe a brain tumour, and how would the children cope? She is tearful, and needs time to compose herself as she tells her story.

The GP evaluates the headache, does a neurological examination and measures BP. Her GP sees her as anxious and depressed. The pleasure has gone out of her life; she feels mostly hopeless and worthless, but is not suicidal.

They explore the possibility she may be depressed and anxious.

Blood pressure and examination are normal; mental state examination is consistent with mild depression/anxiety. These findings are shared, and a plan is made. She will reflect on the main causes of exhaustion, and undertakes to get back to pilates, and go for a 30 minute walk most days. She thinks her brother can visit her mother for the next 3-4 weeks. She undertakes to reduce alcohol to one night per week. Bloods are arranged to check for hypothyroidism, anaemia, diabetes, liver enzymes and a menopause profile. A review is planned for 2-3 weeks.

The GP explains what might help – exercise, mindfulness (the GP suggests a mindfulness app), counselling, and also medication. The GP explains that medication is neither good nor bad but just one of the tools for getting out of a depression. She is nervous of medication, fearing addiction, or that it may alter her personality. The GP is confident that she will get back on top, having previously assisted when she had a moderate postpartum depression after the birth of her second child.

This all takes 22 minutes.

Realising the potential of GP led teams

If additional funding is made available as per the *Slaintecare Report* [3], how will this be applied and what will be achieved with it in terms of care for people with mental health problems in communities?

An important aspect of applying this funding is to closely consider distributing additional funding on a deprivation weighted model, which, given the level of detailed knowledge available on Health Atlas Ireland [4], can now be factored in, and with adequate detail. Additional funding should be used to increase the numbers of GPs and with appropriate supports. This will enable the targeted organic growth of GP teams where they are most needed, and this in turn will enable greater provision of talk therapy services and related supports in the areas of prevention, earlier detection and better follow up care in communities where people live.

Firstly, this will result, in the intermediate term, in improved capacity at general practice and community levels to address volumes of activity at the practice/community level in prevention, including tobacco use, alcohol, exercise and stress management. Such activities will be effective in the primary prevention of a range of mental and physical health problems. Additional funding will enable GPs to incorporate a broader mix of allied health professionals, and this, together with more GPs will enable a greater proportion of mental health care to be delivered in the community/neighbourhood setting of general practice as opposed to referral to secondary care.

Secondly, building these capacities will result in more systematic activity in the management of anxiety, depression and pain in chronic disease management, which are all now known to be important for the effective management of these long term conditions, which are amenable to general practice interventions, and which are critical for delivering best care for these people. People with heart failure and diabetes who are anxious or depressed have a poorer quality of life and survival, and higher costs than when their anxiety and depression are properly cared for.

The ICGP supports the policy elaborated in the *Slaintecare Report* [3], and in the recent HSE report *A Future Together* [5], both of which underpin a 'shift to the left' in terms of a greater proportion of health spending in primary care. In addition to building capacity in mainstream GP delivered services, such a shift will enable the embedding of greater volumes of allied health professional care as well as a more rapid translation of new modalities and new technologies relevant to mental health care, including telemedicine, social prescribing and evidence based use of social media for improved care for the younger demographic. Further, the ICGP recognises the value and impact of the voluntary sector in the development and delivery of mental health services, and the importance of the work done for particular patient groups.

> 'While the prevalence of severe mental illness is small relative to mild-to-moderate mental illness, it tends to dominate the organisation of mental health systems in OECD countries, and consume most of the resources…'
>
> FOCUS ON HEALTH Making Mental Health Count © OECD, July 2014 [6]

Understanding the reality of Irish general practice at present

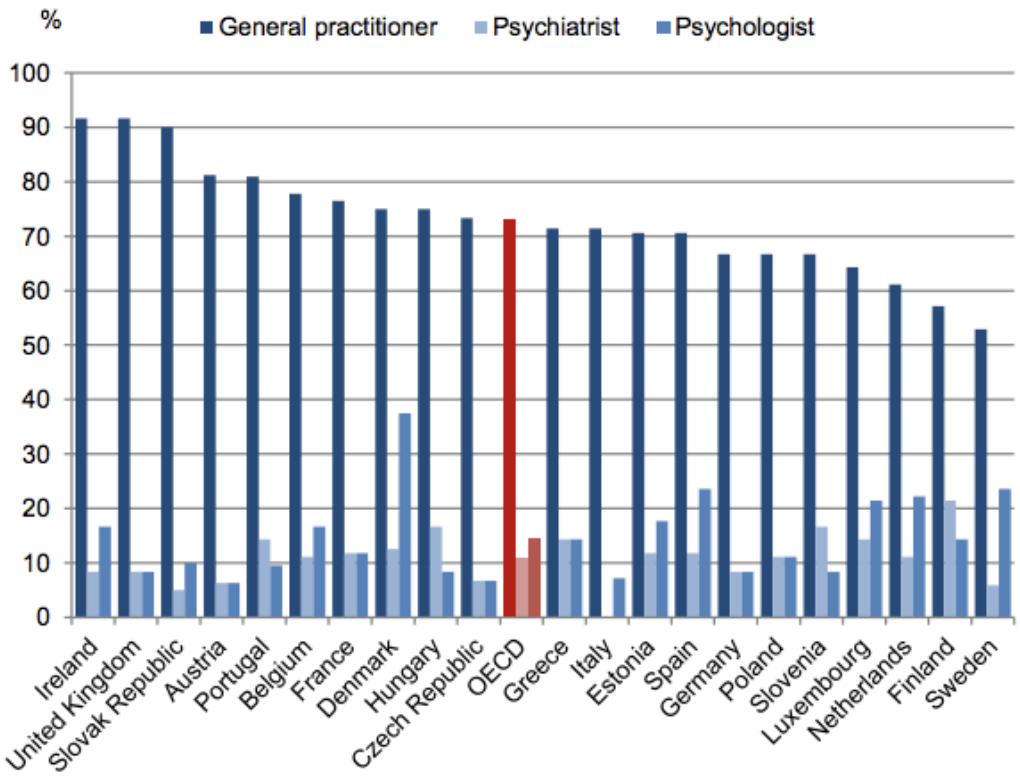
It is the view of the ICGP that the FEMPI cuts to the PCRS funding model, together with a sustained failure to negotiate a new contract for general practice for 39 years, are both major impediments for the delivery of essential community based mental healthcare for Irish citizens. These two issues need to

be addressed as priority issues, followed by a separate strand of transitional funding as clearly outlined in the *Slaintecare Report* [3] and *A Future Together* [5].

If this can be achieved, the ICGP and the GP led part of the Irish healthcare system can and will develop the necessary capacity and innovation which Irish citizens require, in order to achieve better outcomes, in both mental health and in the long term care of frail complex individuals with comorbidities and associated mental health problems.

Through its main activities of training, research and postgraduate education, the ICGP is well placed and ready to enable capacity and innovation leading to more and better mental health care which can be delivered in communities. The emphasis will be on prevention, talk therapies and lifestyle modification, supporting greater availability of allied health professionals, and reduced reliance on pharmacotherapy and distant hospital/specialist services.

Figure 2. Type of provider(s) consulted for mental health problems, selected EU countries, 2010



Source: Health at a Glance 2011 – OECD Indicators, OECD Publishing, Paris, http://dx.doi.org/10.1787/health_glance-2011-en.

OCED. Health at a Glance 2011 – OECD Indicators. Paris: OECD Publishing [7]

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