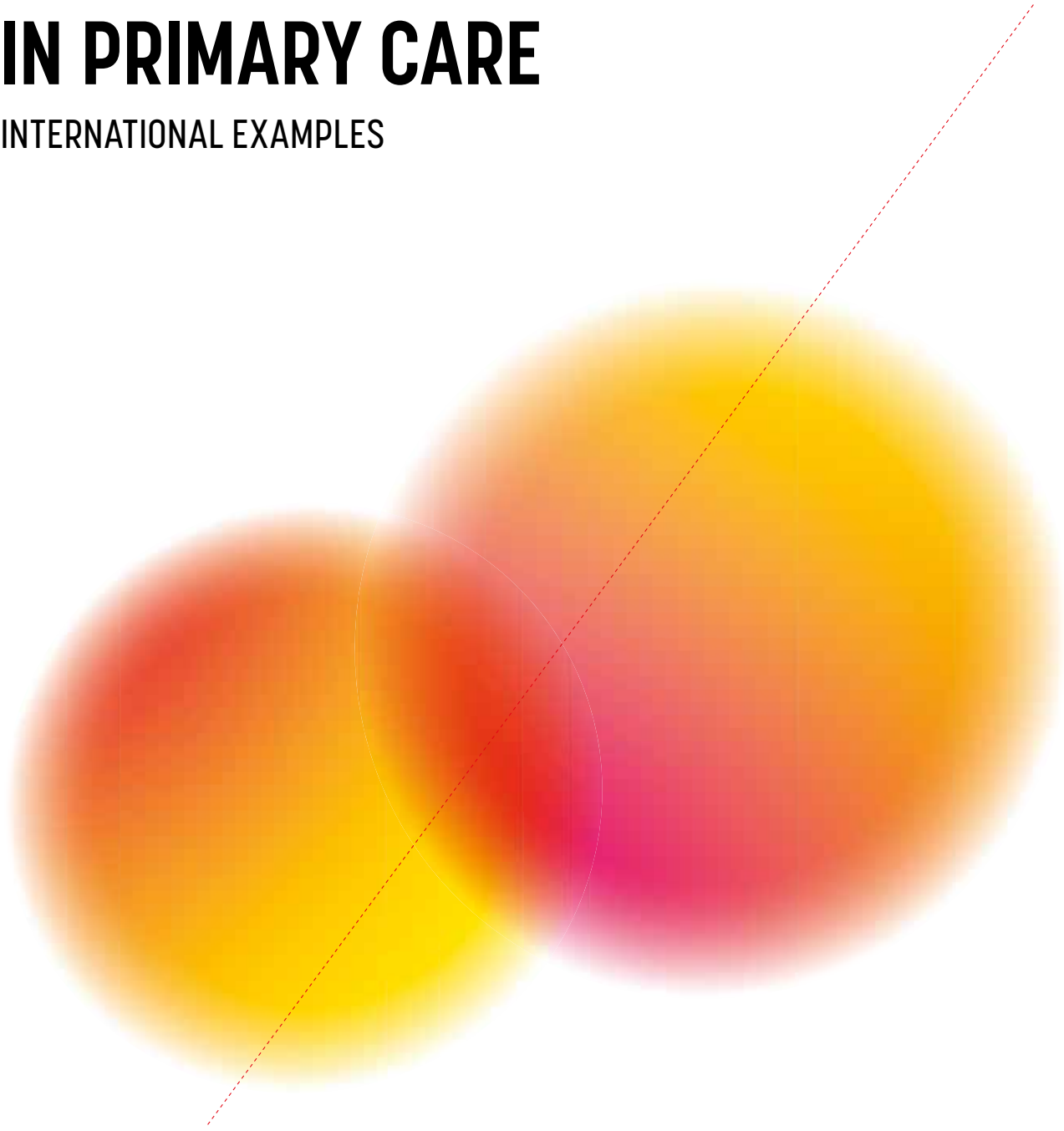
MENTAL HEALTH
IN PRIMARY CARE
INTERNATIONAL EXAMPLES

JUNE 2021



King Baudouin Foundation
Working together for a better society

Julie Renson Fund
Queen Fabiola Fund

Foreword

The Julie Renson Fund, the Queen Fabiola Fund and the King Baudouin Foundation are working together in a partnership built on four principles:

- recognising psychological vulnerability and working to make it more visible by focusing on how it is portrayed among users, in the sector and in society as a whole;
- encouraging an approach that fosters the autonomy of users and their families and their participation in care (valuing lived experience, peer support);
- promoting the recovery approach on every level and in all health care structures;
- paying special attention to socio-economically vulnerable groups and people who have experienced migration.

In the context of the initiatives that have been developed for the 2020 to 2024 period, the Mental Health Funds and the Foundation have set the goal of improving the skills available in the primary care sector so that it can provide the best possible assistance and support to people with mental health problems.

Skills can be improved both by improving knowledge of mental health among workers in primary care and by fostering collaboration with professionals from the mental health sector.

During the exploratory phase, the partners asked sociologist Mark Leys (VUB) to produce an inventory of good practices that exist in this area internationally. This report is based on the good practices that were collected during this process.

The report makes it clear that these practices focus on improving the mental health skills of people working in the areas of health and well-being in primary care. This enables them to manage psychological vulnerability better and provide better and more integrated care to people who are psychologically vulnerable. This care is provided both at home and in local communities through collaboration between the actors involved.

As well as outlining these practices, the study also sought to offer guidelines for implementation of initiatives to improve primary care provision for people with mental health problems.

After an exploratory phase during which practices in Belgium were collected and analysed, the Julie Renson Fund, the Queen Fabiola Fund and the King Baudouin Foundation will work with the Daniël De Coninck Fund to support structural approaches to implementation in practice and to foster collaboration and collaborative relationships between the primary care and mental health sectors in Belgium.

Introduction

Mental health is on the agenda more than ever before, and rightly so. Mental health problems have been shown to be increasing, and it is gradually becoming easier to discuss mental health problems and well-being than it was in the past. There are a number of indications and figures available internationally suggesting that primary care providers (GPs) are also facing questions and problems relating to mental health among citizens and patients. Primary care is, as the name suggests, the primary point of contact to offer guidance to people who have health-related questions. It is therefore right to consider the question of how best to support primary care to identify mental health problems at an early stage and involve the primary care sector in providing treatment, guidance and support. It is not an option to approach mental health problems exclusively from the niche-based or compartmentalised mental health approach, simply because citizens do not choose to take their mental health problems *directly* to mental health providers.

The purpose of this study is to draw inspiration from international examples of ways in which the primary care sector could work with mental health providers and other sector to find ways to address mental issues.

The study provides an overview of a number of good or promising practices that are helping to improve the management of mental health in primary care. We also consider whether and how our ways of working cause a (re)distribution of tasks between primary care and mental health care.

This study looks at a number of international examples from countries in Western Europe. That does not mean there was no inspiration to be found in the United States, Canada, Australia, New Zealand or other countries with less developed health care systems. For the sake of feasibility, however, we focused on cases embedded in more similar health care systems. The literature overview on questions relating to collaboration between primary care and mental health care does include insights from all countries. This study is also intended to provide 'inspiration' rather than providing a representative view of useful practices. There are certainly many initiatives that are not mentioned here but still have major innovative value.

The purpose of this study is to draw inspiration from international examples of ways in which the primary care sector could work with mental health providers and other sector to find ways to address mental issues.

The method that was used

The search for and selection of good practices was based on criteria suggested by the World Health Organisation (WHO) focus points for the integration of mental health care in primary care.

We look closely at initiatives that focus on empowering health and social care providers, citizens themselves and also their families and networks. We include initiatives that help to reduce stigma or foster continuity of care, focus on an integrated approach or improve accessibility and availability for various groups in society.

Where possible we sought out 'sustainable' practices rather than temporary project-style innovations. It should be added here that not all the useful initiatives are already structurally embedded in health care systems at present. For this reason we interpreted this final criterion more flexibly.

The most important objective of this study is to provide inspiration for possible initiatives and approaches in Belgium.

It was decided to select good practices on the basis of a scientific literature review. We were able to use an initial review carried out by the Norwegian Knowledge Centre for the Health Services in 2007[1]. The search for more literature also drew inspiration from the PRISMA (Preferred Reporting Items for Systematic reviews and Meta-Analyses) protocol for scoping reviews[2] and the guidelines set out by Arksey and O'Malley (2005)[3] and by Levac and colleagues[4]. Once again, we do not claim that this study is a full scoping review. In accordance with the study objectives, we did not adhere to algorithms or use explicit inclusion and exclusion criteria.
The search for good practices was mainly inductive. When selecting initiatives and finding concrete descriptions, we made extensive use of grey literature. Useful initiatives are referred to in the academic literature but not described in detail.

1 Hviding K, Bugge P, Ekern P, Brelin P, Hoifodt TS, Nessa J, et al. Collaborative care initiatives for patients with serious mental disorders treated in primary care setting. Norwegian Knowledge Centre for the Health Services. 2008.

