



Mental Health in Europe, role and contribution of Primary Care

Position Paper 2006

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2006 European Forum for Primary Care.

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Preface

The European Forum for Primary Care was established in 2005, with the purpose of strengthening Primary Care in Europe. Primary Care is care that is community based, permanently available and easily accessible. Among the many activities of the Forum is the formulation of a series of Position Papers from 2006 onwards.

Aim of the Position Papers is to provide policymakers in WHO, EU and in the individual European states with evidence and arguments which allow them to support and develop Primary Care. In addition, the Position Papers aim to facilitate the exchange of experience and know how between practitioners in different countries and to identify issues for further research.

The Position Papers are the result of consultation and discussion among many relevant stakeholders in Europe, under leadership of one of the members of the Forum. The format and the process of development of the Position Papers gradually will be standardised, resulting in a series, demonstrating the added value of Primary Care.

Position Papers

2006

- Mental Health in Europe, the role and contribution of Primary Care.
- Encouraging the people of Europe to practice self care: the Primary Care perspective.
- The management of chronic care conditions in Europe with special reference to diabetes: the pivotal role of Primary Care.

2007

- Prevention and treatment of chronic heart failure in Primary Care
- Prevention and treatment of COPD/asthma in Primary Care
- Prevention treatment of chronic renal failure in Primary Care
- Prevention and treatment of depression, the role of Primary Care

Mental Health in Europe, role and contribution of Primary Care

Introduction

Mental Health has been selected as one of the first topics on the list of Position Papers because of its increasing importance in Primary Care.

The burden of Mental Health disorders and illness increases in all countries of Europe and leads to a wide range of national and international initiatives aimed at its reduction. A number of the networks in Europe that work on Mental Health put emphasis on Primary Care. During the development of this Position Paper, representatives of those networks have contributed to this Paper, see Box 1.

Box 1 Contributing organisations to this Position Paper.

- EMIP “Implementation of Mental Health Promotion and Prevention Policies and Strategies in EU Member States and Applicant Countries” that has been running until July 2006 with the overall objective to build and support good practice in the development and effective implementation of mental health promotion and prevention policy and strategy in the Member States of the European Union and in applicant countries. (<http://www.emip.org>)
- The “European Alliance Against Depression (EAAD)” is an international network of experts with the aim to promote the care of depressed patients by initiating community-based intervention programmes in 18 European countries. (<http://www.eaad.net>)
- The Wonca Working Party on Mental Health was established in October 2006 and serves as a focus for the development of mental health issues for Wonca worldwide. It has a strong European representation. (<http://www.globalfamilydoctor.com/aboutWonca/sig/sig.asp>).
- Mental Health Europe (MHE) is a non governmental organisation committed to the promotion of positive mental health, the prevention of mental distress, the improvement of care and the protection of human rights of (ex-)users of mental health services, patients of psychiatric hospitals, their families, and carers. (<http://www.mhe-sme.org>)
- In several countries, national networks operate, like in the UK the PRIMHE (Primary Care Mental Health & Education) network. (<http://www.primhe.org>).

In paragraph one a brief overview of issues and current policy approaches is presented and discussed. In paragraph two, the currently prevailing views on how Primary Care can deal with the increasing burden are presented. Paragraph three offers a number of practices that work in some countries – and may serve as inspiration for other countries or contexts. In paragraph four, a number of outstanding issues for research and policy development is listed.

1 The burden of Mental Health illness and disease.

One quarter of the world's population suffers from mental and behavioural disorders at least once during their life. This assessment is based on the use of the DSM-classification as the golden standard for diagnosis. The burden of neuropsychiatric conditions accounted for 13% of disability adjusted life years (a measure of ill-health and premature death) in 2002 and it is expected to increase to over 15% by the year 2020. Behaviour problems like excessive nicotine and alcohol consumption, gaming and drug addiction are included in what we consider as mental health problems. Poor mental health and mental disorders are present at all ages, for both genders and in different cultures and population groups. However, people with lower socio-economic status are much more likely to experience mental disorders than people with higher socio-economic status. This presents us with an important equity issue.

An unresolved question is to which degree indeed mental health illness and disease are on the increase, and in how far care providers are more sensitive and skilled in dealing with mental health issues, leading to better or earlier recognition. Either way however, the burden as we see it and feel it, increases. Obviously, there is a close link between mental illness and physical illness. Management and appropriate treatment for one disorder, improves the outcomes of other disorders. Also, there is a close link between mental illness and social wellbeing. The relationship between mental illness and unemployment and mental illness and homelessness is clear.

While the global burden of mental health disease slowly increases, there are two different tendencies with opposing results in terms of incidence and prevalence of disease.

