We are looking also into the curriculum which will guide future continuing medical education (CME). In this way, when the medical council decides to introduce re-validation, one need not fear doing extra evaluations other than attending a recognised CME programme which follows a curricular design. This way one would ensure that doctors are kept up-to-date without the need for exams. I believe that we should be giving members value-for-money. CME is only a small part. We have now introduced the opportunity to support research initiatives for those who wish to apply for EU projects. Those who are interested may contact me on bioethicscentre@onvol.net. But I would also ask those who have ideas for the College to come forward. One cannot expect that council does everything and one must be willing also to help find the manpower for initiative. But the more we build the collegiality, the stronger will be our College.

Prof. Pierre MALLIA
MD PhD CBiol MPhil MA(Law) DipICGP MMCFD MRCP FRCGP
President, Malta College of Family Doctors
Email: bioethicscentre@onvol.net

GUEST EDITORIAL

The interphase between family medicine and mental health

Dr Anton GRECH, Ms Sally AXIAK, Prof. Clare GERADA

DeGruy (1996) stated that "*it is fundamentally wrong to speak of mental health as if it is distinct from physical health or health in general*". Generally speaking, and across the world, primary care clinicians deal with mental symptoms as part of a larger more general problem and conversely mentally distressed patients often present with increased physical symptoms. However, and more so within Malta, whilst most patients with common mental illnesses (depression, anxiety, adjustment disorder, alcohol dependence) attend their general practitioner (GP) for help, the more severe and enduring end of the psychiatric spectrum is largely addressed by specialist services, with GPs acting largely only as conduits for referral (McDaid, 2013).

De Hert et al. (2011) reported that the rates of undiagnosed and untreated medical illnesses are higher in individuals with a serious mental illness (SMI) when compared to the general population. In many instances the only contact of SMI patients with health services is through specialised mental health services, and by virtue of their condition they are less able to recognise their own signs of physical illness, solve their problems or care for themselves. Extant literature acknowledges a higher rate of morbidity and mortality in SMI patients (Bailey et al., 2012) but, as DeHert et al. (2011) observed, this is mostly due to modifiable health risk factors.

Wittchen et al. (2003) asserted that primary care doctors are the cornerstone of recognition, diagnosis, treatment and specialist referral for all types of disorders, be they of a somatic or psychological nature. McDiad (2013) stated that *"the best use of both specialist and primary mental health services occurs when an individual can get the help they need at the lowest level of support appropriate for them"*. This is a view that has been gaining ground in recent years with an increasing international trend towards integrating mental health services into primary care services. The World Health Organisation (WHO) has stressed the key role that primary care can play in the treatment of mental health conditions (WHO, 2001). GPs have the advantage of knowing their patients holistically, being aware of their interpersonal, social and domestic circumstances, as opposed to addressing a specific disease or condition. This is extremely relevant in the context of dealing with mental disorder which very often is impacted by social factors and family support. Significantly, robust primary care has been correlated with greater organisational efficiency and better patient outcomes, and consequently primary care is acknowledged

as the hub of current attempts to improve the performance and outcomes of healthcare systems (Fleury et al., 2012).

When individuals require specialist mental health services, it is imperative that their care is shared across the primary-secondary care divide; this ensures that specialist services can focus on individuals who need their skills and intensive support and ensures that their continuing care is delivered in the normal, and less stigmatising, environment of primary care. It also ensures that their other health needs are addressed as with other patients in their community (Fleury et al., 2012, McDaid, 2013).

Studies have examined the willingness of GPs to provide care for patients with SMIs and factors which impede participation in such provision. Oud et al. (2009) stated that a clear distinction must be made between the acute and chronic phases of SMIs. They found that GPs saw their role in the acute phase as being one of identification and referral to specialist services; however, their role in the chronic phase was more ambiguous and less easy to clarify. Whilst many of the participants in this study were willing to have a more extensive role in providing care to this patient group, they identified a need for training in areas such as pharmacotherapy and for a more optimal collaboration with mental health services.