2 http://www.prisma-statement.org/ et https://knowledgetranslation.net/portfolios/the-prisma-scr-prisma-extension-for-scoping-reviews/

3 Hilary Arksey & Lisa O'Malley (2005) Scoping studies: towards a methodological framework, International Journal of Social Research Methodology, 8:1, 19-32, DOI: 10.1080/1364557032000119616

4 Levac, D., Colquhoun, H. & O'Brien, K.K. Scoping studies: advancing the methodology. Implementation Sci 5, 69 (2010). https://doi.org/10.1186/1748-5908-5-69

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PRIMARY CARE AND MENTAL HEALTH CARE

Residential (institutional) care and paternalistic approaches are becoming less important in the organisation of mental health care and the approaches used. Social inclusion, societal participation and empowering people with psychological disorders and vulnerabilities are the guiding principles.
Mental health and well-being are also moving up the agenda. These changes in society mean that mental health is no longer isolated in the 'niche sector' of mental health care: there is a need for integration and collaboration between different sectors and between formal and informal actors.

Throughout the world, primary health care is the first level at which individuals, families and communities encounter the formal health care system. It represents a 'general' form of treatment and care that is delivered close to the local community.
This approach allows it to play a significant role in the integration into society of both mental health care and people with a psychological vulnerability. Making mental health care available through the primary health care sector means that people can access care and treatment close to their home, family, work, leisure activities and social networks, allowing them to remain integrated and active in the community.

One particularly important question is how primary care can give more attention to mental health and be supported in its engagement in this area.

Internationally, primary care is seen as the first level of professional health care, where people present with a wide range of health problems. General primary care services are the first point of contact for the public. Internationally these services are viewed as essential to ensure that the broad spectrum of health care services are available to individuals and families with different needs. The primary care sector is expected to offer accessible care in the neighbourhoods where patients have their permanent residence. They are provided as close as possible to the places where people live. The primary care sector helps to coordinate care processes for patients through coordination with other services.

Primary care goes beyond the role of GPs. It also includes services provided by other professionals in the areas of health care and welfare such as nurses, midwives, support workers and social workers, who have caring and supportive roles in the community.

In most European countries primary care is a compulsory first step that is required to obtain a referral to more specialised forms of care. Other countries - including Belgium - do not have a model of referral from primary care or a tiered system. People can present directly to specialist health care providers in Belgium.

There are two main ways of organising primary care in European countries: solo practices and group practices (which may or may not be multidisciplinary). In recent decades there has been a move towards more multidisciplinary group practices. This is also occurring in countries with a tradition of having more solo practices, with multiple disciplines operating at a single location. In Belgium, this model is seen in medical centres and neighbourhood health centres, while other countries have primary care health centres. There is now scientific evidence that group practices foster collaboration more than solo practices. They foster different and broader perspectives on health problems and may lead to more integrated care.

People with mental health problems or questions often present to primary care first. In this context mental health problems can sometimes present in a disguised form. There are major differences between individuals in this area. In addition to this, the primary care sector increasingly provides *some* of the support for people with serious psychiatric disorders or problems with addiction. In these cases the primary care provider can coordinate their care, help to formulate goals, discuss medication etc. There is now a wide range of activities in which primary care is known to make a contribution.

ACTIVITIES IN WHICH PRIMARY CARE CAN HAVE A ROLE ALONGSIDE ACTORS IN MENTAL HEALTH CARE

- Early detection and initiating care
- Confirming indications for treatment, screening and identifying problems
- Assessment
- Suggesting or starting treatment
- Responding to crisis situations
- Integrating physical (somatic) and mental health care
- Use of medication
- Joint monitoring of the care process and preventing relapses
- Coordinating care and signposting within the system
- Referrals
- Care (case) management
- Proposing goals and fostering social inclusion
- Monitoring and relapse prevention
- Family interventions
- Education and self-care, supporting empowerment
- Health education and patient education
- Family support
- Lifestyle changes
- Eliminating stigma and helping to safeguard human rights
- Reducing stigma
- Reducing barriers to choosing the appropriate form of care
- Working in partnership with community services (on an intersectoral basis)
- Advocacy for the importance of mental health care

The WHO 2013-2020 action plan for mental health recommends integration of general health care, mental health service and welfare provision, and supports a stronger primary care sector. The primary care sector should work closely with other actors including self-care, informal care and specialist mental health services. The integration of mental health services and primary care theoretically fosters coordinated, person-centred care. This is also true for the large group of people with comorbid physical and mental health problems. The main advantages of delivering mental health services through primary care are that this is accessible, affordable and acceptable to people with mental health problems and their families. This approach reduces social inequalities and creates opportunities to ensure greater continuity of care, reducing the risk of stigma. It fosters social integration and improves the management of patients with comorbid physical and mental health problems.

The primary care sector can contribute actively towards normalisation by listening to a person's story empathically and in a non-judgemental way. This approach helps to lift taboos, reduce the stigma around mental health problems, enhance the patient's self-image and foster self-reliance. If patients have sufficient insight, skills and motivation, they can be encouraged to use self-help, or referrals can also be provided to other specialist providers. It is still essential, however, for the GP to systematically monitor the person's condition and continue to be involved in monitoring for the occurrence or disappearance of symptoms.

Source: Kates, N. et al (2018): Improving collaboration between primary care and mental health services, The World Journal of Biological Psychiatry, DOI: 10.1080/15622975.2018/1471218

In addition to these aspects, an integrated approach to mental health care can also help to address capacity problems in mental health services. Integration can help to control staff shortages and provide care and support for patients or citizens with mental health needs.
This is possible as long as there are enough front-line health care professionals with sufficient skills and abilities. These are needed to identify mental health needs and disorders, provide basic medication and psychosocial interventions, help with crisis interventions, refer to specialist mental health services when necessary and take responsibility for coordination of care. Doing this will also address the issue of accessibility.

It is well known, however, that mental health problems do often remain 'under the radar' in primary care.
This is because there is too little awareness and knowledge to recognise these problems or a lack of skills to provide support for people. People often do not talk directly about their mental health. Instead they tend to refer to other concerns (such as a physical health problem, a social issue, relationship problems, unemployment or work-related problems, financial worries or social isolation).
In other words, there is a need to enhance competencies, and also for supportive collaboration with more specialist care providers. Other factors also have a part to play.
The legislative framework and health and social care insurance systems do not always allow or provide incentives for collaboration. Historically, mental health care and primary care have developed as separate sub-sectors. They have different goals and perspectives, different customs and approaches. Effective integration of mental health care and primary care must therefore be addressed both systematically and pragmatically.
The roles,contributions and competencies of each actor need to be identified and harmonised. An approach that considers the requirements and needs of citizens, patients and users is more helpful than maintaining conflicting interests between the identities and features of the individual sectors.

THE IDEA OF COLLABORATION AND INTEGRATION SOUNDS GREAT, BUT DOES IT WORK?

The scientific literature has identified a number of barriers and preconditions for facilitating integrated working between primary care and mental health services.

These barriers involve knowledge and skills, attitudes and views on collaboration. There are also different attitudes and perspectives when it comes to people with mental health problems. Views differ on how the actors involved should deal with the substantive issues involved in mental health care. The idea that primary care should play a part is presented as normative, but in practice primary care staff do not always do this. People working in mental health services are sometimes also sceptical about 'generalist' health care playing an active role in treating mental health problems. In many cases there are few incentives and little leadership to promote new ways of working. Regulatory and financing systems also impose barriers that impede the practical implementation and sustainable development of a new initiative.

	Barriers	Facilitators
	Care users	
Knowledge, skills & attitudes	Lack of knowledge about the health care system	– Motivation to receive support
Accessibility	Financial and geographical accessibility	
	Health and social care providers	
Knowledge & skills	Not able to recognise or treat mental disorders or to use screening tools	– Assessment of their own competency to manage a psychological vulnerability – Knowledge of mental health problems based on training and support.
	Lack of knowledge of the correct medications	
	Lack of training in mental health care	
	Lack of knowledge of mental health care services (and health care in general)	
	The belief that mental health is something separate and a difficult area, in contrast to somatic problems: mental health care is not viewed as a primary care responsibility	
Attitudes & beliefs	Belief that working with people with a psychological vulnerability is difficult	– Agreement that mental health problems are important and that everyone needs to help with their management – Willingness to maintain a long-term relationship with a person who has a psychological vulnerability – Belief that it is better to support people in the community and resume everyday activities – Recommendations that mental health should be mentioned (and screened for) at every visit – Trust among clients – A holistic approach to the client
	Belief that people with serious psychological problems have to be managed in inpatient settings	
	Belief that clients will not comply with treatment	
	(Problems) with medico-legal liability	
	Resistance to the integration of mental health care in primary care	
	Viewed as too much work	
	No interest in the target group (or in working with them)	
	Insufficient experience of financial and other forms of support (staff, training, specialist supervision etc.)	
	Health care system	
Management & leadership	No harmonisation and coordination with specialists from mental health services or psychiatry	– Collaboration in multidisciplinary teams – Coordinated information system – Structural links between primary care and mental health care (via suitable communication channels)
	A health care system that is not capable of supporting the full spectrum of clients' needs	
	Lack of coordinated care planning	
Financing	A lack of clearly agreed roles with other health and social care providers	– Adequate financing that encompasses integration

Source: based on Wakida, E.K., Talib, Z.M., Akena, D. *et al.* Barriers and facilitators to the integration of mental health services into primary health care: a systematic review. *Syst Rev 7,* 211 (2018). https://doi.org/10.1186/s13643-018-0882-7

DIFFERENT STRATEGIES

Various different models have been described to create a mesh of links between the mental health care and primary care sectors: the approach in these models ranges from 'consultation' through 'associate specialist mental health professionals' working in primary health care, to stepped care and matched care, in which either primary care or specialist care is deployed depending on the client's needs, in some cases with collaboration. The models emphasise that primary care is usually the first and most widely used point of contact for citizens or users. It is established initially in primary care that treatment is required and problems are assessed. Inter-disciplinary collaboration then takes place with specialist mental health professionals and services.

