

ConsumerHealth

Accessing mental health

Mind Moves
Tony Bates

I had missed my bus and idly put in time standing in a bus shelter. My awareness shifted between the frenzy of commuters rushing by, leaves brushing over my feet, memory fragments from times past, and work priorities that came sharply into focus and jolted me into the present. Welcome to the merry-go-round of adult consciousness.

I turned around, only to find a face on a poster looking directly at me inviting me to "look after your mental health".

What ever became of Lyon's Tea, Pretty Polly lights or Joe Walsh? Times have certainly changed. The ad's full-length colour photo is part of a campaign to make me pause and think about a very personal aspect of my life.

Like a sore tooth, we only notice our mental health when it hurts. And when it does, pain takes over and shapes how we feel, react and behave to everything in the world.

Dublin in the rare old times didn't concern itself too much with mental health matters. Sex, politics and religion were the stuff of conversations. The very word "mental" made us uneasy.

It conjured up images of people who - we wanted to believe - were not like us. People who spent years in places we didn't talk about, with problems we feared and could not begin to understand.

Easily forgotten people, because they didn't have a voice to tell us how they felt and what they needed.

We exiled them behind high walls and we told ourselves it was for their own good. In truth, our actions had much more to do with our need to maintain an apparently sane "healthy" society.

What we missed completely was the fact that by locking people away for years, we were also locking pieces of our own hearts and minds away.

By depriving them of the support they needed to fashion a life in the community for themselves, we became alienated from aspects of our own personal development that remained "work in progress".

Feelings that went bump in the night, images and memories we wished we could forget, became very uneasy companions.

We learned to fear ourselves, to push away our vulnerabilities in case we might end up like "them".

Mental health is something we experience in our own unique way, but it is not an individual or entirely subjective matter. It is critically affected by how we deal with one another.

If someone close becomes emotionally "stuck" in some way, you can also become stuck. And if you lock someone into a label or a story that is narrow and out-dated, you deprive them of the room they need to heal and grow.

I would like to think we've come a long way from "the good old days" when we feared mental health and deprived people with mental health problems of their basic human rights. Our mental health services are challenged now to engage with people in a humane and respectful way.

Service users are speaking out for themselves and demanding that they be given a role in planning their care and recovery. A very active Inspectorate for Mental Health advocates who speak and act for people detained without consent, and our new Mental Health Treatment Act are evidence of a society that is trying to affirm and protect the dignity of its more vulnerable citizens.

But my optimism was severely shaken when I read Olivia Kelly's report of the National Disability Authority survey at the end of September.

I was stunned to read that one-third of those surveyed "believed that people with mental health difficulties should not be allowed to have children", "fewer than one in five people thought that those with mental health difficulties should have sexual relationships" and a high percentage also thought they - the "mentally ill" - should not be allowed to attend mainstream schools.

These findings suggest a willingness on the part of a sizeable portion of our society to write off people who struggle with mental illness.

There was a time we considered cancer as something fatal. Now we are able to diagnose and ensure treatment for even one individual with breast cancer, there is a public outcry, and rightly so.

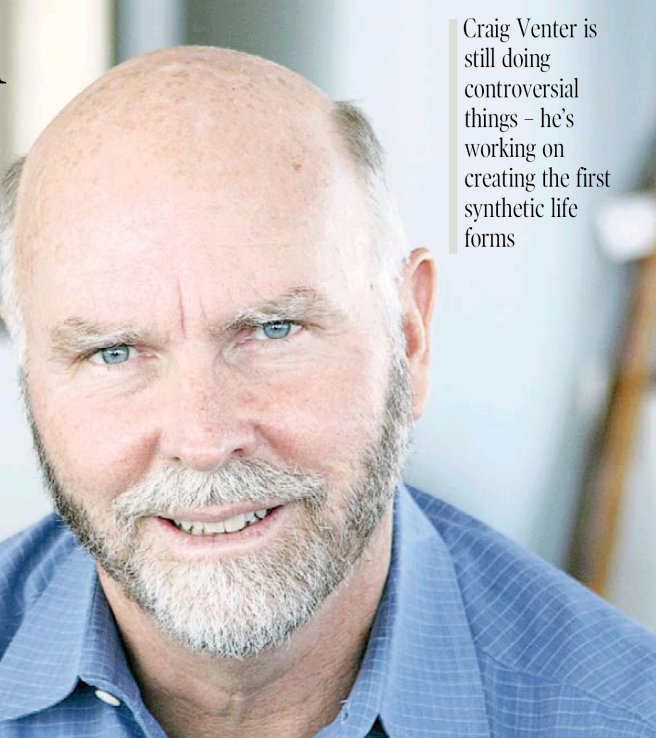
But if a person in mental torment is unable to access the help they need to get their lives back on track, if they are sent home until they become overwhelmed and are completely debilitated by depression and despair, no one seems to care.

