CRITICAL ISSUES IN INTEGRATING PRIMARY CARE AND PSYCHIATRIC SERVICES: AN INTRODUCTION

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Community and comprehensive psychiatry aims to set up collaborative models between primary care provision and psychiatric services. This is a well known and shared priority for any public health organization. Overlapping between mental and physical health, high psychiatric morbidity in general population, necessity to optimize the limited resources available, improving preventive opportunities through early detection and early intervention, reducing burden in relatives and stigma, reducing high rates of mortality in severe mental disorders (compared to the general population) represent just some of the most compelling reasons to set up cooperative models.

Nearly 25% of all patients managed by primary care have problems with mental health; psychiatric services treat only 2% of psychiatric morbidity. The consequence is that primary care setting, especially within the general practioner (GP) system, manages the great majority of psychic problems, not only the so-called Common Emotional Disorders, but also moderate or severe psychiatric disorders.

If the *filter* (Goldberg and Huxley 1991) represented by the GP network works poorly, the quality of mental health assistance will worsen and psychiatric services would simply collapse.

Also several other critical questions need to be further explored. Keeping in mind the central role of primary care and the frame of collaborative models between GP and psychiatric services, three main issues need briefly to be discussed: a) the diagnostic/operative validity of "common emotional disorders" and what is their best setting of treatment b) what we should expect GPs could do for mental health , c) how to set up a collaborative strategy.

Common Emotional Vs Severe Mental Disorders

Differentiation between Common Emotional Disorders (CED) and Mental Disorders (MD) is well known in the scientific community. Notwithstanding, the definition of CED is not clear. Their definitions as *sub-threshold disorders* or *minor psychiatric disorders* do not show the core of these clinical pictures. Besides, CED could be the early presentation of a major psychiatric disorder and, in any case, they bring about actual sufferance, distress and poor quality of life. All these aspects suggest that their detection and appropriate treatments are not easy tasks to accomplish. Working with GPs, I have come up with a useful definition to help GPs in making decisions (detection, referral, treatment in primary care setting)**:** *a common emotional disorder is an objective set of clinical signs (especially anxiety and depression) which brings about subjective distress and low degree of disability*, where "low degree of disability" scores 60 or more on the Global Functional Evaluation. Under this score, GPs know that referral is strongly recommended.

How can we expect GPs might deal with common emotional disorders

The role of primary care in the management of mental health depends on local conditions. In developing countries, GPs are the main resource to improve global health; they are focused on basic health needs of general population and multitasking is required. In these contexts, GPs are compelled to treat severe and common psychiatric disorders. In developed countries, the presence of a second level psychiatric service makes the role of GPs less clear.

Daily practice shows that primary clinical setting has to do with common, moderate and severe mental disorders and the same is true for the psychiatric setting (Thornicrof and Tansella 1999).

What does this evidence suggest? In a public health perspective, the current paradigm is that GPs are in charge for *minor* disorders, leaving to psychiatric services the clinical management of severe psychiatric disorders. GPs should treat CED by interpersonal, supportive, educational and pharmacological tools. A lot of clinical and pharmacological guide lines or treatment suggestions for GPs have been put forward for common disorders and especially for depression (NICE 2009, WHO 2008)

This perspective seems too simple and in daily practice it doesn't work. In my opinion, this approach has a great value in developing countries where the *status* of more specialized psychiatric services is poor, but where these second level psychiatric services are good, the management of common emotional disorders on primary care setting could be wrong.

Firstly, GPs might not want to take responsibility for clinical situations they are not trained to treat. Secondly, as I mentioned before, CED are not always actual "minor" disorders and the distress they really might produce requires more sophisticated help than we could expect in primary care setting. The risk is the