Within Western Europe in particular, there is a tendency to consider unavoidable human suffering, like the loss of dear ones, as a disease episode and to diagnose this as mental illness because of the current system of counting symptoms. This is the medicalisation of stress and sadness. This is reinforced by pressures to prescribe medicines to people who go through a period of stress or mourning: these experiences are often labelled as "treatment required", undermining people's abilities to cope with normal stresses of life.

The opposing trend is that mental health problems often present through physical symptoms and are not recognized, neither by the person affected nor by the care provider whose assistance is asked. Also, mental health problems are often denied because of the stigma attached to mental illness, especially among the lower socio-economic groups. These trends deserve proper attention of researchers, policymakers and practitioners, but they should not divert our attention from the overall picture.

2 Responses to the increasing Mental Health needs.

Populations are best served by a combination of mental health prevention, promotion, care and cure. In practical terms mental health promotion aims to promote thoughts, feelings, behaviour and activities that strengthen well-being in individuals, as well as securing conditions at a community and structural level that are conducive to positive mental health. Prevention, generally, is more focussed on specific mental health problems. Care and cure both refer to the stage where mental health symptoms, illness or disease are present.

Indeed, a number of European states has invested heavily in Mental Health at the level of Primary Care, but others didn't as yet. Also, in all countries there are numerous remaining challenges to the provision of efficient and quality mental health care.

Mental Health is on the international agenda for a number of years already and Primary Care is being emphasised. The European Region of the WHO paid attention to Mental Health over the past years. In 2003, it supported the publication by the Health Evidence Network: "What are the arguments for community-based mental health care?" by Thornicroft and Tansella¹. The last highlight was the WHO European Ministerial Conference "Mental Health, Facing the Challenges, Building Solutions Helsinki, Finland, 12–15 January 2005". One of the recommendations was to "build up the capacity and ability of general practitioners and primary care services, networking with specialized medical and non-medical care, to offer effective access, identification and treatments to people with mental health problems". In 2006 and 2007, this is effectively worked upon. In collaboration with the Mental Health group of WONCA Europe, a guide for caregivers is being developed.

The EU issued a green paper on Mental Health during fall 2005. No particular reference to primary care or community care has been made, which should be interpreted as a lack of awareness of the contribution that Primary Care has to offer. However, the intention of the European Commission (EC) to make more financial resources available for mental health, for example via the 7th Framework Programme, and to assess how structural funds can be better used to improve long-term care facilities (including some parts of mental health care) and infrastructure in the field of mental health warrants support from the EFPC.

In addition, the EC is striving for a comprehensive approach to Mental Health, in line with the WHO Strategy. Such an approach should involve many actors, including health and non-health policy sectors and stakeholders. This results from the green paper analysis which

shows the (growing) impact of decisions of non-health policy on the mental health status of the population.

3 What services can Primary Care offer to people with Mental Health problems.

During the last two decades, two opposing views have been debated in Europe: those who favour providing mental health treatment and care in hospitals, and those who prefer providing it in community settings, primarily or even exclusively. At discussion sessions¹ held to develop this Position Paper, experts from a range of different European countries and different professional groups emphasised the deep influence of history and culture on service providers' understanding of mental health care and their willingness and ability to offer mental health care within primary care. The historical background of health care systems explains to quite some extent these differences. In the Netherlands for instance, mental health care has been set-up mainly by charity groups in past centuries which became not-for-profit non-governmental bodies in the last fifty years. This has led to decentralised and – to some extent - community based services. The opposite occurred in many Central and Eastern European countries where mental health care is provided mainly by governmental institutions as a continuation of the state-owned institutions during communist regimes in the twentieth century.

The third option is to utilize both community services and hospital care. In the latter model, the focus is on providing services in normal community settings close to the population served, while hospital stays are as brief as possible, promptly arranged, preferably located in general hospitals to reduce the risk of passive stigmatization and used only when necessary. This balanced interpretation of community-based services goes beyond the rhetoric about whether hospital care or community care is better, and instead encourages consideration of what blend of approaches is best suited to a particular area at a particular time. The various elements of balanced care need to be well integrated.

This debate gains importance because of the increase in the incidence, prevalence and burden of mental ill health which is reflected in an increase in demand for consultations and treatment. We advocate for a strong involvement of Primary Care in all countries: in prevention, diagnosis and treatment. This is the most accessible and effective way of addressing the needs of people. Also, deinstitutionalisation of mental health services and the establishment of services in primary care and involvement of family/friends, will contribute to social inclusion and to the (re)integration of patients in society.

While support from the international organisations mentioned in paragraph 2 is welcome, its practical result is, amongst others, that Thornicroft and Tansella² offer us a framework for the organisation of Mental Health Care. The organisation of Primary Care differs between countries but some of the organising principles are common across Europe. One of the key messages is that in all countries, from low to high resource countries, primary care is the appropriate level to provide most of the mental health services. The services to be provided in primary care are:

- screening and assessment;
- talking treatment, including counselling and advice;
- pharmacological treatment.