In a *matched care* model, everything does not necessarily have to go through primary care: it is possible to present to mental health services directly (as in a tiered system) but primary care is an integral part of the health care system. This 'sector' focuses on interventions such as case management, liaison work, shared care, care coordination, shared decision-making on goals and treatment, support or guidance plans etc.

A number of models have a focus that extends beyond the collaboration between formal assistance or care providers. These aim to involve, *empower* and support patients (self-care) and informal and/or family carers (informal care) by seeking to teach them skills that will reduce the burden of work for formal health and social care providers and services. If the informal system can offer a measure of support and assistance or if skills can be acquired in other sectors (e.g. day centres, social assistance in the home, self-help groups etc.) this can reduce the pressure and burden of work in the mental health care sector. It is possible to create links with *social prescribing* (*prescription sociale* in Canada, and *welzijn op recept* in the Netherlands): the main focus here is on connecting and integrating people in the fabric of society. In these situations, primary care providers refer individuals or work alongside providers of non-medical support.

Some approaches focus on interventions to improve clients' competencies (training, lifestyle interventions, psycho-education etc.).

Kane et al. identified 10 principles (based on the WHO guidelines) on various levels that can be used in structuring collaboration frameworks.

AT THE HEALTH CARE SYSTEM LEVEL

- Awareness raising and advocacy are needed to change attitudes and behaviours and to overcome stigma.
- Policymakers including policy guidelines and plans) must explicitly address the role that the primary care sector can and should play in mental health care.
- Professionals in primary care must receive adequate education, training and supervision to allow them to provide appropriate, high-quality mental health care.
- Collaboration and integration are a process, not a one-off initiative.
- Improving collaboration is a means (not an end in itself) of arriving at better care and guidance (outcomes) for people with a psychological vulnerability or problems with addiction.
- Perspectives and policies are needed to harmonise the provision of care at the local, regional and national levels.
- Collaboration is needed with a wide range of sectors, including NGOs, local initiatives and volunteers.
- There is a need for agreement on the populations that are eligible to receive treatment and support in primary care and those who should ideally be supported in specialist facilities.
- There is a need for adequate financial and human resources to address the provision of care.
- Professionals in mental health care must also be made more aware of the importance of collaboration with primary care. They need to receive better teaching and training in this area, and should also receive payment to ensure that collaboration actually takes place.
- Initiatives that are set up to strengthen collaboration must be supported and embedded in a policy framework and must not be left to function on a 'standalone' basis.
- Changes on the front line need to be supported by a national or regional policy framework that promotes collaborative care.

TO CREATE A STRUCTURE FOR COLLABORATION

- Activities are planned through a process of collaboration from the outset. Clear goals are set and these are assessed and adjusted through joint consultation when this is found to be necessary.
- Mutual respect and support for each other's strengths and limitations is a requirement for engaging in collaboration.
- Personal contact and direct communication between health and social care providers are essential factors to improve the quality of care and work together successfully.
- There is a need for interdisciplinary teams that operate effectively.
- The approach is chosen on the basis of the resources available, local cultural characteristics, geographical factors and the severity of the mental health problems.
- Partners need to have a flexible attitude and must be willing to make adjustments on both sides.

TO PROVIDE CARE

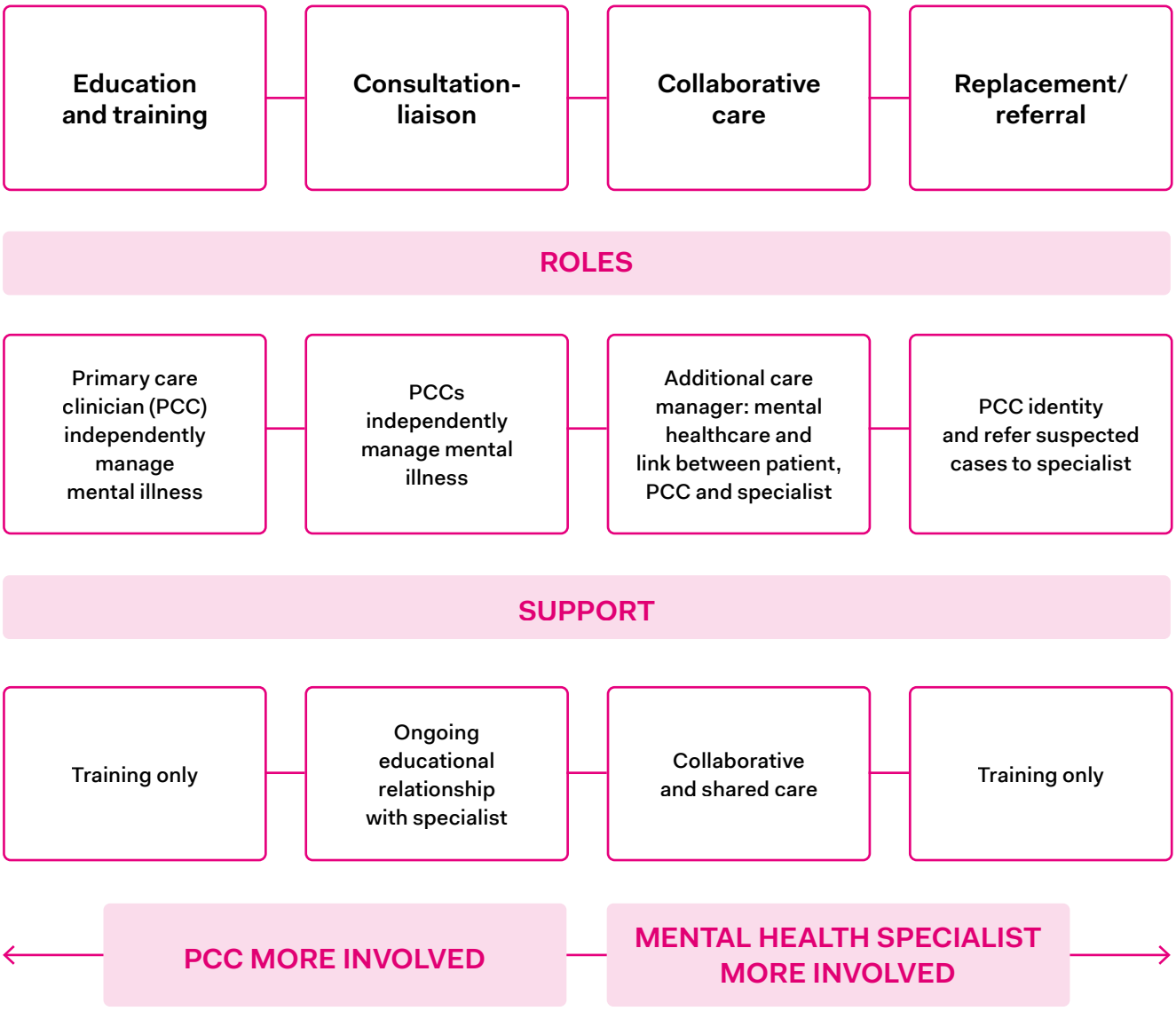
- The tasks that are allocated to the primary care sector must be realistic and must match the skills and knowledge available in primary care, as well as the interests of those involved and the resources available.
- Patients must have access to the psychotropic medications they need.
- Care, treatment and support must be organised in a way that is patient-oriented and must be adjusted in line with the changing needs of the individual (and their networks).
- Social determinants must be taken into account when providing care.
- There is a need for effective coordination when it comes to using and drafting care plans.
- A regular flow of information between those involved is necessary.

Bower and Gilbody carried out a number of systematic reviews and one meta-review into models of collaboration between primary care and mental health care[1].

Bower and Gilbody (2005) identify (see also the graph below):

- Staff training in primary care.
- Consultation-liaison functions between primary care and mental health care.
- Shared case management and collaborative care
- Organised temporary referral, with shared follow-up.