Mental difficulties are part of the human condition. We are all prone to black moods, irrational ideas and a million insecurities. And some of us get to feel this way more often than others, and need a lot of patience and care. Problems can be resolved, people can recover.

We do our own mental health a big favour when we help someone get back on their feet. And as a society we become a lot healthier when we demand that those who experience severe and enduring distress get the kind of help that we now know works.

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The man who took on the public



Craig Venter is still doing controversial things - he's working on creating the first synthetic life forms

Craig Venter's name may not be well known to the public but mention it to a scientist, doctor or medical researcher and it becomes a lightning rod for strong emotions - he is often damned and praised in a single sentence.

Venter is the flamboyant doctor and researcher who controversially lit a fire under the global project to sequence the human genome when he started a private initiative in competition with a huge publicly funded project.

Even many of his strongest detractors acknowledge this major project with its massive health and economic implications could have dragged on years longer if not for Venter's intervention. His ability to think differently introduced pioneering, fast and accurate techniques for sequencing that transformed the project.

But he sparked controversy by not just introducing those techniques in the face of much initial derision but also by planning to patent the gene sequences. This more than anything else galvanised the public project, with its goal of keeping the genome fully public.

In the end, the two projects drew neck and neck, and final results were published almost at the same time in 2000. President Clinton then intervened, and announced the genome would not be patented.

The recent publication of Venter's autobiography, *A Life Decoded*, has reopened the discussion about genetics, research, medicine, patents, and whether some major projects with a human health impact should be publicly funded, not privately.

Below, three Irish specialists weigh in on Venter's role and contribution to our knowledge of ourselves.

♦ Dr Aoife Lysaght, lecturer in genetics and molecular evolution, Trinity College Dublin:

I think you could sum him up by saying he's a scientific entrepreneur. He was always extraordinarily ambitious. Ambition spurred on his achievements.

Competition certainly sped up the public genome effort, though I was involved in the public project so I



Karlin Lillington speaks to three experts in the field of genetics about Craig Venter - scientist, entrepreneur, doctor and researcher with big ambition

do see it from the other side. It's true that the private genome sequencing effort wouldn't have worked without data produced by the public effort.

There was a feeling at the time that it wasn't quite appropriate - that the human genomes shouldn't be private and commercial, because it had such potential to be of benefit to the world.

The fact that the public effort caught up with the private one and they came out in the same week meant that the genome couldn't be patented.

Venter does have this ability to go for big projects, and I do think that's important. His institute, TIGR (The Institute for Genetic Research), is also very well respected and has contributed a lot to the scientific community.

The genome is important because the very essence of a lot of medicine these days is genetic. Even a small amount of knowledge about a gene can have huge effects on the drug design process. Knowing how things work properly is important to knowing how things go wrong. Also, having a whole genetic sequence from many species allows us to understand how they evolved.

♦ Dr Asim Sheikh, law lecturer and barrister specialising in patents, genetics and medicine, University College Dublin:

Sequencing the human genome was an historic, groundbreaking project and with big research you

need big personalities. There were also big ramifications for humankind now and in the future.

The sequencing was to be a 10-15 year public project and as data became available, it would be made public. Then Craig Venter came along and introduced the possibility of a private initiative that would be patented. His view was that without private investment, you are never going to get investment into new therapies and treatments.

There is a Constitutional background in the US that you can patent living things. But for many talking about patenting life is talking about ownership of life and that reminds us of slavery and makes us very uncomfortable.

Venter was one of those who argued that bits and pieces of the genome are not life itself; that life is certainly much greater than the genome. In some respects, that argument has some merit, and the next part of the mystery is to understand this book of life.

The patent system is there to protect an intellectual process that results in an idea. It has to be "novel" - that's a key aspect - and there are questions as to whether DNA can be considered "novel".

Also the idea has to be worthy of industrial use, and as they progressed it, they couldn't immediately identify processes it could be used for. So it is questionable if they could have patented the genome.

Most medicines we take come from billions in private investment. We are quick to damn the profit makers and slower to recognise what they have done. If you were to suggest an alternative public option, that would

mean the public putting a similar amount in as pharma companies. I don't think you can divorce private from public.

Venter will certainly be remembered for provoking controversy, but he also brought the private/public controversy to the fore. It made us think about what the genome meant as our human heritage.

♦ Dr Siobhán O'Sullivan, director, Irish Council of Bioethics:

He is such a divisive character. He came across as being quite cavalier. He perfected the technique for sequencing. But the thing he'll be remembered for is the whole debate over the public/private projects. But he motivated the whole project. The public project was already running behind when Venter popped up and said, "We're going to do it faster" and changed the motivation for public researchers to do it far quicker and more efficiently.

And while the patent issue was huge, long before Venter came on the scene the idea of patenting bits and pieces of genes was being mentioned. When he arrived it almost became a soap opera drama between large personalities involved with the projects and the subject came to the fore.