To the extent that they are available, specialists may back up staff at the primary level, to provide training and consultation on request of the primary care staff for complex cases. When available, specialists also can provide inpatient assessment and treatment, when requested.

When resources are available, additional services may be offered: outpatient or ambulatory clinics for complex cases; community mental health teams, acute patient care, long term community based residential care and occupational care or day care. These are called mainstream mental health care.

When further resources are available, specialised or differentiated mental health services may be added. Schematically, this can be presented as follows, see figure 1.

Figure 1 Mental health service components for low-, medium- and high-resource countries. Modified from Thornicroft and Tansella¹.

	Low- resource countries	Medium- resource countries	High- resource countries
<u>Primary mental health care with specialist backup</u> <i>Primary Care staff:</i> Screening and assessment, talking treatments, including counselling and advice, pharmacological treatment. <i>Liaison and training with mental health specialist staff, when available for:</i> <ul style="list-style-type: none"> • training and consultation in complex cases • inpatient assessment and treatment in cases which cannot be managed in primary care 	X	X	X
<u>Mainstream mental health care</u> * Outpatient/ambulatory clinics		X	X

* Community mental health teams (CMHTs) * Acute inpatient care * Occupational/day care			
<u>Specialized/ differentiated mental health services</u> * Specialized CMHTs, including early intervention teams and assertive community treatment (ACT) teams. * Alternatives to acute hospital admission, including: home treatment/crisis resolution teams, crisis/respice houses, acute day hospitals. * Alternative types of long-stay community residential care, including intensive 24-hour staffed residential facilities, less intensively staffed accommodation and independent accommodation. * Alternative forms of occupational and vocational rehabilitation like sheltered workshops, supervised work placements, cooperative work schemes, self-help and user groups; clubhouses/transitional employment programmes, vocational rehabilitation and individual placement and support services.			X

Primary Mental Health services are cost-effective: they are associated with improved health and quality of life outcomes, with costs often no higher than in institution-based services McDaid and Thornicroft, 2005³.

However, the paradox of the Central and Eastern European region is that most mental health services were – and still are – provided in institutions with few if any existing primary mental health services. In the low- or middle income countries of the region health system reform is overdue. Bulgaria and the Ukraine are two examples: they provide all the structures and services of a high income country as described in table 1 but lack the provision of primary mental health services. Long lasting and ongoing support for the development of community based mental health care is provided by several international agencies, one of them being the Global Initiative on Psychiatry (<http://www.gip-global.org/>).

The same message, taking another form comes from the WHO Regional Office for Europe. Dr Matt Muijen recommends the model as presented in Figure 2. It shows that Primary Care has a pivotal role to play in Mental Health in Europe and from that follows that the role of the GP and other gate-keeping professional staff is crucial.

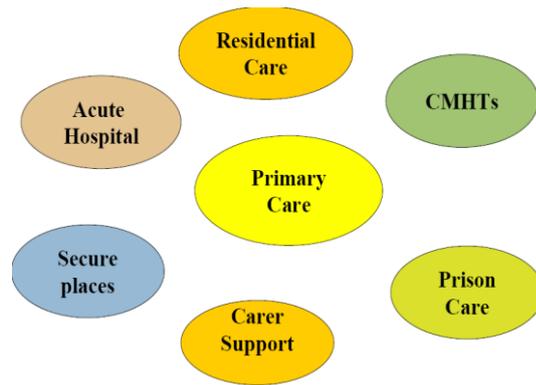


Figure 2: New Thinking and Models in European Countries

In some countries, the concept of Stepped Care has evolved, which is a model of mental health care provision that makes use of both primary and secondary care. Stepped Care involves treatment that is intensified based on patient non-response. The sequence in care delivery is that, as a start, the shortest and least cumbersome treatment is provided that can be expected to produce the desired effect. When this treatment does not give the wanted result, a more intensive treatment is provided, which may include a referral to more specialized services. Burnout, depression and alcohol use disorders are among the problems for which stepped care has been developed. Stepped care can be considered as a disease management programme, which offers continuity of care according to an algorithm.

General practitioners (GPs) and other Primary Care professionals also can play an important role in early recognition of mental illness, in particular of suicide. GPs and nurse practitioners are often the first to whom a patient with symptoms turns in the medical system, and they have relevant knowledge of their patients, which could help with the identification of risk factors. Indeed, they have a clear opportunity to offer effective interventions. This needs particular skills, which are not often trained in training programmes or CME in Europe.

