Collaboration Between Mental Health Services and Primary Care: The Bologna Project

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Overview: Management of anxiety and depressive disorders within the community necessitates collaboration between mental health services and primary care. While cooperative projects do exist in many countries, Italy's National Health System does not have a program designed to address this issue. In Bologna, a cooperative project arose as a spontaneous undertaking between mental health professionals and primary care physicians. A model of collaboration was designed specifically for the Italian National Health System, consisting of a network of primary care liaison services (PCLSs) instituted within the community mental health services. PCLSs are managed by a staff of specially trained mental health care professionals and are designed to facilitate communication between physicians, and they provide continual and multifaceted support consisting of diagnostic assessment and focused clinical intervention. PCLSs also provide formal consultation-liaison meetings and a telephone consultation service designed to promote communication and enrich diagnostic assessment and treatment.

Discussion: PCLSs are innovative, not only because they represent one of the first collaborative efforts in Italy to date, but also because of their innovative design, which is specific for the Italian National Health System. Overall, the project yielded a good result. Primary care physicians utilized the service extensively, and together with psychiatric personnel were satisfied with the outcome. These results, when compared with the traditional separation between the 2 services, are encouraging. Our model could be adapted for most communities in Italy, but must be preceded by shared recognition of local need.

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Anxiety and depressive disorders occur frequently in the general population,[1,2] are associated with high degrees of subjective distress and disability,[3–5] and have heavy social costs.[6] As a result, these disorders represent an important public health problem, which involves not only mental health services, but primary care as well. In fact, many patients with anxiety and depression are seen and managed in primary care, even in those countries where mental health services are available and efficient.[7] The crucial role of primary care in management of these disorders is receiving more attention from health service organizations, and a close cooperation between primary care physicians and mental health services is underway in many countries.[8–11]

In Italy, there is growing awareness of this problem, and although initiatives to address this issue have begun,[12–18] vague government health policies remain. A cooperative project for management of patients with anxiety and depressive disorders has been undertaken in Bologna as a result of 10 years of clinical and research collaboration between the local University Psychiatric Clinic, the Community Mental Health Centers (CMHCs), and primary care physicians.[19] The framework of our project differs from the cooperative models that usually exist between mental health services and primary care.[9–11] It should be understood that, although the Italian National Health System is a type of socialized medicine system, it does not subsidize a primary care service, but instead operates on a physician-reimbursement basis. Thus, we created an original model of joint working ideally suited to our national health care system.

THE BOLOGNA COLLABORATIVE PROJECT

The Bologna Collaborative Project is an attempt to develop an effective system of collaboration between primary care physicians and CMHCs. The greater Bologna Local Health District is sectored into 8 catchment areas, each serving approximately 80,000 people, with each having an outpatient psychiatric facility of approximately 50 primary care physicians. We designed a Primary Care Liaison Service (PCLS) within each catchment area as a specialized component of the local CMHC, with the aim

of formulating an ongoing collaboration with the primary care physicians. PCLSs are located within the CMHC or, alternately, at various outpatient facilities within the districts. PCLSs consist of a multidisciplinary staff: usually a consultant psychiatrist, a resident psychiatrist, and a psychologist, all of whom have received specific training in this type of joint work and spend, on average, 2 days weekly providing this service. To facilitate contact and communication with primary care physicians, direct telephone lines have been activated and one-on-one meetings are held as necessary. Moreover, consultation-liaison meetings are scheduled at regular intervals. Additionally, citywide coordination of activities is entrusted to a consulting committee consisting of representatives from CMHCs and primary care.