1 Bower, P., & Gilbody, S. (2005). Managing common mental health disorders in primary care: conceptual models and evidence base. BMJ, 330, 839-842
Bower, P., Rowland, N., & Hardy, R. (2003b). The clinical effectiveness of counselling in primary care: a systematic review and meta-analysis. Psychological Medicine, 33, 203-215
Bower, P., Rowland, N., Mellor, C., Heywood, P., Godfrey, C., & Hardy, R. (2005). Effectiveness and cost effectiveness of counselling in primary care. Cochrane Database of Systematic Reviews, 3
Bower, P., & Sibbald, B. (2000a). Do consultation-liaison services change the behavior of primary care providers? A review. General Hospital Psychiatry, 22, 84-96.
Bower, P., & Sibbald, B. (2000b). Systematic review of the effect of on-site mental health professionals on the clinical behaviour of general practitioners. BMJ, 320, 614-617.
Bower, P., & Sibbald, B. (2005). On-site mental health workers in primary care: effects on professional practice. Cochrane Database of Systematic Reviews, 3


Education and training
Consultation-liaison
Collaborative care
Replacement/ referral
ROLES
Primary care clinician (PCC) independently manage mental illness
PCCs independently manage mental illness
Additional care manager: mental healthcare and link between patient, PCC and specialist
PCC identity and refer suspected cases to specialist
SUPPORT
Training only
Ongoing educational relationship with specialist
Collaborative and shared care
Training only
PCC MORE INVOLVED
MENTAL HEALTH SPECIALIST MORE INVOLVED

Gask and Khanna (2011)[1] identify:

- Approaches in which an individual professional is attached to a primary care practice (attached professionals)
- Use of consultation liaison staff
- Collaborative care approaches
- Community mental health teams

Mapanga and colleagues (2019)[2] identified nine strategies for improving approaches to mental health in primary care:

- Specialist community-oriented services
- Integration of care / collaborative interventions,
- Task reallocation / shared approaches to care
- E-health interventions
- Group therapy vs. individual therapy
- Strategies to empower families, carers and patients
- Psychotherapy and psychosocial interventions vs. / combined with pharmacotherapy
- Early diagnosis and preventive strategies
- Systematic strategies that could change the behaviour of care providers and enhance the quality of care.

An American literature study by Brown et al (2020)[3] identifies three types of collaboration.

- Coordinated models are focused on communication. These can vary from minimal collaboration to remote collaboration. When services are coordinated, the minimum aim is to share information routinely when patients are being treated in both settings or have been referred. Exchanging information is also intended to bridge the cultural differences between primary care and mental health services.
- When facilities or professionals are co-located, primary care and mental health care are physically accommodated in the same facility. 'Referrals' do occur in situations that begin as medical cases but also turn out to involve mental health problems. Co-location fosters communication. Although regular collaboration is not always needed in these services, it becomes much more likely because it is more often seen as the obvious thing to do.
- In integrated care, responsibility for the care plan and treatment is shared: a common care strategy and plan are followed.

Other authors have used similar classification systems.[4] The classifications in the literature are mainly useful in providing a common language for the extent and form of collaboration and also because they offer a number of insights into possible ways of structuring collaboration.

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1 Gask L, Khanna T. Ways of working at the interface between primary and specialist mental healthcare. Br J Psychiatry. 2011 Jan;198(1):3-5, sup 1. doi: 10.1192/bjp.bp.109.075382. PMID: 21200068.

2 Mapanga W, Casteleijn D, Ramiah C, Odendaal W, Metu Z, Robertson L, Goudge J. Strategies to strengthen the provision of mental health care at the primary care setting: An Evidence Map. PLoS One. 2019 Sep 6;14(9):e0222162. doi: 10.1371/journal.pone.0222162. PMID: 31491022; PMCID: PMC6731011.

3 Brown,M; C A. Moore, J MacGregor J R. Lucey; Primary Care and Mental Health: Overview of Integrated Care Models, Journal of nurse practitioners, Volume 17, ISSUE 1, P10-14, January 01, 2021 DOI: https://doi.org/10.1016/j.nurpra.2020.07.005

4 Collins CH, D.L.; Munger, R.; Wade, T. *Evolving models of behavioral health integration in primary care.* New York2010 https://www.milbank.org/wp-content/uploads/2016/05/Evolving-Models-of-BHI.pdf

Coordinated care

- PCPs and behavioral health providers communicate in a tradional generalist-specialist format
- **Example:** PCP refers a patient to a local behavioral health provider who assumes the mental health care and management
- **Clinical example:** Primary care clinic referring to local free-standing mental health clinic

Co-Located Care

- PCPs and behavioral health providers are physically located in the same facility and may share resources
- **Example:** PCP refers patient to behavioral health specialist within same healthcare system
- **Clinical example:** Many community health centers have co-located mental health departments in the same building

Integrated Care

- PCPs and behavioral health providers work on the same team and assumed shared treatment plan of the patient
- **Example:** PCP and behavioral health specialist meet in the same room, at the same time, with the patient
- **Clinical example:** Cherokee Health System (Tennessee)

Coordination of care and collaboration

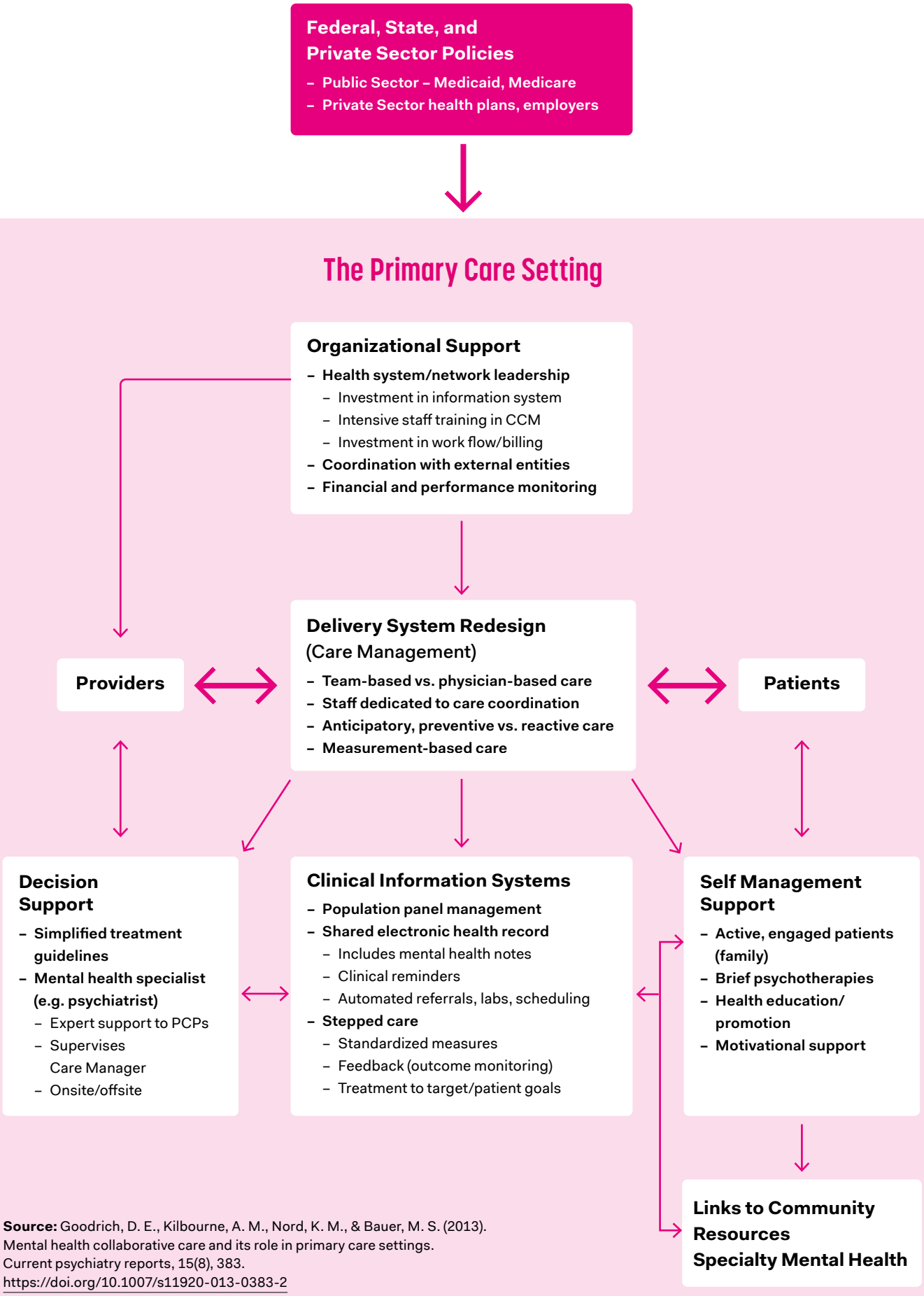
Coordination of care and collaboration characteristically involves gradients. Projects and initiatives that focus on coordination of care usually aim to improve information sharing, communication and collaboration.
A number of projects look for ways to ensure that important information is available to all those involved in the process. Every care provider involved from different services must be willing to share the required information with the others involved, either verbally (bilaterally or in a multidisciplinary team, in writing or electronically/digitally).

