Primary Care Mental Health in Greece

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1. Towards the mental health care reform in Greece
2. PHC in Greece: the current setting
3. How PHC mental health works
4. Current efforts: a focus on guidelines development
5. Summary points
1. TOWARDS A MENTAL HEALTH CARE REFORM IN GREECE

- The Greek mental health reform, the “Psychargos” program
- A national strategic and operational plan to develop a community-based mental health service system
- It was jointly funded (75% by the EU) and it ended in December 2009
- Several and noteworthy achievements but also constraints and barriers
- Sustainability a key today issue

Loukidou et al, Psychiatriki 2013
2. WHERE WE NOW?
THE CURRENT GREEK PRIMARY CARE SETTING

- Lack of integration
- Lack of coordination and continuity of care
- More focus on medical care, less on health promotion
- Lack of multidisciplinary collaboration
- Quality affected by economic crisis

Lionis et al, IJIC 2009;
Kringos et al, BJGP 2013;
Markaki et al, Int Nurs Rev 2006;
Brotons et al, Prev Med 2005
Lionis and Petelos, Qual Prim Care 2013
Tsiligianni et al, RRH 2013
3. HOW PHC MENTAL HEALTH WORKS

- Primary care mental health services: lack of integration with the community mental health issues.
- Clinical performance: Certain unrecognised mental health conditions, limited use of diagnostic tools, more in prescribing and less in health promotion.
- Research in general practice mental health: it is limited but it is speedily improving.
- Emerging issue: a rapid increase of depression and multimorbidity.
- Key actions recently undertaken: intensive courses by the Greek Association of General Practice, the guidelines project and the development of screening tests.
4. CURRENT EFFORTS: A FOCUS ON GUIDELINES DEVELOPMENT

"Development of 13 General Practice Guidelines for the management of the most common diseases and conditions in primary health care", MIS: 464637
METHODOLOGICAL FRAMEWORK

- Modified algorithm introduced by Kaiser Permanente (2012)

- ADAPTE methodological framework (http://www.adapte.org)

A Guideline Manual regarding the methodological procedures was written by the project’s research team. Within details about the process and the evidence based tools used can be found.
MODIFIED ALGORITHM INTRODUCED BY KAISER PERMANENTE (2012) THAT WAS USED IN THE PROJECT
METHODOLOGY - FIRST STAGE

First step-defining questions and searching the guidelines resources:

- Identification and definition of each disease
- Formulation of the clinical questions. Search algorithms (MESH terms, Boolean approach, search filters)
- Identification of guideline resources and high quality electronic databases for literature research (i.e. Pubmed, Cochrane)

Second step–searching and assessing the literature

- Guidelines review and assessment → AGREE tool (http://www.agreecollaboration.org)
- Quality of the literature:
  - Meta-analysis and Systematic Reviews → AMSTAR tool (http://www.biomedcentral.com/content/pdf/1471-2288-7-10.pdf)
  - RCTs → Tool from the Centre of Evidence Based Medicine (http://www.cebm.net/index.aspx?o =1157)
METHODOLOGY-SECOND STAGE

- Formulation of the recommendations based on the selected bibliography

- Appraisal of the level of evidence of each recommendation (methodological framework of the Australian National Health and Medical Research Council (http://www.nhmrc.gov.au))
First round
- The members of the consensus panels evaluated the recommendations.
- The review groups took after consideration the level of agreement of the panelists along with the comments made and re-formulated the statements.
- Consensus meeting of the expert panel.

Second round
- Re-ranking of the refined statements.
- Grading the level of recommendation of each statement - Evidence Statement Form of NHMRC (http://www.nhmrc.gov.au)
SELECTED GUIDELINES-GAD

- “It is recommended for general practitioners and other Primary Health Care doctors to consider the diagnosis of Generalized Anxiety Disorder for people who visit PHC frequently and need reassurance about chronic physical health problems and present symptoms of ongoing anxiety and are repeatedly worrying about a wide range of different issues”.

- “It is recommended for general practitioners and other Health Care Professionals in PHC to consider before screening, the use of specific questions:
  - Do you worry excessively about everyday things such as your family, your health, work or finances? Does your family or your loved ones tell you that you worry too much? “
  - “Do you have difficulty in controlling your worry and does this interferes with your work, your activities, your relationships or your physical health?”

- “If you suspect GAD it is recommended for general practitioners and other PHC doctors the use of GAD-2 (Generalized Anxiety Disorder-2) or GAD-7 (Generalized Anxiety Disorder-7) diagnostic questionnaires”.

- “In case of non-response to drug treatment it is recommended to general practitioners and other PHC doctors the use of pregabaline or venlafaxin or azapirones or tricyclic antidepressants”.