To assist primary care physicians with the management of patients with anxiety and depression, PCLSs provide continual and multifaceted clinical support consisting of diagnostic assessment and focused therapeutic interventions and, additionally, consultation-liaison activities. Diagnostic assessment is based on World Health Organization Diagnostic and Management Guidelines for Mental Disorders in Primary Care[20] and includes the establishment of a psychiatric diagnosis, the identification of symptoms or problems reported by the patient and of significant life events, and the possible description of dysfunctional coping behaviors. According to protocol, should the psychiatrist determine that a clinical presentation is complex and a single visit inadequate, several visits may be scheduled to effect proper diagnostic evaluation. This assessment is followed by a proposal for treatment that includes pharmacologic intervention, counseling, and proposals for further treatment if needed. Information is then forwarded to the primary care physicians in a typed report designed to be thorough but concise. Attention was given to the protocol's format, which ultimately resulted in a user-friendly tool relatively free of psychiatric jargon. Written communication is often accompanied by telephone communication or interpersonal contact to increase understanding and cooperation between psychiatrists and primary care physicians. In severe cases, upon agreement with the primary care physician, the psychiatrist will supplement the assessment with pharmacologic intervention. This assumption of patient care by the psychiatrist is temporary, and after patient response has been evaluated, responsibility of care is resumed by the primary care physician. Occasionally, there are patients deemed too serious to be treated within the above-mentioned system; the care of these patients is then assumed by the CMHC, and, in adherence to PCLS protocol, primary care physician consent is obtained prior to transfer.

The PCLS also provides brief psychotherapy, conducted by either a psychologist or resident psychiatrist working under the supervision of the consulting psychiatrist. This treatment is limited to a maximum of 6 visits, is based on the principles of brief psychodynamic psychotherapy,[21] and is mainly oriented toward assisting the patient with clarification and understanding of his or her disorder.

The PCLS also provides consultation-liaison activities. Meetings are in the process of being organized in which the psychiatrist will meet regularly at the PCLS office with a maximum of 8 primary care physicians for the discussion of cases. In addition to formal consultation-liaison activities, a telephone consultation service[22] has been activated. Easily accessible during regular PCLS hours, this service can supplement interpersonal meetings, facilitate the discussion of patients post assessment, advise primary care physicians regarding the clinical management of the patient, and promote access to other services provided by the PCLS.

DISCUSSION

The Bologna project is innovative, not only because it is one of the first collaborative efforts in Italy between mental health services and primary care, but also because it has been designed specifically for the Italian National Health System. In contrast to those countries in which governments are responsive to the problem of widespread anxiety and depressive disorders,[8,11] our project did not stem from a national or regional health policy, but instead was a spontaneous undertaking by mental health professionals and primary care physicians. As a result, our project has been adopted by the Local Health District and is currently being promoted citywide. In the 1980s, motivated primary care physicians began an initiative with psychiatrists from Bologna University and CMHCs that addressed the issues surrounding anxiety and depressive disorders. During a series of focus conferences, problems with interface were discussed and identified. At that time, the only existing interface procedure recognized by CMHC regulations was referral for psychiatric assessment, which often occurred among professionals not directly acquainted and did not provide support for primary care physicians, as confirmed by a study conducted in the nearby city of Reggio Emilia.[23] One should also consider that Italian CMHCs operate under an open-access policy and accept and treat patients with anxiety and depressive disorders independent from primary care. As an outcome of the focus conference, primary care physicians concluded that their practice should include management of patients with anxiety and depressive disorders. Understanding that effective management of anxiety and depression requires an integrated effort, the psychiatric community concurred, also emphasizing that better coordination between primary and secondary care was needed. The Bologna Collaborative Project was implemented experimentally in 3 of Bologna's 8 districts in

1997 and is currently being extended to include all districts.

Our interface between CMHCs and primary care is unique when compared with joint working models in which mental health care professionals are collocated to administer support directly to primary care practices.[9–11] In Italy, primary care is guaranteed to each citizen, but a formal primary care service does not exist and primary care physicians are reimbursed by the government for each patient allocated to them. Primary care physicians work individually instead of in group practices, so it was necessary to first define potential collaborative activities within the established CMHC structure. Anticipating that defining potential collaborative activities within CHMCs might not foster the psychiatrists' understanding of characteristics and needs of primary care and, conversely, that primary care physicians might have difficulty distinguishing PCLS from traditional mental health services, we formatted the program in such a way as to promote reciprocal understanding. To that end, the PCLS is staffed by a group of specially trained professionals and has specific hours of operation and direct telephone access. In some districts, the PCLS offices are located within the outpatient clinics, thus operating as an entity distinct from the CMHC. Mental health care professionals chose to solicit communication and collaboration with primary care physicians in all phases of the project. Shared responsibility for planning, joint forums to design an easily accessible service, and formal and informal discussions were encouraged.