The literature indicates that effective communication must be timely, frequently repeated, understandable and accurate. A minimum of shared understanding between the actors is required. This includes goals and working methods, and in more advanced forms methods for joint decision making must be found.
The research indicates that if there is greater mutual respect and trust in each other's knowledge and skills, collaboration is more likely to be successful and effective, benefiting the client.

Collaborative care

Collaborative care is a term that is frequently seen in the US literature and it goes one step further than coordination. *Collaborative care models* (CCMs) are implemented in practice in various ways, but they comprise a number of core elements: the priority is teamwork, the team operates out of primary care and the guiding principle is that a pathway is followed, which may include long-term follow-up.

> Goodrich and colleagues identified six conditions for making this model work well
>
> – Organisational support;
> – Reorganisation of working processes (*care management*);
> – Use of *clinical information systems*;
> – *Decision support* for health and social care providers;
> – Supporting the client in self-management and monitoring risks;
> – Developing relationships between the client and support in the community.



Source: Goodrich, D. E., Kilbourne, A. M., Nord, K. M., & Bauer, M. S. (2013). Mental health collaborative care and its role in primary care settings. Current psychiatry reports, 15(8), 383. https://doi.org/10.1007/s11920-013-0383-2

Co-location of attached professionals with different types of expertise

Co-location comprises organisational and logistical integration of professionals in the same facility and the same location. In this area, multidisciplinary co-location is a way to bring together appropriate knowledge and skills. Co-location makes it possible to have a multidisciplinary team with the expertise required to identify the needs of the patient or citizen and develop a comprehensive approach. In theory this can avoid the fragmentation of care for patients with complex needs. Professionals in the same location and working in the same facility have more opportunities to meet and share information, and have a greater ability to influence and learn from each other.

The team does not always need to be fully integrated: in some models a professional with expertise in mental health care is included in the organisational structure so that expertise can be brought in where necessary. In a number of Belgium's neighbouring countries this approach is actively supported by the government.

The UK's National Health Service has introduced a new role in primary care: the primary care mental health worker (PCMHW). In practice these individuals have very diverse profiles (behavioural health specialists, care managers, clinical specialists in mental health care, mental health nurses, peer supporters; psychiatric social workers, psychiatrists, (clinical) psychologists, primary care psychotherapists, registered nurse advisers / practice support staff. These staff have varying backgrounds, training and experience and they are given different degrees of autonomy and responsibility.

Many GP practices in the Netherlands have a *GP practice mental health support worker*, abbreviated to POH-GGZ. The POH-GGZ can clarify questions, carry out diagnostics, prescribe short courses of treatment or provide (longer-term) support and guidance to people with mental health symptoms, or for a mild or stable chronic mental health disorder. The key factor here is the adaptability of the individual concerned and his/her self-management skills. The POH-GGZ is usually trained as a socio-psychiatric nurse, social worker or (junior) psychologist. The POH-GGZ is someone with knowledge and experience of mental health care. The POH-GGZ advises both the GP and the patient on possible ways of managing the symptoms and on the possible involvement of social workers, self-help websites, a psychologist or a mental health institution.

Source: https://www.trimbos.nl/kennis/poh-ggz

Reverse co-location

In the English health care system there is also the phenomenon of *reverse co-location* where a GP is co-located at a mental health institution, providing physical care for people with mental health problems.

In the United States, the SAMSHA-HRSA Center for Integrated Health Solutions identifies six levels of collaboration and integration.

COORDINATED CARE

Level 1 —Minimal Collaboration
Mental health and primary care professionals work in separate facilities and have separate systems. Health and social care providers rarely communicate. If communication does take place, this usually occurs because a care provider needs specific information about a shared patient.

Level 2 —Basic Collaboration at a Distance
Mental health and primary care providers have separate facilities and separate systems. Providers view each other as resources and communicate regularly about shared patients. This communication is usually driven by specific questions. For example, a GP may request a copy of a psychiatric assessment to find out whether there is a confirmed psychiatric diagnosis. Mental health care is usually viewed as specialist care.

CO-LOCATED CARE

Level 3 —Basic Collaboration Onsite
Mental health and primary care providers work together on the same site and may or may not share the same practice space. The care providers still use separate systems, but communication occurs more regularly due to their proximity, usually by telephone or e-mail, with occasional meetings to discuss shared patients. Movement of patients between practices usually takes place through a process of referral, which is more likely to succeed because the practices are in the same location. Care providers may feel that they are part of a larger team, but the team and the way it works are not clearly defined, so most decisions on patient care are taken individually by individual care providers.

Level 4 —Close Collaboration with Some System Integration
There is closer collaboration between mental health providers and primary care providers, due to co-location in the same practice space, and there is a degree of care integration due to the use of some shared systems. In a typical model, a primary care institution could integrate a mental health professional. In an integrated practice the primary care reception schedules all the appointments and the mental health provider can access and contribute to the medical record. In many cases discussion is required for complex patients with multiple health problems, and this can take place through personal communication. The more opportunities professionals have to share patients, the better their basic understanding of each other's roles.

INTEGRATED CARE

Level 5 —Close Collaboration Approaching an Integrated Practice

There is a high level of collaboration and integration between mental health and primary care staff. The various health care staff begin to work as a real team, with frequent personal communication. The team actively looks for systematic solutions because it recognises obstacles to the integration of care for a wider range of patients. Some problems, such as the availability of an integrated medical record, cannot be resolved immediately. Health care staff understand the different roles of the team members and they have begun to change their practices and the way care is structured in order to achieve patients' goals more effectively.

Level 6 —Full Collaboration in a Transformed/ Merged Practice

The highest level of integration leads to the greatest changes in practice. More intensive collaboration between health/and social care providers may allow the pre-existing system cultures (two separate systems or a single developing system) to merge into a single form of transformed or merged practice. Health and social care providers and patients see the operation as a single health care system that treats the whole person. The principle of treating the whole person is applied to all patients and not only to certain target groups.

Source: https://www.pcpcc.org/sites/default/files/resources/SAMHSA-HRSA%202013%20Framework%20for%20Levels%20of%20Integrated%20Healthcare.pdf et https://napavintners.com/community/docs/Mental-Health-SAMHSA-integration-model.pdf

Support, teaching and training

Some action strategies focus on improving the knowledge and skills of primary care staff. This is not done simply on an ad-hoc, random basis, but systematically: adequate training, supervision and emotional support are all important to ensure that staff can take responsibility for people with a psychological vulnerability or addiction and provide the support they need. The underlying idea is that non-specialist health and social care providers work better and more effectively when they are supported, without actually being specialist health and social care providers.

In a 'consultation-liaison' role, the liaison person is intended to support non-specialist health and social care providers: the underlying idea is that there should be regular contacts between a psychiatrist and the primary health care staff, so that consultation between the psychiatrist and primary care staff occurs before automatic referral to specialist mental health services. When a decision is made to refer, contact is maintained and feedback is provided to the primary care team. The way in which the liaison role is delivered (and funded) varies considerably between health care systems. In Belgium, for example, consultation-liaison psychiatry is structured around the relationship between a general and psychiatric hospital but there is no structural link to primary care.

A FEW GUIDING INSIGHTS FROM THE LITERATURE

A number of key insights can be distilled from the literature.[1]

Developing collaboration and collaborative relationships between primary care and mental health care does not happen by itself. There is a need for adequate incentives and it takes time to learn to collaborate. Attention must also be devoted to providing support and coaching for these activities. More substantially, a distinction must be made between system-related collaboration that is initiated on a structural basis (through regulation and funding) and ad-hoc project-type initiatives (which are often pilot or project initiatives).

Co-location and interdisciplinarity in primary care appear to offer significant added value, both for citizens and patients and also for health and social care providers. They foster accessibility and create more opportunities for dialogue and mutual learning, while also being less stigmatising for service users.

Collaboration *in itself* does not offer any guarantee that knowledge and skills will be developed in the area of managing mental health problems. Learning skills takes additional effort and attention, and there is a need for incentives to promote mutual learning and support.

Training in mental health for non-specialist primary health care staff is an effective strategy to achieve improvements in the management of mental health. It not only impacts the knowledge base but also significantly influences attitudes and beliefs. For non-specialists, it also contributes to the acquisition of basic confidence in recognising and managing mental health problems.

More initiatives and insights will be needed to take a more systematic approach to what has been learned, possibly with additional support from guidelines. Teaching and training in which representatives of the various sectors are able to interact *actively* will make it easier to move towards shared ways of working. This is because the actors are already on board with the process during their training.

Support for initiatives targeting a shared approach and greater integration can provide significant incentives to not only talk about the principles and insights but also to make them work in practice.

