

Editorial

The extraordinary potential of primary care to improve mental health

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Mental health service in primary care has traditionally been viewed as the Cinderella of the health system. Mental illness contributes 12% to the global burden of disease, yet European countries spend on average about 5% of their health budget on mental health care.¹ The new European Community member states spend an even smaller proportion of their health budgets on mental health services, perhaps around 2%.¹

In the last few years, however, mental health services in primary care attracted considerable interest and the importance of mental illness in primary care became apparent. Nine out of ten depressed patients are treated only in primary care.² Over three quarters of patients consulting their general practitioner admit to at least one psychosocial problem, over one third report that psychosocial problems impact on their present health,³ and up to two thirds of suicide victims contact a general practitioner in the four weeks before their death.⁴

In addition, the general public, surveyed more than a decade ago, preferred to see general practitioners rather than psychiatrists for depression and to receive psychological treatments and counselling rather than drug treatment.⁵ This perhaps indicates that seeing a psychiatrist is still associated with considerable stigma, but also provides primary care professionals with an opportunity to engage patients effectively.

The realisation of the importance of mental health led to numerous recent developments and initiatives both in the UK and internationally. Three of those appear to be especially pertinent for primary care.

The Helsinki declaration

In January 2005 the *Mental Health Declaration for Europe* and the *Mental Health Action Plan for Europe*

were endorsed by the ministers of health of the 52 countries of the European region of the World Health Organization at a meeting in Helsinki.^{6,7} The declaration stated that the process of de-institutionalisation in mental health has been largely completed in Western Europe, following Italy's pioneering example as far back as 1978. De-institutionalisation meant a dramatic increase in the role of primary care in mental health with the accompanying re-distribution of the resources. Importantly, the declaration called for investment in mental health to achieve parity with investment in other areas of health.

The IAPT

Unlike many other countries of the European Region of WHO, the proportion of health budget spent on mental health services has increased to over 10% in the UK.⁸ This increase, however, has traditionally focused on severe and enduring mental illness and in practice was oriented at a relatively small number of people with disabling psychosis. Disability associated with depression and anxiety, with over six million sufferers in the UK alone, was one of the key reasons behind the introduction of the IAPT (Improving Access to Psychological Treatment) initiative. Within IAPT regional training programmes are being set up to deliver evidence based treatment for 900 000 more people suffering from anxiety and depression, with half of them moving to recovery and 25 000 fewer on sick pay and benefits by 2010/2011.⁹ This initiative aims to train 3600 new therapists and is underpinned by £173 million budget (IAPT). IAPT is a logical consequence of the introduction of NICE guidelines for the treatment of depression and anxiety disorders where psychological therapies, especially cognitive behavioural therapy (CBT), play a key role.

The Royal College of General Practitioners Position Statement on Mental Health and Primary Care

The Royal College of General Practitioners Position Statement on Mental Health and Primary Care (reprinted in this issue) clearly highlights mental health as a national priority for primary care in the UK. Reducing stigma, addressing health inequalities, improving quality and enhancing communication with secondary care are the key messages of the Statement. The Statement creates a framework for the delivery of IAPT and perhaps for the expansion of IAPT in the future.

These developments, although extremely timely and welcome, are unlikely to change the role of mental health services in primary care immediately and universally. This may prove especially problematic in the provision of mental health services for children and ethnic minorities.

London has the highest proportion of immigrant and ethnic minority population of any UK region. There are significant discrepancies in the provision of mental health services to different ethnic groups. The most consistent findings are that African–Caribbeans with mental health problems are disproportionately found in forensic, psychiatric, and prison populations and among compulsorily detained patients.^{10,11} They are more likely to receive antipsychotic medication and less likely to be offered psychotherapy.¹²

Mental health of children remains an important gap in the current policy and recent initiatives and is not, at present, covered by the IAPT. The growing evidence for child health screening in preschool facilities and schools underlies government support for a child health promotion programme.¹³ In contrast, promotion of mental health and prevention of mental illness in children is still in its infancy. This is mirrored by relatively poor incentives for general practitioners to institute holistic child health programmes, leading to service fragmentation and inadequate resource allocation.¹⁴ Child mental health is perhaps the most obvious area of expansion for IAPT in primary care service in general due to the importance of psychological therapies in this patient group.

Mental health services in primary care are currently in vogue. They are the subject of numerous government initiatives, research projects and service innovations. This is perhaps the best opportunity for years to tackle chronic under-investment, stigma and inequalities in mental health and to turn Cinderella into a princess. Permanently.

CONFLICTS OF INTEREST

None.

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