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Models of collaboration between general practice and mental health services in Italy

Domenico Berardi*
Biancamaria Bortolotti**
Marco Menchetti**
Annarosa Bombi**
Ilaria Tarricone**

* Professor of Psychiatry, Institute of Psychiatry, Bologna University

** Institute of Psychiatry, Bologna University

ITALY

ABSTRACT – *Background and objectives:* Anxiety and Depressive disorders represent an important public health problem, which involves not only the mental health services, but the General Practice as well. This paper examines models of Collaboration between General Practice and Community Mental Health Services developed in Italy.

Methods: Different Consultation –Liaison activities are presented. For every Collaboration model advantages and disadvantage are discussed.

Results: The structured Consultation Liaison Service is based on supplying diagnostic consultation and therapeutic interventions in support of General Practitioners (GPs). The service could be based in either a Community Mental Health Centre (CMHC) or externally. Diagnostic evaluation can be followed by brief and focal therapeutic interventions, in support of the GP's therapeutic plan. The spontaneous collaboration in small centres are frequent in rural areas where the contained dimensions of the services and the direct acquaintance between psychiatrists and GPs encourage the personalization of the collaboration. The model of Liaison and Group-Training focuses on direct contact between consultant and GPs. In the course of regular meetings, the consultant gives the GPs supervision and education, and they can discuss the therapeutic plans for patients requiring specialist intervention.

Conclusion: The empiric classification presented should be considered an attempt to represent a complex reality. Every service, in fact, carries out activities that are necessarily wider than abstract typologies and that overlap with other models' activities.

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Introduction

Anxiety and depressive disorders, globally defined as common psychiatric disorders, frequently occur in the general population[1] and are associated with high degrees of subjective distress and disability[2-4]. A recent multi-center survey including people from 14 countries in the Americas, Europe, the Middle East, Africa and Asia found that anxiety disorders are the most common mental disorders in almost all countries with prevalence in the range 2.4% to 18.2%. Depressive disorders are the next most common with prevalence in the range 0.8% to 9.6%[1]. Considering the number of days out of role (days in the past 12 months in which patients were totally unable to carry out their normal daily activities), people suffering from the more serious forms of common psychiatric disorders reported at least 30 days in the past year. In 1990 unipolar major depression was the fourth cause of disability-adjusted life years (DALYs), an index represented by the sum of life years lost due to premature mortality and years lived with disability adjusted for severity[5]; a projection for 2020 indicates that depression will be the second cause of DALYs after ischemic heart disease[6]. An in-depth analysis of disability with Medical Outcome Study Short Form-36 found that patients with depression present the widest pattern of impairment as they are limited in their family and social relationships, have low vitality, have a negative perception of emotional well-being, and tend to complain of bodily pain, to have a negative perception of general health and to be limited in carrying out daily activities. Patients with anxiety disorder show similar limitations in the mental domain and a relatively less severe impairment in the physical domain[7].

As a result, these disorders represent an important public health problem, which involves not only the Mental Health Services, but the General Practice as well. In fact, many patients with anxiety and depression are seen and managed in General Practice, even in those countries where mental health services are available and efficient[8]. In fact, the WHO Collaborative Study on Psychological Problems in General Health Care (PPGHC) reported that 12.5% of subjects attending their general practice clinic are affected by a depressive disorder and that 10.5% are affected by anxiety disorder[8]. Similar prevalence values were found in Italian General Practice Clinics[9].

The crucial role of General Practice in the management of these disorders has been recognized in most Western countries and collaborative projects between General Practitioners (GPs) and psychiatrists have been developed, especially in the United Kingdom and in North America[10-13]. In these countries, GPs have a key role in the management of mental illness; as gatekeepers to secondary care, they play a central role in the pathways to care for people with psychiatric disorders.

The Italian context

In Italy, in contrast, the role of general practice in the management of common psychiatric disorders is not long established. Although guaranteed to each citizen, in Italy general practice is not organized in a formal primary health care service. GPs are not employees of the National Health Service, but work for it on the basis of a nationwide contract and are funded with a fixed allowance per patient. Moreover, Italian GPs usually work individually instead of in Group Practices. Residents are free to choose the GP, but each GP can have no more than 1500 subjects on his or her list.