- “It is recommended to general practitioners and other PHC professionals to pay specific attention for special population groups (immigrants, Roma, elderly people, inhabitants in remote areas) to facilitate their access to health services, taking into consideration their cultural differences and educational level”.

Specific thanks to Prof. Gabriel Ivbijaro, Dr. Juan Mendive and Dr. Wolfang Spiegel for their substantial contribution to the development of this guidance
Consider the diagnosis of GAD for people who present symptoms of anxiety or/and excessive worry, as well as for individuals who visit primary healthcare frequently for chronic physical health problems and/or need reassurance about them.

1. Diagnostic Tools: GAD-2, GAD-7, Specific Questions
2. Diagnosis of GAD
3. Therapeutic Choices

1.1 Therapeutic Choice: Psychological Treatment
   - CBT
     - 11-15 weekly sessions, each lasting 1 hour
   - AR
     - Applied Relaxation
   - OTHERS
     - Guided self-help
     - Non-CBT (e.g., yoga, mindfulness)
     - Educational group

1.1.1 Response to Treatment
   - Response
   - No Response

2.1 Therapeutic Choice
   - Pharmacological Treatment
   - Combination of Psychological and Pharmacological Treatment

2.1.1 SHORT-TERM (0-6 months)
   - 1ST LINE
     - SSRIs / SNRIs (6-12 weeks)
     - SIP (no longer than 4 weeks while waiting for response to antidepressants)
   - 2ND LINE
     - Prazosin
     - Venlafaxine
     - Antidepressants

2.1.2 LONG-TERM (12-24 months)
   - 1ST LINE
     - SSRIs / SNRIs
     - Prazosin
     - Venlafaxine
     - Antidepressants

2.1.3 Response to Treatment
   - Response
   - No Response

3. Treatment Continuation/Follow-Up in PHC
SELECTED GUIDELINES-DEPRESSION

- “It is recommended to General Practitioners and other Primary Health Care physicians, the use of two brief screening questions for the recognition-identification of depressive symptoms to high risk subjects (personal or family history of mental disorder, chronic health problem, recent loss, substance abuse, minorities, impoverished subjects, etc).”

- «It is recommended to General Practitioners, other Doctors as well as other Primary Health Care professionals to provide, if they are appropriate trained, psychological therapies (behavioral activation, cognitive behavioral therapy, interpersonal therapy, problem solving therapy) before or simultaneously with initiation of pharmacological treatment or to refer to a specialist or mental health services in other case”.

- “In patients with moderate or severe depression, General Practitioners and other Doctors in Primary Health Care are recommended to use antidepressant medication in combination with psychological therapy, since it is available”.

- “It is recommended to General Practitioners and to other Doctors in Primary Health Care to encourage patients on antidepressant medication who respond to treatment to continue to take the antidepressant for at least 6-12 months after full remission of an episode of depression in order to reduce the risk of relapse”.

Specific thanks to Prof. Gabriel Ivbijaro and Dr. Lucy Kolkiewicz for their substantial contribution to the development of this guidance.
A PRACTICAL ALGORITHM FOR DEPRESSION

Management of Depression in PHC

- **Psychological therapies:**
  - Behavioural activation
  - CBT
  - Interpersonal therapy
  - PST

**Mild depression**
- Provide psychological therapy (e.g., CBT) and if not appropriate, trial an antidepr.

**Moderate-severe depression**
- Use of Second generation antidepressants (e.g., SSRIs)

Initial follow up of therapy

- Adults not at increased risk of suicide:
  - First assessment: within 1-2 weeks
  - Response: 
    - Partial response: increase dose afterwards
    - No response: after 4-6 weeks

- Adults at increased risk of suicide:
  - Refer to multidisciplinary PHC team to assess risk of suicide

Classification of Depression
- Comprehensive clinical assessment (completeness, degree of functional impairment, duration of episode)
- Use of DSM-V (mild/CD-I)

Referral to secondary health services
- Failure of management: recurrent depression not responding to prior therapy or comorbidities affecting the antidepressant medication
- Antidepressant resistant to initial therapy: diagnostic uncertainty
- Direct referral: severe suicidal ideation, psychotic symptoms, serious risk of harm to themselves or others, with severe and persistent self-neglect and depressive symptoms to treatment

Dealing with other mental or physical disorders
- Psychotherapy: therapeutic management
5. SUMMARY POINTS

- There are strengths and weaknesses in primary care mental health in Greece.
- The recession has a serious impact on population morbidity and mental health care services.
- There is threat on previous achievements of the Greek mental health care reform.
- The lack of integrated primary care and the overuse of prescribing raises many worries.
- The development of practice-based guidelines is a positive issue but it needs to be implemented and evaluated.
Thank you for your attention!!