It was really the first time people thought about how we fund science, how we view life forms, and also ourselves. He's still doing controversial things - he's working on creating the first synthetic life forms. We're talking about things that could be very beneficial and, of course, could make him billions, but also very unknown and potentially dangerous. We don't know what would happen if we released such a new life form into the environment.

Venter has forced the consideration of such things and made the public more aware of such debates. Bioethical and legal discussions tend to trail the science. We need to be slightly more forward thinking.

♦ Craig Venter: *A Life Decoded*, Penguin/Allan Lane. Price: €38.

Crippling quality of care in hospital



There is no single, simple or cheap way to preventing the dreaded hospital-acquired infections, writes Hilary Humphreys

Within recent years, hospital infection has become a major issue for the health service in Ireland. This has arisen because of the increasing "consumerisation" of healthcare. Patients legitimately ask more questions about the quality of the care they receive and have greater expectations.

There is also increasing concern about MRSA and, most recently, *Clostridium difficile*. However, hospital-acquired infection is not new and has been around for as long as hospitals.

When a patient is admitted to hospital there is always a potential risk that even the most routine of procedures could result in a complication. No procedure, no drug and no aspect of healthcare is without some risk.

However, if the admission is appropriate, that risk will be more than counter-balanced by the benefit for the patient and their family in terms of improved health. Hospital infection is an example of a healthcare complication which affects a small minority of all patients admitted to hospital.

For those who are affected, however, the

consequences can include potential death, acute and chronic illness or have financial consequences for the patient, his or her family, the healthcare service and society as a whole.

Today, we are stretching ever further the boundaries of healthcare with major and welcome new developments. These include chemotherapy for previously untreatable cancers, organ support to keep patients alive while in intensive care and a greater range of transplant procedures to replace failed organs.

But at the same time we expose a new group of vulnerable patients, who previously would have died, to the possibility of acquiring hospital infections. In addition, the increasing longevity of patients, and the use of some drugs that weaken the body's own defences against infection, means that there is a continuous need to improve our preventative measures as we potentially expose more patients to infection.

Last year most acute hospitals in Ireland took part in the Hospital Infection Society Prevalence Survey of hospital infection which was carried out in Britain and the Republic.

In the Republic about one in 20 patients (5 per cent) had a hospital infection. Of these, 10 per cent were due to MRSA. The remaining nine out of 10 hospital infections were caused by other microbes, mainly bacteria.

The majority of hospital infections are treatable and while there is considerable scope for improving our approach to preventing hospital infections in Ireland, we will never achieve a zero rate for these infections.

What is not clear at present, due to inadequate information, is exactly how much of the 5 per cent of hospital acquired infections is preventable.

There is no single, no simple and no cheap solution to preventing and controlling infection in hospitals, especially as this issue has been largely ignored in our health system until recently.

The Department of Health and Children and the Health Service Executive have now prioritised this area for attention and action, and this is indeed welcome.

However, we have an enormous amount to do if we are to equal the success of countries such as the Netherlands, Switzerland, Denmark and the other Scandinavian countries, and also if we are to meet the expectations of the public.

These countries have invested in preventative measures for 30 years and more and their efforts have been accompanied by the evolution of a culture that recognises infection prevention as intrinsic to all healthcare delivery.

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“Any strategy to minimise infections in hospital must include the education of workers”

healthcare workers on what is appropriate practice, as well as the education of patients, visitors and the public.

It must also enhance the professional practice of all healthcare workers such as in the area of hand hygiene (hand washing) and in the use of disposable aprons and gloves. The introduction of national and local surveillance data is essential to provide up-to-date information so that early interventions can be made.

Hygiene in hospitals is important too as our hospitals must not only look clean but have minimal numbers of microbes on the floor, on the beds or anywhere else. Recent hygiene audits have been welcome as they have at long last prioritised this area within our health system.

We must also make significant investments in terms of appropriate facilities and personnel. The practice of housing six com-

plete strangers in a room together, sharing a bathroom and shower, harks back to an era when patient privacy was not considered important and when patients were less complicated in terms of their susceptibility to developing infection.

Current recommendations emphasise the need for more single rooms and artificially ventilated facilities to prevent the likelihood of infections spreading by air. Indeed, future hospitals are likely to have at least a half or more of all beds in the form of single rooms with appropriate isolation facilities.

We need a hospital capital development programme to ensure this occurs. Moreover, many of our hospitals do not have the relevant expert personnel such as microbiologists, infection control nurses and others to support the change necessary.

While it will never be possible to prevent all infections, it is clear that we can do much better in Ireland and it is probable that we can reduce rates of infection significantly. New developments may not immediately result in fewer hospital infections in the short term, especially as our health system functions at or near full capacity.

But even the prevention of one infection should be seen as a success for the patient, who is discharged from hospital well, the healthcare worker who can take pride in the quality of the service delivered to the patient, and the health service generally.

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