Primary Care offers opportunities for surveillance and screening as well. Here, an important question remains unresolved as yet: whether screening programs at population level for depression or anxiety on the basis of early symptoms are appropriate. While benefits may seem obvious, these programmes may result in an increase of medicalisation of the population which, to a large extent, can cope with these first signs. Besides this, one has to be careful to introduce screening programmes in low-resource countries. It is important to

have the resources to offer services and achieve positive health outcomes for patients, once they have been identified⁴.

What conditions are required or supportive for the effective fulfilment of this role by Primary Care? What are unresolved questions, at the level of policy and practice?

- First and foremost, countries need appropriate legislation in order to allow for provision of Mental Health care at the primary level which is providing adequate treatment.
- We should acknowledge the extreme variability between states of Europe in spending on mental health services and the outcomes of good mental health services. This is a basis for more concerted action.
- All countries need a flexible financial system which follows the needs of patients and evidence based care options for services. This means: to define packages of services in long-term contracts of Primary Care providers with funding organisations (insurance funds or state funding) in order to be able to react in an active and flexible way to the needs of people with psychiatric and psychosomatic problems.
- The development of appropriate human resources as a separate clear objective, as in a number of countries there is little support for specific training of GP's and development and for increase in the number of non-GP staff, like psychiatric nurses. A difficulty in the development of performing Primary Mental Health Care is the fact that training and education of professionals working at primary level often has been not appropriate. They did neither receive sufficient training in skills and knowledge in this sub-domain nor in effective cooperation between the different professions. This is a problem all over Europe and sharing curricula and training systems between countries is necessary.
- Service users and carers have knowledge and skills to offer as an important contribution to planning and developing services. In order to give them a voice and an organisational platform, the WHO-Euro strategy therefore calls for support to organisations representing patients or clients and informal carers. In addition, carers and family members play an essential role in the provision of care but this often is not acknowledged and they may feel alone and unsupported. Therefore, programmes need to be developed to strengthen the caring and coping skills and competencies of families and carers and to offer respite care.

So far, our concern in this Paper has mainly been with care for people who are already affected. To tackle the problem of mental ill-health in European countries, a public health approach to action is crucial, encompassing and prioritizing promotion and prevention alongside care and rehabilitation. Primary Care offers also opportunities for work in these

areas. It does contribute to prevention by stimulating social cohesion within neighbourhoods and by and enhancing wellbeing of individuals.

The promotion of mental health includes the development of appropriate policy responses to medicalisation of human suffering, like support to self care and to non-drug care. Patient / consumer organisations may contribute to further reflexion on this subject.

4 Good practices, **learning lessons about mental health in primary care across Europe**

We need to find ways of converting research findings into excellent day to day practice. Health care is littered with examples of research and good and bad practice that could be helpful to others, but are never converted into day to day practice or disseminated - wasting both the research and the benefits that might be accrued by the patient. Therefore, we start with an overview of relevant examples throughout Europe.

While above we advocated for a balanced care model in mental health care, the transition from one system to another requires careful planning and implementation. As said, in most new democracies in Central and Eastern Europe the basis of mental health care is in large institutional care with specialized and differentiated mental health services. While developing more primary care oriented care, close collaboration with these large, specialized, institutions is imperative. A too drastic downsizing of the number of hospital beds will create problems at community level and within services dedicated for other clients. The latter has been the case in Italy and more recently in Holland and Australia⁵. Prisoner-clients within with mental health problems faced a lack of appropriate care. Well resourced inpatient and community forensic services both are required.

In Finland mental health services have moved from large hospitals to health centres in the search for integration versus fragmentation. It was a response to the dissatisfaction with the flow of patient information and to the low efficiency of large organisations. Funding incentives were installed. Experiences with this reform vary, but are encouraging. Most importantly, many psychiatrists adjusted to the new approach, accepting their new roles.

Access

Good access to health care for all citizens, especially the vulnerable and poor, is a basic condition for relevant health care.⁶ Problems of access are related to the structure and funding of healthcare services to and the extent to which hard-to-reach groups are enabled to use health care services. There are considerable differences in access to publicly funded healthcare services across Europe, and the ratio of care delivered in primary, secondary or tertiary care settings.⁷

While understanding and accepting these differences, the search is now for best practices that are relevant for many countries. There are several primary care surveillance networks in Europe that contribute to this. More comparative work will be possible if the networks use the same criteria for a minimum number of factors to allow comparable estimates of morbidity.⁸