Innovative approaches have come into being internationally as a result of small-scale local projects, and a lot can be learned from these. There comes a point, however, when scaling up experience and building sustainability require a 'systemic framework'. Support from the government (through regulation and funding) can play an important supporting role in harmonising mental health care and primary care. Research is needed into the ways in which the two parts of the health care system can relate to each other in stepped or matched care approaches, to move both parts of the system away from compartmentalised approaches. When this is done it will be vital to monitor the specificity and boundaries between the expertise and competencies of the various actors involved. This must be achieved without making the process more bureaucratic and therefore less effective. The aim is to have a process with clearly agreed roles, where there is space to develop approaches tailored for the local context. Systematic government incentives to promote collaboration and integration are still being implemented too slowly, but these incentives are needed in order to scale up and evolve towards structural and sustainable ways of working.

1 See also Health London Partnership (2017) Informing the development of models of primary care in mental health https://www.healthylondon.org/wp-content/uploads/2017/10/Scientific-literature-review.pdf

Governments can play a crucial part in the development of a vision and programmed approach, with clearly defined concepts, goals and action boundaries for the various actors.

Participative ways of working in which all the formal and informal actors involved (including clients themselves and their immediate networks) work together interactively, are most effective. This interaction involves working on shared goals and will make it easier to define agreed roles more clearly. It is then possible to have a comprehensive view of the resources that are available.

Without resorting to excessively formal rules and procedures, projects must pay attention to agreements on the roles and responsibilities of all those involved in the process. If there is no communication in these areas and agreements are not made, there is a risk that too little will happen or that the situation will become unclear. Discussion of these agreements can also focus on the knowledge and competencies needed by the various actors involved.

When efforts are being made to integrate mental health services and primary care, there is a need to work on a shared steering mechanism. This will allow effective coordination and harmonisation, mainly to ensure coherence between the ways of working in the two sectors.

The literature frequently mentions the importance of process and impact evaluation for the purpose of continuous improvement. These evaluations are not an end in themselves or a mechanism for imposing sanctions. Their aim should be mostly formative, to foster collaboration and integration in the interests of society. Generally, the view is that too little systematic attention is paid (internationally) to developing initiatives for systematic evaluation of the existing barriers and of the conditions that could make it easier to improve impacts for both health and social care providers and clients, with the aim of moving towards sustainable ways of working.

02

EXAMPLES

UNITED KINGDOM

The organisation of mental health care in England is coordinated by the *National Health Service* (NHS), a public health care system that is free of charge for its users. In most cases the policy is that a referral from a GP is required in order to access mental health services, but in some cases patients and users can also contact mental health services themselves. The policy in England has a strong focus on *community mental health care*. The NHS policy has promoted local approaches in recent years (also in terms of governance and the use of financial resources). This is intended to improve the accessibility and efficiency of the system. As the public sector organisation in this context, the NHS focuses on innovation and change in the organisation of mental health care, including incentives for collaboration. A number of initiatives have come into being in this context.

Co-location and integration: integrated community care and mental health in Lambeth (South London)

In the South London borough of Lambeth, it was decided in 2018 to carry out a fairly fundamental reorganisation of the local system for accessing and using mental health care. This involves people with mental health problems being supported jointly from primary care. The structural reform focuses on using clinical pathways for a rapid response in crisis situations in the context of the general UK-NHS *Integrated Personalised Support Alliance* (IPSA) programme.

A telephone help line is provided (*SLaM 24 Hour Mental Health Support Line*) and an *Out of Hours Peer Support Service* staffed by people with lived experience. This is intended to help people who are experiencing a crisis when other services are not available. The *Patient Advice and Liaison Service* (PALS) provides free information, confidential advice and health-related support for patients, families and their carers. This service provides information and advice on health services including hospitals, GP practices and other community health services.

In 2010 the *Lambeth Living Well Collaborative*[1] was set up. This is a platform consisting of primary care staff, service users, informal and formal health and social care professionals, in collaboration with the local authority. The platform is explicitly intended to engage in consultation and help to shape the care provided locally, particularly for people with severe and enduring mental health problems.

This approach is being adopted simultaneously with the phasing out of an obsolete psychiatric hospital and the transition to a new hospital on a different site. A public participation process has been set up to discuss the impact of closing and moving the hospital.

This platform has been working on a *single point of access* as a way of finding suitable care, which is coordinated by GPs. There are three *Living Well Centres*, which focus specifically on mental health care. The centres employ a multidisciplinary team of health and social care providers consisting of a psychiatrist, nurses, (psycho)therapists, social workers, people with lived experience and local volunteers and neighbourhood workers. The activities are designed to provide short-term support for people with relatively mild or moderate mental health needs and for a target group of individuals with very severe and intensive care needs.

The idea behind setting up these *centres* is to improve the accessibility and integration of care. In addition to the centres there are also active mobile teams in the community, a telephone help and support line and an outreach team comprising neighbourhood workers and volunteers who can provide localised support.

The neighbourhood has created the *Treehouse* (*a 24/7 supported 'step forward' house*) to receive and accommodate people on a temporary basis. The neighbourhood is also continuing with its structural work on supported living initiatives.

1 https://lambethtogether.net/living-well-network-alliance/about/

An evaluation study[2], which included a health economic evaluation suggests that the results from this integrated model are promising.

The key lessons were that for a large proportion of users, the work of the 'hub' means supporting them on their road to recovery. Through the centres people have succeeded in reducing the number of people who have needed referral to more expensive specialist services, by adopting a more integrated approach. The new, integrated approach also makes it possible to support users in a number of different areas. This aspect is very highly valued because it means that users themselves have learned to take more responsibility and find their own way. In societal terms, the services are used by the whole spectrum of the population based on demographic, cultural and socio-economic characteristics. In other words there is no selectiveness in the services that are provided.

Collaborative care: co-location and integration: Sandwell PCT

Sandwell is an area of England's West Midlands conurbation characterised by socio-economic disadvantage (high unemployment and high cultural diversity (black, Pakistani or Indian origin etc.) and significant numbers of homeless people. Action was taken in 2006 in response to the realisation that the interactions between primary care and other (mental) health services were too fragmented or that people with mental health problems were often being referred incorrectly or inappropriately from primary care. It was noticed that GPs and primary care had too little knowledge of suitable services, or the services they were referring to did not respond appropriately when receiving referrals.

In the context of reforms of the *National Health Service* a C*ollaborative primary care model for wellbeing* initiative was created. Its founding principles were co-location, integration and collaboration[3].

Mental health care and primary health care services were brought together on a single site for people with mild to moderate problems and also for patients with serious psychiatric problems. One significant idea behind the co-location was to help to reduce stigma. Organisationally, co-location was accompanied by the integration of primary care and mental health budgets. This made it possible to ensure that it was made clear which mental health treatment and support was part of primary care and what is referred to locally as *low intensity and wellbeing services*, and which forms of care should ideally be reserved for more specialised mental health care services. Alongside the integration of funding and budgets, a collaboration model was also put forward for mental health in general and for specific problems such as alcohol misuse, dementia and perinatal mental health.

Shared care protocols and integrated clinical pathways are being created for well-defined target groups. It was immediately made clear that these had to be implemented in a non-rigid, flexible way, with special efforts to ensure consultation with clients and allow them to participate. Priorities and ways of working had to be matched to local needs (for example there was scope to address the mental health needs of the LGBTQ population, psychological problems affecting people with hearing impairments, people of Pakistani origin with specific mental health needs etc.)

2 zie https://www.lambethcollaborative.org.uk/wp-content/uploads/2019/01/ENC-2-LWN-Hub-Evaluation-Presentation-Year-3-19.12.18.pdf et https://lambethtogether.net/wp-content/uploads/2020/11/201112-Lambeth-Living-Well-Alliance-Progress-Report-FINAL.pdf

3 https://www.nhsconfed.org/-/media/Confederation/Files/Publications/Documents/Case-study-report-on-Sandwell.pdf

In these reforms, the organisation of the various services was structured in a stepped care model. The aim was for basic care to be provided through self-care and in primary care, while more serious needs always went to specialist services. The route back to primary care was also made easier when the client's condition permits this. The purpose of *low-intensity services* is to allow clients to be supported to engage in self-care at the earliest possible opportunity, while also being helped and supported to deal with their psychological vulnerability and improve their emotional resilience. A central online and telephone contact point was created for mental health problems (*a Sandwell wellbeing hub*). The 'hub' follows a holistic approach based on primary care and community care, with the aim of improving social, mental and physical health and well-being in Sandwell. A well-being coordinator is responsible for coordinating a number of services for people with more serious problems. The model used for those with more complex needs involves clinical supervisors who seek to work alongside well-being coordinators to provide support for patients who contact the service.

The 'hub' uses a single shared referral form, making it possible to know what services are available and their patient's possible risks. A similar form has also been developed for referrals to secondary psychiatric care, which has a single point of access.

Efforts have also been made to support primary care and low-intensity services through teaching and training.