Mental health care is provided by Community Mental Health Centers (CMHCs) with multi-professional teams (psychiatrists, psychologists, nurses, social workers and occupational therapists), which mainly take care of people with severe and enduring mental health problems. In Italy CMHCs, differently from other specialist services, are a primary level structure freely accessible for the citizens without General Practice filter. GPs refer only one third of the patients who ask for a visit to a centre, while another one third is referred by other physicians or social services; the last third seldom has any previous contact with health care providers[14].

The state of cooperation between General Practice and Mental Health is an unresolved issue. At the end of the 1990's some innovative single-sited spontaneous experiences of cooperation and integration between General Practice and psychiatry have been implemented in some cities[15,16]. However, in 1999 that the Italian National Health Care System recommended that the CMHCs develop General Practice Consultation-liaison services[17].

The lack of national health policies on the management of common psychiatric disorders in General Practice, along with the lack of a General Practice filter to CMHCs implies, in our experience, poorly coordinated pathways to care. In fact, these patients can be visited by either GPs or psychiatrists, regardless of the severity and prognosis of their disease.

Collaboration in the Emilia-Romagna Region

In Italy, the Emilia-Romagna regional Health Service has been the first to encourage the implementation of psychiatric consultation services dedicated to General Practice. Initially, the regional Health Service commissioned CMHCs to set up consultation services and to implement collaborative projects with General Practice[18]. Subsequently, a specific program was promoted named after Giuseppe Leggieri, a GP very committed to improving psychiatric activities in primary care who died before his time. The Giuseppe Leggieri regional program mandated that each of the ten regional Health Trusts set up a network of CMHCs Professionals, GPs and Public Health Physicians. The network has to be developed in each of the health trust districts and has to promote and follow-up collaboration projects.

Considering the differences which characterize the Health Trusts of the Emilia Romagna, the regional health service followed a bottom-up approach to define the model of collaboration between General Practice and Mental Health Services. Thus, the Region conducted a survey on the existing experiences of collaboration. The examination of the Consultation Services implemented in the region shows three main models.

1) Structured Consultation-Liaison Service. A specific and specialized Primary Care Liaison Service is set up within the local CMHC, with dedicated personnel. This service acts as interface with General Practice, provides support to psychiatric activities of GPs, and is aimed at managing non complicated common psychiatric disorders in cooperation with them. This model mostly set up in the bigger towns such as Reggio Emilia[19] and Bologna[9,15].

This structured Consultation Service in Bologna showed several strong points: for example, a clear differentiation in respect to general psychiatric activities of the CMHCs, the definition of pathways to care for non complicated common psychiatric disorders

different from more severe psychiatric disorders, and a wide support to GP not limited to assessment but including clinical management. The weak points arethe cost of the service, and the risk of bureaucracy due to the complexity of the model.

2) The model of Group Liaison. This focuses on direct contact between psychiatric consultant and GPs. In the course of regular meetings, the consultant gives the GPs supervision and education, and they can discuss the therapeutic plans for patients requiring specialist intervention. The meetings usually take place in a group setting. In some situations, for example, the Mental Health Service includes a "reference psychiatrist" delegated to cooperate with GPs in his own area. In this model, the strong interaction between GP and psychiatrist, often helped by a professional nurse, leads to genuine, continuous cultural change.

This has many advantages: mutual operational and training value, the sharing of problems in a team, the possibility of greater attention to doctor-patient relationships, and the opportunity to extend teamwork benefits to more patients. However, this model is not common: probably related to the difficulty of involving psychiatrists and GPs in a system requiring much harder work in terms of care and time.

3) Spontaneous collaboration in small centers. The main characteristic of this model is the flexibility of the programs and interventions. This way of working exists mainly in rural areas, where the contained dimensions of the CMHC and the direct acquaintance between psychiatrists and GPs encourage the personalization of the collaboration. The consultant can provide both diagnostic consultation and therapeutic interventions for GPs' patients in his own area, depending on the specific needs. In this model, consultation-liaison activities are not formally differentiated from the general activities of the Mental Health Service, but are carried out as they are needed in a flexible way.