- Time banking: Time Bank intends to create a network in which the constituent members can help and support each other in the local community. It is a community-currency scheme in which “neighbours help neighbours” exchange their time. For every hour a member spends helping someone he is entitled to an hour’s help in return - they earn a time credit. Time-credits are saved in each member’s account. When a member needs help himself he can withdraw his credits from the Time Bank spending this credit getting an hour’s help from somebody else. Members may otherwise save credits for times of need, or donate them to someone else. Experiences in the UK and Germany show that such mutual support networks not only thrive in a sustainable manner, but that they also contribute to the social inclusion of people that otherwise would be at risk of loneliness.
[\(http://www.londontimebank.org.uk/\)](http://www.londontimebank.org.uk/)
- Relationship Competence Training (RCT) is a conceptual framework for assessing a family’s ability to mobilize their relational support in times of distress. RCT provides an empathic way of dealing with the “compassion fatigue” that health care providers often experience when managing complex family health issues in constantly changing and quality-strained primary health care environments.⁹
- The Devon (UK) book prescription scheme. The self-help book prescription scheme runs in Devon from January, 2005 onwards and represents a collaboration between the Faculty of Health and Social Work, University of Plymouth, the library services across Devon (Plymouth, Devon and Torbay) and the Primary Care and Partnership Trusts across Devon. Operation of the scheme: the central component of the scheme is a self-help booklist with 36 titles covering many of the anxiety and depression

related mental health problems commonly encountered in primary care. All titles on the booklist are stocked within many of the main libraries across Devon. To access the books held within the library, the concept of a drug prescription which 'authorises' and activates borrowing was adopted. In the first instance Graduate Mental Health Workers who have been extensively trained to support the scheme issue book prescriptions to their clients. Over time the use of the scheme will be rolled out to include other health professionals. The client will present the book prescription at the local library, upon which the librarian 'dispenses' books in the same way that pharmacists dispense medication. Librarians have received appropriate training in the support of this scheme. A full range of supporting materials have been professionally designed and printed to support and publicise the scheme.

- The Mental Health dispensaries in Bulgaria use standard guidelines for the follow-up of patients regarding the response to medication. In case of a bad response the patient is referred to specialized services, mostly at secondary care level.
- Knapp et al in the UK ¹⁰ show that evidence based psychological therapies can lift at least half of those affected out of their depression or chronic fear. Most of those therapies are short, forward looking therapies which can be offered to patients at the Primary Care level.
- Computerised therapies for common mental health problems. The integration of computerised therapies like "Beating the Blues" into a stepped care, primary care mental health service has been described in a paper following 54 clients. It was found that the therapy significantly reduces depression¹¹. Other positive results of computerised therapies for common mental health problems are described in a paper of Cavanagh and Shapiro in the Journal of Clinical Psychology.¹²
- In some countries, initiatives are taken to create integrated care for people with dementia. These initiatives are not only focussing on the delivery of care and support but also on elements such as early detection of dementia, specific targeted information systems, self management, the support of the informal carer and social activities. Early detection in combination with suitable follow up will increase the wellbeing of people and therefore their quality of life.

Box 2, a dementia protocol, emerging from General Practice

In Simpelveld, the Netherlands, a dementia protocol was developed from 2001 onwards, as part of the National Dementia Programme. Care providers at Primary Care level cooperate with each other through a “dementia protocol”. This cooperation includes the family, taking into account the care provided by the family and the care that the family itself may need. By including them in the care system the family feels supported by the professional care providers. A “dementia-team”, formed by a General Practitioner and Social Nurse specialized in Geriatrics, gets into action on basis of information from the patient’s network. The main objectives are early recognition of dementia, and a quality approach by systematically reviewing the cases. The protocol comprises the following elements:

- * A first diagnosis by the GP, if needed assisted by the social nurse, on the basis of a home visit. Physical examination is part of the initial assessment.
- * Start of treatment, if required.
- * The dementia team meets at least 2 times per year to discuss all patients with dementia
- * Before this meeting a consultation of the family carer or informal carer by the GP has been done.
- * All findings (somatic, mental and social) and all referrals and their follow up are recorded.
- * The file managed at Primary Care level is the basis for all care providers and gives a clear picture on the developments over time.

- Throughout the Netherlands more than 100 Alzheimer Café’s have been created over the past years. These are monthly informal meetings for patients, partners, relatives, care providers and other interested persons. Starting with a presentation of an expert, those present can exchange ideas, information and experiences¹. Attendees feel supported and encouraged. (www.alzheimer-nederland.nl)



Box 3: Maintaining positive mental health

The following ‘positive steps’ for achieving and maintaining positive mental health have been described as the ‘five fruit and vegetables of mental health’:

- | | |
|--|-----------------------|
| * keeping physically active | * caring for others |
| * getting involved and making a contribution | * learning new skills |
| * doing something creative | * taking a break |
| * asking for help | * eating well |

* drinking in moderation

* valuing yourself and others

* keeping in touch with friends and loved ones

* talking about your feelings

National Institute for Mental Health in England.

