

Mental health services in primary care

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In the UK, only 13% of people with long-term mental health problems are in employment, compared with 35% generally of people with a disability (Royal College of General Practitioners, 2005). Nearly 2.6 million individuals receive incapacity benefit and/or severe disability allowance and, of these, close to 1 million are claiming incapacity benefit due to mental ill health. The management of this enormous number of people – providing support to them and helping them get back into employment – is an issue that cannot be addressed adequately by our specialist mental health services. Accordingly, other models of service delivery need to be considered. The three thematic papers in this issue look at this issue from the perspective of three highly contrasting societies.

First, there is a fascinating report by Professor Yu Xin together with colleagues Liu Jin and Ma Hong. They are based in Beijing, and discuss the way in which China is attempting to deal with such problems in the decades after the end of the Cultural Revolution and the emergence of a very different social revolution. As the structures of the old society disintegrated, both literally and metaphorically, health services became increasingly hospital-based; the model of the barefoot doctor was consigned to history. But it has recently been recognised that building a strong primary care infrastructure is essential, especially in mental health. We learn how this is being implemented.

In Egypt, which is not particularly well supplied with psychiatric services relative to the size of its population, people with mild mental health problems are supported primarily by their extended families, whereas those with more serious disorders are admitted to hospital. An ambitious plan, by which

mental healthcare was to be integrated with primary care, came about through a collaboration with the government of Finland. Unfortunately, as Nasser Loza points out in his report, the principle of treating people with serious mental illnesses in the community was not welcomed by the population at large, nor by psychiatrists, who felt they were at risk of losing influence and income. The subject is still under discussion, with no clear progress.

Finally, we do have a remarkable success story, in the form of an initiative in Chile, which could serve as a model for countries with far better developed health services. Alfredo Pemjean reveals the way in which bold and novel moves to reorganise mental healthcare have empowered primary care practitioners and enabled them to work more closely with specialist colleagues from hospital services, in order better to serve the population with mild to moderate disorders. While there are many strengths in the Chilean system, Dr Pemjean also points out that there are still outstanding weaknesses, which will need to be addressed in due course. One important problem, a recurring issue in these thematic papers, concerns the necessity of integrating community self-help with professional services; the value of building links between the public and psychiatric services is easier said than done.

Reference

Royal College of General Practitioners (2005) *Position Statement: Mental Health and Primary Care*. RCGP. Available at http://www.rcgp.org.uk/PDF/clinspec_printed%20version%20mental%20health.pdf (accessed November 2009).

THEMATIC PAPER – MENTAL HEALTH SERVICES IN PRIMARY CARE

Integrating mental health into primary care: the policy maker's perspective and experience in China

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In China, 'community' was an alien word. Many people used to live in dormitories (*Danwei*), to which they were assigned by government according to their work units. 'Dormitory form' community was closely linked to where

people worked, and thus administration and supervision were simple, as was the provision of health services. In each *Danwei*, a clinic provided basic healthcare not only for its employees but also for the other residents of the