Clinical activities provided by the PCLS for physician support include diagnostic assessment and focused treatment intervention. Diagnostic assessment is an integral part of the clinical support system as it is usually the primary clinical intervention, although at times further clinical intervention may be needed. Our diagnostic assessment provides a better clinical understanding overall, in that the psychiatric diagnosis is supplemented by a recognition of the presenting complaints, life events, coping style, and other information relevant to the formulation of a treatment strategy. Differing from traditional referral, our diagnostic assessment is performed by psychiatrists familiar with the working methods and needs of primary care physicians. Furthermore, the assessment process is not limited to a single visit, but can be obtained over a number of visits if needed. Finally, the report that is forwarded to the primary care physician is clear, concise, and designed to encourage discussion between the physicians.

In some cases, the diagnostic assessment alone is inadequate for the management of the patient by the primary care physician, and the consultant psychiatrist implements the treatment plan. This represents an extension of the diagnostic assessment and is utilized only in complex and severe cases to return the patient to the primary care physician after an initial treatment response has clarified the clinical picture. Because the psychiatrist takes temporary responsibility for the patient, there is a risk of overlapping tasks and of diminishing the primary care physician's role. However, we decided that this procedure would be the best compromise versus returning the patient to the primary care physician with an incomplete assessment and/or referring the patient directly to the CMHC.

The most appropriate solution would perhaps be the integration of diagnostic assessment with consultation-liaison activities. As will be addressed further, we want to promote consultation-liaison activities and therefore reduce the need for treatment implementation by the PCLS staff. Yet another intervention is brief psychodynamic psychotherapy, which supplements the treatment provided by the physician, who ultimately remains responsible for the management of the patient. Several studies have shown that psychological intervention is useful in the management of medical outpatients with anxiety and depression, with the most widely used forms of therapy consisting of counseling and behavioral treatment.[24,25] Recognizing that the effectiveness of brief psychodynamic therapy in outpatients has not been widely studied, we chose to follow the standard generally practiced in Bologna and, additionally, focused our intervention on the patient's most immediate needs. Moreover, to further integrate psychotherapy with the treatment plan, the PCLS therapist provides the physician with an informative summary.

One of the initial forms of collaboration between CMHCs and primary care undertaken by our group in Bologna were consultation-liaison activities. We consider this to be a fundamental element of the cooperative project and have thus designed 2 different procedures. There is both a formal consultation-liaison process, in which mental health and primary care providers meet in groups for case discussion, and a telephone consultation designed to promote communication and enrich diagnostic assessment and treatment. However, formal consultation-liaison activities have so far been implemented in only a few districts owing to the numerous difficulties encountered, among which are the problems in planning meetings between professionals working in different places and having conflicting work schedules. Therefore, we hope that greater emphasis on consultation-liaison will be possible as awareness grows and relationships between professionals are strengthened.

We consider our joint endeavor to be positive as it has promoted reciprocal understanding between physicians regarding individual needs and methods of practice, with a resultant enhanced perception of the dual roles in the treatment of patients with anxiety or depression. The initiation of the PCLS was well received, and a substantial number of primary care physicians utilized the service. Having noticed that brief, focused intervention within the

collaborative project ensured more effective treatment for a significant number of the patient population, psychiatric personnel gave positive feedback overall. Additionally, the initial data confirm that PCLSs result in more appropriate referrals to secondary care; thus, the risk to Italy's open-access mental health services system of receiving a high number of insufficiently screened patients could be reduced.[23] Should this trend continue, PCLSs will be sustainable in terms of resources. It appears that the transfer of personnel from general CMHC activities to PCLSs is justified by a more appropriate triage of patients with anxiety and depressive disorders. However, a more in-depth analysis of resource destination and care pathways is currently being undertaken to determine the actual cost-effectiveness of our service. Finally, improved communication between physicians promises future possibilities for cooperative projects related to the treatment of patients with chronic psychotic disorders, as research has confirmed that joint care leads to substantial improvement.[26,27]

CONCLUSION

The Bologna collaborative project has defined an innovative model of interface between mental health services and primary care that is ideally suited to a health care system in which most primary care physicians practice independently. However, we emphasize that implementation of this model elsewhere must be preceded by a commitment to identify conflicts between primary care and CMHCs to formulate a model of collaboration tailored to local need.

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