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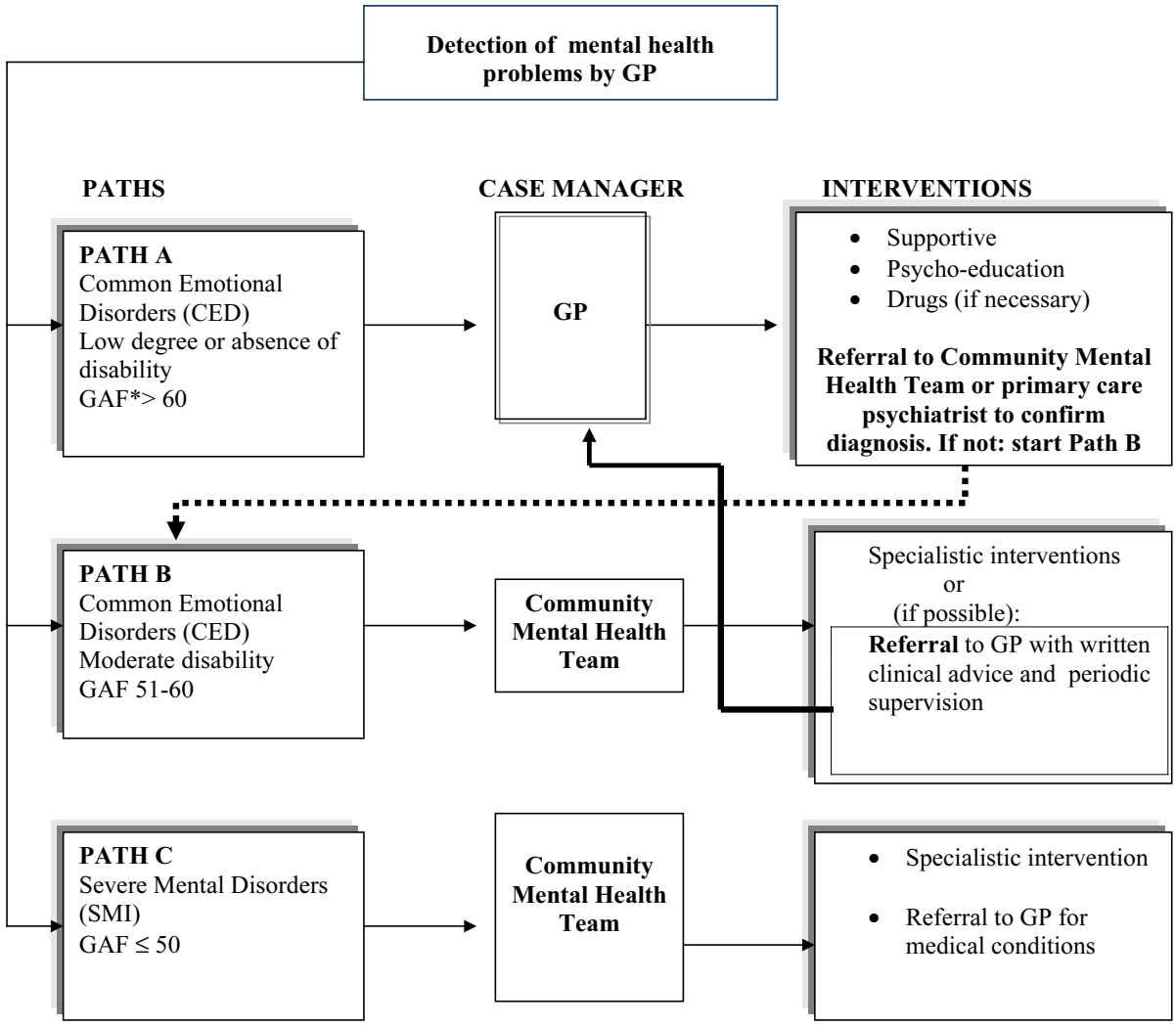

Figure 1

* Global Assessment of Functioning

over-use of pharmacological tools in primary setting even with patients that could benefit primarily from psychotherapy. My last statement opens the controversial issue of public psychotherapy, but this goes beyond the purpose of this paper.

What could we do actually expect GPs might do for management of mental health?

a) First of all, they should be *aware of the presence of mental distress or (hidden) mental disorders in their patients*. They should always make an evaluation of mental status. A lot of instruments have been proposed to improve clinical and therapeutic skills of *GPs* to help clinical judgment; in my opinion specific rating scales are not useful; much better is, for example, the GHQ-12 Goldberg and Williams (1988) which gives an overall evaluation on general mental status rather than specific disorders.

b) Secondly, GPs should be able *to evaluate whether to make a referral to psychiatric services or not*. This is a crucial decision for clinical management. GPs should be supported by a clear algorithm built up and shared with local psychiatric services. Moderate and severe mental disorders need to be referred, while common emotional disorders might be kept and treated in primary care setting. In my experience, a *three-step frame* is useful to make decisions. I will discuss this point later.

c) GPs should know *the basic issues of mental problems*. This basic knowledge makes easier to put forward psycho-educational interventions, to give tips and advices, to suggest basic information to seek further help.

d) GPs have to be aware of psychiatric consequences of organic conditions and pharmacological treatments *to make a differential diagnosis*..

e) If they decide not to refer the patient to psychiatric service, GPs should have *the expertise to treat the patients with antidepressants and BDZ, if*

necessary. That implies an adequate knowledge not only about pharmacological compounds, but also about the basic references for the management of anxiety and common depressive disorders. This is especially important for depressive disorders owing to the problems related to putative bipolarity and substance abuse.

f) Last but not least, an *interpersonal ability is required*. This is the most relevant treatment ingredient, but the less taken into account in physician training.

Models of collaborative working

Improving mental health in the community for common and severe disorders means building up cooperative strategies between primary and secondary care. These cooperative models should give appropriate answers to five core issues (Richards and Bower 2011): access, equity, utilisation, effectiveness and cost-effectiveness and patient-centeredness'.

A lot of models of interface working have been developed (Gask and Khanna 2011). There is a strong interest and research about the impact and cost-effectiveness of such models. We know that 1) purely educational models for GPs by psychiatrists have a poor impact on daily practice of primary care workers, 2) pure referral models (from primary care to secondary care) is untenable, 3) current paradigm of common disorders in the charge of primary care lacks equity and effectiveness.

The only way is developing working models based on active interaction between primary and secondary settings. These models are also the best way for GPs to take on new skills and improve their ability to cope with mental health problems.

The basic features of integrated models are described in the **figure 1**.

This simple model shows two main points: 1) the working interface between primary and secondary care is always interactive, 2) the responsibility of CED is a matter of multidimensional evaluation and not simply based on misleading concepts such as *sub-threshold* or *minor* disorders.

If other resources are available, more complex and comprehensive models – such as *collaborative care*, *stepped care* and *matched care*- may be built up.

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