In fact, integrating services between the two systems (primary health care and mental health care services) is a complex process, even where this process has been well established as is the UK National Health Service (Lester, 2005). There are certain obstacles to the successful integration of mental health care into the primary care setting such as time limitations associated with the pace of primary care practice, competing demands, lack of availability or access to other essential professionals (such as psychologists and social workers), and inadequate knowledge on the part of primary care clinicians due to the somatic and biological orientation of medical education. This is especially so when addressing the integration of the delivery of services for SMIs (Kelly et al., 2011).

The WHO (2001) set out a number of principles for addressing such barriers to integration. These included: the inclusion of primary care in mental health policy and planning; appropriate training and support of staff; information technology infrastructure; provision of financial support; a team based approach with an emphasis on communication; the provision of a mental health coordinator to drive integration and the acknowledgement that integration is a process not an event.

Current restructuring of national health care systems in Malta, especially as regards to mental health services, provides an excellent opportunity to weave mental health care into the fabric of primary health care. With this in mind, the government mental health services have recently launched a scheme of collaboration between GPs and the government services' mental health multidisciplinary teams, in the follow up of stable psychiatric patients suffering from psychosis or affective disorder within the community. Training of GPs interested in joining the scheme has already started and is planned to be an ongoing process. This scheme is far from being all-inclusive, but is just the initial step in what would hopefully be a fruitful collaborative process between Maltese GPs and Maltese psychiatrists and their teams, with the ultimate aim being the holistic wellbeing of Maltese sufferers of mental illness.

REFERENCES

Bailey, S., Gerada, C., Lester, H. and Shiers, D., 2012. The cardiovascular health of young people with severe mental illness: addressing an epidemic within an epidemic. *The Psychiatrist,* 36(10), pp. 375 -378.

DeGruy, F., 1996. *Mental Health Care in the Primary Care Setting. Primary Care: America's Health in a New Era*. [online] Available at: <https://www.nap.edu/read/5152/chapter/16> [Accessed 22 November 2016].

De Hert, M., Cohen, D., Bobes, J., Cetkovich-Bakmas, M., Leucht, S., David, M., Ndetei, D. and Correll, C., 2011. Physical illness in patients with severe mental disorders. II. Barriers to care, monitoring and treatment guidelines, plus recommendations at the system and individual level. *World Psychiatry*, 10(2), pp. 138–151.

Fleury, M., Imboua, A., Aube, D., Farand, L. and Lambert, Y., 2012. General practitioners' management of mental disorders: A rewarding practice with considerable obstacles. *BMC Family Practice,* 13(19).

Kelly, B.J., Perkins, D.A., Fuller, J.D. and Parker, S.M., 2011. Shared care in mental illness: A rapid review to inform implementation. *International Journal of Mental Health Systems,* 5, p. 31.

Lester, H., 2005. Shared care for people with mental illness: a GP's perspective. *Advances in Psychiatric Treatment,* 11(2), pp. 133-139.

McDaid, S., 2013. *Mental Health in Primary Care in Ireland: A briefing paper*. Mental Health Reform. Dublin.

Oud, M., Schuling, J., Slooff, C., Groenier, K., Dekker, J. and Meyboom-de Jong., B., 2009). Care for patients with severe mental illness: the general practitioner's role perspective. *BMC Family Practice*, 10(1), p. 29.

Wittchen, H.U., Mühlig, S. and Beesdo, K., 2003. Mental Disorders in Primary Care. *Dialogues in Clinical Neuroscience*, 5(2), pp.115-128.

World Health Organisation, 2001 *The World Health Report 2001 – Mental Health: New Understanding, New Hope*. [pdf] Available at: <http://www.who.int/whr/2001/en/whr01_en.pdf> [Accessed 22 November 2016].

Dr Anton GRECH
MD, PhD (Maas.), MSc (Psych) (Lond), FRCPsych (U.K.)
Mental Health Services, Mount Carmel Hospital, Attard, Malta; Department of Psychiatry, Medical School, University of Malta, Msida, Malta
Email: anton.grech@gov.mt

Ms Sally AXIAK
MSc HSM (Melita), BSc (Hons) Mental Health Nursing, RMN, RNMH
Mental Health Services, Mount Carmel Hospital, Attard, Malta

Prof. Claire GERADA
MBE FRCGP FRCPsych
General Practitioner, Hurley Group, London SE11 4HJ , U.K.