Psychiatry, which is both a health science and a social science, is centrally placed to richly benefit from qualitative and quantitative research methods.

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A model for primary mental healthcare in Ireland

Dear Editor – We read with interest Kierans and Byrne's paper and presentation of a model for primary mental health care in Ireland.[1] We welcome the advancement of the debate on primary care mental health. We agree there is a need for further developments within primary care, and the model proposed has many benefits. However we can also see some difficulties and advise a more collaborative approach between primary and secondary care.

The primary care practitioners the authors refer to are similar to the graduate mental health workers, who have been introduced as part of the Improving access to psychological treatments (IAPTS) in the UK. There is evidence that GPs do not trust the graduate workers.[2] Fletcher et al[3] described how a collaborative approach would ensure the role of the graduate mental health worker was embedded into the service, but they described many problems in setting up the posts, with graduates often unsupported and the process not having managerial support. Farrand et al[4] conducted a qualitative evaluation of the role, and concluded that early difficulties were linked to inappropriate referrals and lack of clear role definition. They advised it was a valuable addition to a stepped care approach to mental healthcare in primary care. However, one of the key determinants of the impact of enhanced primary care mental health resources is the extent and quality of integration and communication at the interface between primary and secondary care. Lester et al[5] found that patients assigned mental health workers in primary care were more satisfied with their care than controls but outcome was no different. Tylee and Walker[6] use this finding to emphasise that 'bolting on' extra resources to existing care strategies does not improve outcome. Tey argues for systemic change, using collaborative care to introduce a chronic disease model for mental illnesses.

There is a risk the model proposed may result in a greater burden on specialist mental health teams. Consultation liaison models, where a consultant psychiatrist attends the general practice every six to eight weeks, has been shown to improve the appropriateness of referrals and improve the detection of those with mental health problems.[7] We have found these meetings can be used to inform GPs on the availability of community resources, including self help groups, and recommend that any quasi specialists in mental health would be incorporated into these meetings.

We would be interested in knowing of other practices throughout the country, where there is greater liaison between primary care and secondary care, or where mental health professionals are working in primary care.

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New long-stay psychiatric in-patients: a comparison of UK and Irish national audit

Dear Editor – The above mentioned interesting study by Daly and Walsh, on new long-stay Irish patients in 2006; which was published in *Ir J Psych Med 2009; 26(3): 134-139.* The author thanks Daly and Walsh for their efforts to report on the first national level Irish study on NLS psychiatric in-patients.

This letter aims to compare the Irish study with much cited UK audit by Lelliott in 1992[1,2] so as to stimulate further discussion and promote further research.

The Irish study covered all the NLS psychiatric in-patients coming from catchment population of ~4.4 million (Ireland population census, 2006); while the UK audit 1992, covered; estimated population: 26% of England; 7% of Scottland, 41% of Wales; 82% of Northern Ireland; served by 59 mental health services of NHS (total catchment population~15.2 million).

The UK study (n = 905) was cross-sectional, by census; while Irish study not only identified (by census on 31/03/2006), described NLS sample (n = 460), but also surveyed it after one year reporting that over two thirds of NLS patients (n = 315) were still residing at psychiatric units or hospitals, and 20%, (n = 64), had become old long-stay patients (stay five years and over).

The UK study included patients aged 16-64 years, staying over six months up to three years while the Irish study included patients aged 16 years and over (and had 40% patients (n = 185), aged 65 or over), with stay of one year to less than five years.

It is interesting that the UK study included a lower limit of long-stay as six months (rather than the traditional one year or over, as in the Irish study). This was because many participating units had a small number of acute beds and stay over six months was undesirable there; while the upper limit of three years was chosen, as the six-month lower limit for length of

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