Making it possible: improving mental health and well-being in England, 2005

- In the community health centre “Together better” in Den Bosch, the Netherlands, a joint initiative of professional care providers and local community members did result in the provision of care for women with psycho-social problems, named “The Stream”. They provide a “walk-in surgery hour” in which community members provide assistance to others based on their own experiences. The combined care by a professional and a “real life” expert adds value. Its objective is to provide care with a low threshold to those women in need in order to prevent admissions. The project with good results on secondary prevention of mental health problems received a WHO award for the best Community Based Health project. In spite of this success it remains very difficult to get this type of activities financed by authorities or insurance companies.
- The Wellbeing Project in Liverpool, United Kingdom, promotes positive mental health & wellbeing. It is a professional organisation undertaking health promotion activities and delivering training and education to communities. Volunteers are the backbone of the work. The project recruits young people, older people, working adults and individuals who have had personal experience in mental health distress.
(www.wellbeingproject.co.uk)



- Another project from Liverpool is the CALM activity. CALM stands for the Campaign Against Living Miserably, targeted at young men aged 15-35, one of the most difficult target groups, as suicide is the biggest killer of this age group. CALM looks at suicide by approaching it from a lifestyle arena, rather than a health arena, by embracing music, sports, entertainment and reaching young men in the places they are at and using a language they are comfortable with. CALM raises awareness of depression amongst young men and encourages them to seek help through social marketing approaches. (www.thecalmzone.net).

Quality of care

Key to quality is that one of the core roles of the generalist is acknowledged: to help patients make sense of often-paradoxical symptoms in the context of their whole life story. Listening and helping patients to reflect can often be more relevant than having 'correct' answers. How someone is able to function within a family and a community is more important than the diagnostic label. At its best, when the system is welcoming and the clinicians have the skills and make time, general practice is ideally placed to work with patients with mental illness; however, poor primary mental health care also has the potential to do harm.

- Working with standard Mental Health guidelines issued and agreed upon by General Practitioners and Psychiatrists results in logic and accepted chains of care. It is a pre-condition to an effective model of stepped care, as shown earlier.
- One step further is the patient-centred case consultation whereby a psychiatrist and a general practitioner together conduct a consultation, in a primary care setting. The psychiatrist does not take over the treatment, but advises the GP, after the consultation. This confirms the position of the GP as a cornerstone in community health care and, by lowering the threshold for psychiatric treatment, enhances possibilities for the psychiatric treatment of somatising patients.¹³ This approach has achieved positive results in the Netherlands. The number of somatoform symptoms diminishes and the main somatoform symptom improves after the psychiatric consultation. Psychological well-being, especially social interaction, anxiety and depressive symptoms improve. General functioning improves, especially in persistent somatoform pain disorder. The total utilisation of health care services as well as utilisation of general practice health services drops or rises only slightly, whereas it rises substantially in the care as usual group. For the GPs who want to get deeper involved in mental health problems, this is a useful intervention that enhances their effectiveness. In case of serious somatoform disorder, it seems to be worth the time investment and clearly pays back for the GP. This form of treatment of somatoform disorder deserves to be implemented as it drastically improves patient well-being and alleviates the burden that these patients form for the medical care system.

Multi-disciplinary teams within Community Mental Health care can play a key role in helping to prevent and limit mental illness in children and adolescents. Health visitors, general

practitioners and other members of the team are in a prime position to observe the dynamics in vulnerable households and offer interventions when coping thresholds are reached.

- How to create multidisciplinary teams? By training together. In the Netherlands, in the framework of the Diabolo-project 2002/2003, good results were achieved by a training module “Multidisciplinary cooperation for health professionals in the Primary Mental Health Care”. The training was developed by a collaborative initiative of several teaching institutes for GP’s, health psychologists, social psychiatric nurses and social workers. Previously, in most of the teaching institutes the attention for multidisciplinary work was too limited. A continuation of this successful integrated training programme proved to be impossible because of budgetary limitations.
- A study of Dr Biago Valente et al¹⁴ on a model for collaboration and participation between GP and psychiatry presented at the 2006 WONCA conference in Florence concludes the following: The GP can carry out a primary role in the early diagnosis and in the integrated management of the patients with psychiatric disorders. The results obtained in this experience could find more effective application on wider populations by campaigns of information and focused projects of training of the GP in the management of the psychiatric disorders.
- Stanojevic presented another study at the WONCA 2006 conference. The Community Mental Health Reform as part of Primary Health Care in Bosnia Herzegovina¹⁵ showed the same positive results by multidisciplinary teams for prevention and treatment of psychosis, addictions, mental problems of children and adolescents, affective and anxious disorders. The reform was inspired by similar models in Trieste, Italy, and is ongoing. It requires a lot of enthusiasm, voluntary work and knowledge and, in comparison with the Trieste (Italy) model which was taken as example, they have been able to come half-way. A pre-condition is sustainable funding.
- Multi-disciplinary care (social workers, psychologists, medical doctors, nurses) was developed at 4 pilot sites in Sverdlovsk (RF) in a community setting for children with mental health or behavioural problems. It led to great increase in multidisciplinary working, improved diagnosis and reduction of (a) severe diagnoses, (b) in-patient admissions and (c) prescription of high levels of drugs. This has been a project of the Early Intervention Institute from St. Petersburg in close collaboration with partners from Sverdlovsk. <http://www.eii.ru>