The strong point of this model is the development of knowledge, mutual trust and synergy. The weaknesses of this model are related to the personalization of the service, with the suspension or delay of consultation activities when the psychiatrist is not at work.

The Bologna Primary Care Liaison Services

The Primary Care Consultation Liaison Service (PCLS) set up in Bologna is a specialized component of the local CMHC, with the aim of formulating an ongoing collaboration with the General Practice physicians. Since 2002 the Service provides support to GPs of the area around Bologna (about 400,000 inhabitants and 300 GPs). PCLS consists of multidisciplinary staff: consultant psychiatrists, resident psychiatrists, psychologists and nurses, all of whom have received specific training in this type of joint work and spend, on average, five hours weekly to provide this service. To facilitate contact and communication with primary care physicians, direct telephone lines have been activated. Additionally, city-wide coordination of activities is entrusted to a consulting committee comprised of representatives from CMHC and General Practice.

To assist primary care physicians with the management of patients with anxiety and depression, PCLS provide continual and multifaceted clinical support consisting of diagnostic assessment and focused therapeutic interventions. Diagnostic assessment is

based on WHO Diagnostic and Management Guidelines for Mental Disorders in Primary Care[20], and includes the establishment of a psychiatric diagnosis, identification of symptoms or problems as reported by the patient, significant life events, and the possible description of dysfunctional coping behaviors. Assessment is followed by a proposal for treatment which includes pharmacological intervention, counseling, and proposals for further treatment if needed. Information is then forwarded to the General Practice physician in a typed report designed to be thorough, but concise. Written communication is often accompanied by telephone communication or interpersonal contact in order to increase understanding and cooperation between psychiatrists and GPs. In more severe clinical presentations, upon agreement with the GP, the psychiatrist will supplement his assessment with pharmacological intervention and/or counselling. This assumption of patient care by the psychiatrist is temporary, and after patient response has been evaluated, responsibility of care is resumed by the GP. Occasionally, there are patients deemed too serious to be treated within this system, and the care of these patients is then assumed by the CMHC.

Concurrently with this experience, thanks to the growing tendency to create Group Practices of GPs in the Emilia-Romagna Region, a consultation activity has been also developed in the General Practice setting[21]. Under the supervision of a senior psychiatrist, a psychiatry resident is assigned to the Group Practice to visit patients referred by GPs, twice a month. Compared with standard Consultation activities within PCHC premises, patients seen in Group Practices are younger and have a more recent onset of symptomathology. Liaison in the General Practice setting seems to allow for a more prevention oriented work but is more resources consuming.

Discussion

The Emilia-Romagna general practice consultation liaison network stemmed from spontaneous initiatives undertook by psychiatrists and GPs which were subsequently recognized and supported by the Regional Health Government. We believe that such a flexible approach allowed for an homogeneous development of the net across the whole region.

The difference between services could depend on various factors, including geographical characteristics and resources dedicated to the activity. It stands to reason that the structured Consultation Service prevails in big towns, while the Liaison and Training Group Model is more prevalent in smaller centres. Our experience suggests that in bigger towns it is more difficult to promote regular meetings with GP groups, therefore preferring services based on clinical support. The spontaneous collaboration in the small centre model could represent an initial step towards more structured models or the only feasible intervention in very small CMHCs.

All models of collaboration presented were located outside General Practice, because in Italy GPs work mostly in solo practice instead of in Group Practices. Recently, General Practice organization is changing due to the growing tendency to create Group Practices of GPs. Consultation Liaison Psychiatry in Group Practice is a new experience in Italy, which requires evaluation. First data seem to suggest that opening a consultation outpatient clinic directly in the context of General Practice meets different care needs, and in particular makes it simpler for the GP to refer young patients, patients with brief psychiatric histories and patients with functional somatic symptoms, who typically do not like to be sent to the psychiatric services.

In conclusion, evaluation of experiences conducted in Italy induce us to think that the collaboration between General Practice services and Mental Health services have allowed to actuate a more complete and effective answer to needs of people with mental disorders in the community.

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Address for correspondence:
Domenico Berardi
Institute of Psychiatry
Bologna University
Viale C. Pepoli 5
40123 Bologna
Phone: +39051 521552, Fax: +39051 521030
E-mail: domenico.berardi@unibo.it