The work of the *Esteem* is coordinated with the 'hub'. The *Esteem* team aims to support people with mild to moderate psychological disorders and complex social needs at an early stage. The aim is to prevent deterioration and referrals to secondary care. It seeks to enable patients to take control of their own lives through guided therapies and through self-help resources. The team itself consists of six link workers (people with lived experience and social workers) who coordinate the care. These act as 'navigators' for patients through the health and social care system (for example social services, debt advice agencies, counselling for drugs misuse, therapeutic services, peer support groups etc.). The *Esteem* team targets care packages to patients' needs and for this reason it relies strongly on relationships with other services, including volunteers and self-help groups. The patient is never left unsupported: if a therapy or care intervention is unsuccessful, they are encouraged to try a different service via the *Sandwell Wellbeing Hub*.
The care coordinator refers to the new service so that patients cannot 'get lost' within the system. This is different from the standard practice in which a patient has access to a specific number of therapy sessions and then has to seek a new referral from the GP once these have ended or if their condition has not improved.

Online mental health community: Big White Wall developed into Together All

Big White Wall is a digital platform and a digital community that supports its members to organise their own care together with and with guidance from care providers and people with lived experience. It offers a range of therapeutic interventions:

- 24/7 clinically moderated services and access to the community
- Incentives for creative self-expression
- Forums for exchanging ideas and maintaining social contacts
- Group support and therapies
- Resources for self-care in relation to psychological problems
- Peer support networks
- Online one-to-one therapy via webcam, audio and instant messaging with experienced counsellors and therapists

IRELAND

In Ireland a process of reflection has been going on for two decades now and policy documents have been written on the collaboration between primary care and mental health care. The policy document *Vision for Change*[1], which dates from 2001, identifies a 'central role' for primary care in the provision of mental health care. GPs are easily accessible to citizens and preparatory research showed that citizens are more willing to address mental health problems with their GP than to present to specialist mental health services.

This is why GPs and primary care centres are identified as 'gatekeepers' for early detection, treatment and support. *Vision for Change* also states that people with long-term psychological problems are at greater risk from physical health problems and that GPs therefore have an important complementary role in regard to somatic care within this group. The policy vision explicitly focuses on in integration and collaboration.

It includes calls for a model of consultation and liaison between primary care and mental health care and states that everyone should have access to a wide range of interventions in primary care for psychological problems that do not require specialist mental health care. The programme also addresses the importance of teaching and training and other forms of support for primary care in the area of mental health.

Ireland does, however, face tensions between theory and practice: progress with implementing the vision behind the policy document has been difficult in practice. The success of accredited teaching and training programmes for primary care staff has also been limited due to the small number of participants. Based on these observations, a policy document was therefore released in 2006 to give a concrete shape to the principles set out in *Vision for Change*, according to the concept of *shared care*. Once again, major debates ensued.[2]

1 https://www.hse.ie/eng/services/publications/mentalhealth/mental-health---a-vision-for-change.pdf

2 For a discussion of this, see https://www.mentalhealthreform.ie/wp-content/uploads/2013/07/Mental-Health-in-Primary-Care-in-Ireland1.pdf

SHARED CARE

Shared care is a model that was originally developed in the context of chronic care (particularly for diabetes) in which primary care doctors and specialist doctors work together to outline a care plan for and with a patient on the basis of their needs.

The type of organisation can vary (NB: this does not take into account differences between health care systems):

- **Community clinics:** specialists visit or run a facility (clinic) in primary care. The communication is informal and takes place on site in a multidisciplinary team meeting with both specialist and primary care team members. In the basic model, a specific system is set up for regular communication between specialist care and primary care, but more intensive and advanced variants are also possible.
- **Liaison:** this meeting is attended by specialists and members of the primary care team, who discuss and plan the ongoing treatment of patients within the service.
- **Shared care record card:** a formal technique or method of sharing information. The card is kept up to date by the client.
- **Computer-assisted shared care and electronic mail:** an ICT-supported record system brings together all the activities and information that are relevant to the support and treatment provided for a client. The system can be accessed by mental health providers and primary care staff. The system may also include a function to maintain contact with the client, providing follow-up and inviting them for regular appointments.
- **Shared care systems:** other 'systems' for developing shared protocols, referral guidelines, teaching and training, information exchange systems which are all intended to support the provision of support for clients in a structured and collaborative way.

A *Guidance Paper*[1] from 2011 on 'a shared care approach to primary care and mental health care' advocates for shared care and includes recommendations on implementation. Although this document is not the formal policy of the Irish government, the document calls for the setting up of consultation liaison functions, co-location, working with a team coordinator who has a link role, teaching and training for primary care staff, regular meetings between primary care services and the active use of *community mental health teams* who develop integrated activities with primary care. The guiding principles are collaboration, improved information exchange also in the form of regular gatherings and meetings with primary care staff, *community mental health teams* and specialist services. Organisationally, efforts are also being made towards co-location of different centres. As in many other English-speaking countries, the design and way of working are based on the stepped care approach.

In Ireland's four health regions, initiatives have been rolled out since that time for co-location or *community mental health centers* based in the immediate vicinity of primary care facilities.

Source: http://www.tara.tcd.ie/bitstream/handle/2262/79599/Smith_et_al-2017-The_Cochrane_Library.pdf?sequence=1)

Liaison support: East Cavan Primary Care Liaison

The *East Cavan Primary Care*[2] *Liaison Service* was set up in five GP practices. From 1995 to 2002 the psychiatrist, a psychiatric trainee and a community psychiatric nurse visited the five practices about once every six weeks. At these meetings patients were discussed in detail. (The patients themselves were not present.)

Evaluation of these activities showed that patients were referred less frequently to specialist mental health services (and only for serious disorders). The ability to work within a primary care facility also had a significant effect on reducing stigma so that mental health problems can be discussed and addressed. In that sense this way of working also improved the accessibility of mental health care. It was also reported that this way of working had a positive impact on the use of emergency services for people with psychological problems in the area.

Important lessons were learned about collaboration:
- Primary care staff and mental health staff approach patients in different ways.
- The discussion and approach often ran into difficulties due to a lack of administrative support.
- The use of trainees during consultation / liaison psychiatry requires trainees to receive better support and training.
- The psychiatrist needs to have appropriate skills to communicate and have discussions with GPs.
- The way of working and the liaison consultations model needs to be adapted in line with the differences between urban and rural areas.

It was also reported that the initiative was very vulnerable because it was strongly dependent on a single person, a committed psychiatrist who strongly and enthusiastically supported this new working method. When that person left the region, this had a significant negative impact on the concrete roll-out and experienced usefulness of this liaison function.

One significant hindrance to the implementation of *shared care* that has been reported in Ireland is that there is less primary care provision in underprivileged communities where mental health needs are sometimes highest. As a result it is not possible to ensure that the same level of service is equally accessible to the population. This is precisely also the target group that points to financial barriers to access.

1 https://www.hse.ie/eng/services/publications/mentalhealth/advancing-the-shared-care-approach-between-primary-care-specialist-mental-health-services.pd

2 https://www.hse.ie/eng/services/list/2/primarycare/pcteams/cavanmonaghanpcts/cavanapct/

Counselling in primary care and the Stepped Care Approach (CIPC): Roscommon

This is an initiative in which five primary care staff supervised by a psychologist from the mental health facilities provide low-intensity psychological treatments and support rather than making referrals to more expensive specialist psychiatry.

Counselling in primary care is available for adults aged over 18 years with mild to moderate psychological and emotional problems (depression, anxiety, panic reactions, relationship problems, bereavement and stress).
Eight counselling sessions are offered with an accredited counsellor/therapist. *Counsellors*/therapists use a series of psychological therapies depending on the clients' problems and needs. Counselling approaches comprise person-oriented, cognitive behavioural therapies, psychodynamic, integrative and supportive therapies.

The initiative is being set up in collaboration with the organisation APSI (*Access to Psychological Services Ireland*). The range of psychological services provided in consultation with primary care includes:

- Guided self-help (GSH): an individual is supported for four to six weeks using leaflets and worksheets and both telephone and face-to-face contacts with a professional.
- Group activities: groups (e.g. a stress management group) with a maximum of 12 members attend group sessions of 1.5 hours for 7 weeks, facilitated by two mental health providers.
- One-on-one short cognitive behavioural therapy courses of six sessions for people with a diagnosed clinical need.
- Online supported cognitive behavioural therapy (cCBT): videos and teaching material are made available. Clients are expected to work through the course over four weeks.

1 https://www.mentalhealthreform.ie/wp-content/uploads/2018/04/Mental-Health-in-Primary-Care-in-Ireland1.pdf


FRANCE

In France the question of coordination of care and collaboration between primary care and mental health care is on the policy agenda[1]. Agreements in principle have been concluded in this area for a partnership between GPs, primary care and psychiatry. Recommendations have also been made to improve collaboration and coordination through quality councils and national consultation groups. Principles have been established on who is the responsible treatment provider and how to manage monitoring of comorbidity, as well as principles on information sharing and mutual accessibility by telephone, the way in which care is delivered at the patient's home by their GP and the mental health team, how primary care expertise and training are provided, and how 'mirror' training with psychiatrists and GPs can be put in place to promote mutual learning. The policy framework for modernisation of health care (law no. 2016-41 of 26 January 2016) focuses on the importance of coordination when developing territorial mental health projects (PTSM in French). France is also seeking to bridge the gap between guidelines and principles and implementation in practice.
The initiatives in France are also often set up on a local, ad-hoc basis.