- Cost-effectiveness of treatment of depression in primary care. In June 2006, Judith Bosmans defended her PhD thesis “Cost-effectiveness of treatment of depression in primary care” at the Amsterdam Free University Medical Center. Bosmans compared four treatments for depression in primary care.
 1. A pharmacy-based intervention to increase adherence to antidepressants
 2. A disease management program, that consisted of screening, diagnosis and treatment major depression in elderly patients.
 3. Interpersonal psychotherapy delivered by mental health workers in primary care practices for depressed patients aged 55 years and older.
 4. Standardised usual care by General Practitioners with and without antidepressants.

There were no significant differences in costs or effects between the groups receiving the study interventions and the groups receiving usual general practitioner care.

Therefore, the overall conclusion of the thesis is to continue usual general practitioner care for depression in primary care. However, many patients had not recovered at the end of the follow-up indicating that there still is room for improvement in the usual general practitioner care for depressed patients. Future research should provide evidence on how to improve care for depressed primary care patients.

- In the United Kingdom, Primary Care counselling by Counsellors & Psychotherapists in Primary Care (CPC) was developed. Primary care counselling is a distinct and specialist discipline requiring core training and specialist knowledge. Primary care counsellors have undertaken extensive psychological therapy training over several years and are able to offer treatment to NHS patients presenting with a diverse range of symptoms and difficulties. Patients aged over 16 years can benefit from such psychological treatment interventions when presenting with mild to moderate symptoms of mental illness and in some cases multiple and complex difficulties. Primary care counselling is generally time limited – patients are seen for an average of six 50-minute sessions, which may be weekly, fortnightly or spread over a longer time period.

Working closely with GP’s and the wider multi-disciplinary team, the primary care counsellor is trained to assess the patient’s need and suitability for therapeutic treatment (including risk factors) and to work with the patient over an appropriate length of time. The primary care counsellor’s specialist skill allows for a therapeutic treatment alliance with an extremely wide range of patients and to use an appropriate and relevant intervention as required. <http://www.cpc-online.co.uk>.

- While numerous studies have shown that the incidence and prevalence of psychiatric disorders among primary care patients is substantial, the recognition and treatment rate of the most common of these disorders, i.e. depression, anxiety, dementia and alcohol abuse, is not always satisfactory. Two strategies have been proposed in Vienna, Austria, to increase the rather low recognition rate of common mental disorders in primary care: the use of screening instruments and extensive psychiatric training for general practitioners. The training programme consisted of two 3-hour sessions four weeks apart. An educational instrument, a short interview named TRIPS (Training for Interactive Psychiatric Screening), which is an adapted form of PRIME-MD, was used to train single-handed general practitioners in Vienna. Of the 31 participating general practitioners 26 attended all three sessions. There was a significant increase in the mean number of correctly answered questions between baseline and session two, and a further increase between the second and the follow-up session. General practitioners rated TRIPS as a practical and useful tool for family practice and stated that its use met with patients' approval.

Box 4 Recovery: a multidisciplinary and community based approach.

The National Institute for Mental Health in England issued a Guiding Statement on Recovery in January 2005. The aim is the development of recovery-oriented services that can be used by people as tools to support their recovery. Recovery has a number of different meanings within the mental health and substance misuse communities. It includes the following meanings:

- * A return to a state of wellness (e.g., following an episode of depression);
- * Achievement of a personally acceptable quality of life (e.g.: following an episode of psychosis);
- * A process or period of recovering (e.g., following trauma);
- * A process of gaining or restoring something (e.g., one's sobriety);
- * An act of obtaining usable resources from apparently unusable sources (e.g., in prolonged psychosis where the experience itself has intrinsic personal value);

To help people to recover optimum quality of life and have satisfaction with life in disconnected circumstances (e.g., dementia) a recovery-oriented system of mental health care will be an integrated network of culturally capable services and supports that first promote recovery. These services and supports will include:

- * The full range of hospital and community-based services, including those in secure settings and prisons;
- * Self-help and peer-run services, that the NHS and Local Authorities fund, facilitate, or foster;
- * Their family, partner, and friends;
- * Faith communities and Individuals and groups in local communities.

A recovery-oriented system of care will:

- * Focus on people rather than services;
- * Monitor outcomes rather than performance;
- * Emphasise strengths rather than deficits or dysfunction;
- * Educate people who provide services, schools, employers, the media and the public to combat stigma;
- * Foster collaboration between those who need support and those who support them as an alternative to coercion.
- * Through enabling and supporting self-management, promote autonomy and, as a result, decrease the need for people to rely on formal service and professional supports

Sustainability of care

Good Mental Health Care requires sustainable financing models which are adjusted to the needs at Primary level. However, the contrary is often true: the payment systems used within the different European countries are currently the main guiding principle that define the treatment / care pathways of clients with Mental Health problems. This is counterproductive and not cost-efficient. It often leads to unclarity why certain forms of care and treatment are reimbursed and why others not.

Many examples of discontinuation of care provision or development quality caused by a disruption of available finances can be given throughout Europe.

- In the paragraph on quality of care the lack of further funding for multidisciplinary training in the Netherlands was mentioned. Another example comes from Denmark: General Practitioners are reimbursed for the provision of 7 mental therapeutic consultations per patient per year. The training/supervision for GP's to perform this task adequately is to be arranged and paid by themselves. In Copenhagen there has been an experiment with the supervision being paid by the municipality (in that period 60% of the GP's joined the supervision groups) but has been downscaled because of reduction of the finances received from the municipality.
- In Bulgaria, some expensive psycho pharmaceutical drugs are reimbursed, which is at one hand positive for patients to have access to those drugs. On the other hand, this exhausts the resources and consequently possibilities for stepped care models. In several European countries the criteria for reimbursement are intransparent.
- In France, psycho pharmaceutical drugs consumption is highest in Europe as a result of 1) strong lobby of the pharmaceutical industry, 2) medicalisation by the GP and 3) more and stronger demands for drug prescription by the patients. This is facilitated by

the financial system that easily reimburses the prescription of psycho pharmaceutical drugs but hardly psychological treatment provided by psychologists.

Informal and formal direct payments affect accessibility and equity of care. From the recent WHO Europe publication: Levelling up (part 2): a discussion paper on European strategies for tackling social inequities in health¹⁶: “In countries where formal and informal private payments constitute a large and often increasing share of total health care costs, the only viable option to reduce inequities in care is a gradual shift towards public prepayment schemes”.

This was also the conclusion enshrined in resolution WHA 58/33 adopted in 2005 by the World Health Assembly. High user fees should be gradually replaced by public funds via taxes or public health insurance schemes, or both. The transition needs to take into account:

1. increased public funding for improving the capacity and quality of the existing public health care system – in particular, for treating poverty-related diseases;
2. tax-financed health insurance cards provided free or at a marginal cost to poor people or families and children;
3. development of employer-based health insurance schemes that include family members;
4. exploration of the potential to link existing public health insurance schemes, to facilitate cross subsidies between different schemes; and
5. development of compulsory subsidized health insurance schemes that, together with other already established health insurance schemes, can achieve universal coverage.

5 **Unresolved matters**

Further debate is needed on some outstanding questions concerning primary care and mental health.

- What should be the approach towards difficult-to-reach marginalised people and others with mental health problems who do not show a clear demand for care?
- What approaches are effective in reducing the stigma and social isolation that is currently associated with mental illness?.
- If medicalization of clients within Mental Health Care should be avoided, what other approaches within Primary Care do we have towards these clients which will have a supportive effect on their well-being
- What is the “help seeking behaviour” of Europe’s populations and what are the differences within Europe? How can we avoid medicalisation, without, simultaneously, overlooking needs that require our services? Can we influence the pathways in this “help seeking behaviour”.
- More strategies to improve detection and diagnosis of mental health problems in primary care are necessary. The gatekeeper function of Primary Care should be better defined and put in practice with important issues like screening and identification for further care or treatment. Which professions should be involved in gate keeping?
- Further evidence is required to support the claim that early detection leads to a decline of chronic psychiatric problems.
- How to safeguard confidentiality in the use of patient files between Primary Care and Secondary Care.
- What are organisational principles for funding of Primary Mental Health, that are applicable to the many different health systems that Europe has?
- Human resources: how should capacity building within Europe be guided, knowing the open borders within the European Union for professionals, including the professionals involved in Mental Health care at Primary level?
- Measuring the equality of distribution of psychiatric services is an exercise in descriptive economics. It is thus just one aspect of examining distributional issues. R. F. G. Williams and D. P. Doessel¹⁷ used some simple data to illustrate the measurement of distributions of psychiatric services. Some of these distributions were determined to be relatively more equal. Equal distribution of psychiatric services is not necessarily equitable, nor is relatively unequal distribution in all cases inequitable.

Mental health status, age, gender, location, income and other parameters all contribute to the equation that defines how mental health services should be distributed in order to provide for equity.

- The potential for e-consult and other internet services for prevention or treatment of Mental Health problems is largely unexplored. This needs urgent attention, since there may be benefits for so many people in Europe.

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