1 https://www.has-sante.fr/upload/docs/application/pdf/2018-10/guide_coordination_mg_psy.pdf

Building knowledge and learning from each other

In Paris (13th and 5th arrondissements) an initiative has been started to engage in multidisciplinary consultation and case analysis with psychiatrists and GPs from the community. Two types of meetings are identified:

- Clinique psychiatrique en médecine générale [clinical psychiatry in general practice] meetings: these are chaired by psychiatrists and provide opportunities general knowledge sharing with GPs about psychiatric presentations and symptoms: sometimes these are based on cases.
- A different type of meeting, the Staffs Psy [psych staff meeting] allows GPs to discuss their own cases and experiences in detail and draw up a plan for individual patients together with the psychiatrists.

Consultation-liaison and co-location: Centres de Santé

A 'Multidisciplinary health centre' (*Maisons de Santé Pluriprofessionnelles*, *MSP)* is a type of facility in France where different disciplines (doctors, nurses, physiotherapists, psychologists etc.) provide care from a single location (the health centre or "house"). Initially these facilities were mostly introduced in rural areas, in regions facing shortages or with a low density of various types of care providers.

- In Saint-Nazaire (Loire-Atlantique), consultations spécialisées de psychiatrie en MSP [specialist psychiatric consultation in the multidisciplinary health centre] are provided in these health centres by specialist staff who come along to improve the treatment of people with psychological problems.
  The aim is that these consultations should improve access to specialist psychiatry or mental health care.
- In Lille (Equipe de psychiatrie du secteur 59G21 de l'Établissement public de santé mentale (EPSM) [Psychiatry Team of Sector 59G1 of the Public Mental Health Team] in Lille-Métropole) a consultation agency for mental and psychological health, has been in existence since 2001 and is integrated within a group practice with six GPs. Consultations are provided and based on experience from co-location this brings about direct discussion and dialogue between psychiatrists and GPs. There are opportunities to move towards shared ways of working, action can be taken faster to deal with acute problems requiring a multidisciplinary approach and the structure encourages psychiatrists and GPs to learn from each other.
- Similar initiatives have been described in Yvelines (in the Paris region), Cretail, and in Toulouse, where psychiatric nurses, psychiatrists and a psychologist are available to support GPs. In Yvelines the patient is actively involved in a shared care approach.
  The patient is always contacted by the psychiatric nurse first to investigate whether and how support and guidance can be provided. It may be possible to consider the involvement of members of the patient's family or network. After the shared consultation(s) the GP retains responsibility for managing the patient.
  Follow-up to this initiative has shown that GPs were positive about the collaboration and this way of working if they were not able to make a diagnosis or if were uncertain about it. It created an opportunity to design a treatment plan together (including medication) or assess whether more specialised patient follow-up was necessary and who would provide this.
  In a limited number of cases, however, it was also reported that there was a difference of opinion between the psychiatrist and the GP, which was sometimes confusing for the patient.

Early detection and intersectoral case management and the integrated approach:

SAMSAH Prépsy[1] (Paris) is an early detection project that works on the basis of case management principles and focuses on young adults (18 to 25 years) with symptoms. This initiative has developed from an intersectoral collaboration and it is seeking to set up an integrated management process. The goal is to limit the risk that disorders will develop into serious problems.
This is done by providing specialist, coordinated support, with an approach that promotes the user's autonomy. The service analyses the needs of young adults in various areas of their lives and estimates what role the social network could play. SAMSAH works via case management to provide support and guidance and is responsible for coordinating care for the young adults. It focuses on collaboration and on integrating the work of primary care staff with each other and with other actors from welfare, leisure, the employment market and cultural sector.

The SAMSAH Prépsy team consists of a psychiatrist, a GP, a doctor responsible for the information system, a psychologist, nurses, nursing assistants, teachers, an administrative worker providing coordination and an integration specialist. It supports 40 users.
The service is funded by the General Council of the city of Paris, ARS Île-de-France, the Regional Council of Île-de-France and Fondation de France.

Walk-in centre for self-help groups and people with lived experience: La Trame

La Trame is a platform in the Paris Saint Denis district, which was set up in 2019 by the association *A Plaine Vie en Mutuelle La Mayotte*. The project is supported by the Caisse Nationale de Solidarité pour L'Autonomie (CNSA) and the Fondation de France, which had run calls for projects to support people with mental health problems.

The platform is the result of collaboration between self-help groups. The goal of the project is to promote inclusion, individual support and reducing stigma for people with psychological disorders. Another aim is to facilitate access to social entitlements and care. Families and carers are actively involved, but people with lived experience and peer-help are also key.
The project is run from a single location with a team of four professionals and 15 volunteers. The professional team supports people who are not receiving any care support or have no links to the local mental health care network.

They make radio programmes that give a voice to people with lived experience, with weekly or daily reports on events and activities (*Bruits de couloir, une expérience radiophonique au sein du GEM de Saint-Denis*).

No evaluations were found on the impact of this project.

1 G Gozlan chapter 25 Le SAMSAH Prépsy, une intervention médico-sociale précoce par le case management pour les jeunes avec schizophrénie https://www.elsevier.com/fr-fr/connect/psy/le-samsah-prepsy,-une-intervention-medico-sociale-precoce-par-le-case-management-pour-les-jeunes-avec-schizophrenie
G Gozlan Améliorer la coordination dans le champ sanitaire et médico-social pour limiter le risqué de handicap psychique. Étude du cas Prépsy. Gestion et management. Université de Versailles-SaintQuentin en Yvelines, 2015. https://tel.archives-ouvertes.fr/tel-01236499/document

Socio-economically vulnerable groups: PASS Psy (Permanence d'Accès aux Soins de Santé en Psychiatrie) [Psychiatric Care Access On-call Service] and Equipes Mobiles Psychiatrie Précarité (EMPP) [Mobile Teams for Psychiatric Risk]

PASS is a generic legal system in France that focuses on vulnerable at-risk populations who often fail to access care, treatment and support. These are medical and social support teams that aim to facilitate access for poorer people. PASS Psy is an intervention that is mainly intended to give adequate support to people in vulnerable situations with complex problems and psychosocial needs.
This should help them access psychiatric, psychological and social help and ensure that they do not become victims of social exclusion. Many of these teams were originally set up within psychiatric hospitals, but they are certainly not restricted to hospital-based activities.
The interventions follow an integrated approach, with support provided involving a diverse range of actors, including mental health care, social welfare and primary care, with a focus on care coordination. The approach also goes further, with local efforts to develop a sustainable network of partners with structural collaboration who share experiences relating to this at-risk target group.

Every PASS Psy-team includes social workers, nurses and GPs or other doctors and works from a single site or from the *Santé Mentale et Exclusion Sociale, SMES [Mental Health and Social Exclusion]* offices.

Most PASS Psy teams were initially implemented in urban areas. In practice the team mainly works on an outreach basis, and frequently intervenes in crisis situations. Thanks to their approach, the teams are successful in tracing and picking up homeless and insecurely housed people, as well as socially vulnerable people who have experienced migration and are at risk of falling through the social safety net. That does not mean that people in these groups no longer face problems.

The EMPPs can be seen as complementary to the PASS Psy. These teams have been set up to "*provide better support for the mental health needs of people suffering from economic vulnerability and social exclusion (through) creation of mobile teams specialising in psychiatry that are integrated in a coordinated overall system. EMPPs are responsible for promoting access to care for these groups*". EMPPs have to be incorporated in *Programmes Régionaux d'Accès à la Prévention et aux soins (PRAPS) [Regional Programmes for Access to Prevention and Care]*, partly to prevent social problems being 'psychiatrised'. They have a bridging role between primary care, social welfare, social entitlements etc. The role of the EMPP is to go to the person themselves and their focus is preventive. They target a group of people who are not finding managing to access care and welfare, particularly in remote parts of France. They also maintain a presence in facilities or infrastructure sites where economically vulnerable people sometimes get in contact (crisis care centres, day centres for homeless people etc.) and they also have the explicit mission of acting as a link between different professionals and facilities to respond to the needs of their target groups[1].

1 An explanation of their work involving 14 teams in OCCITAINE is described in https://hal.archives-ouvertes.fr/hal-02160432/

THE NETHERLANDS

The Netherlands is focused on improving outpatient mental health care and reducing the number of beds.

In the Netherlands, mental health care is organised on the basis of a stepped care approach. Since 2014 mental health care was restructured by the government into a three-tiered system:
1. The GP with a practice mental health support worker (POH-GGZ)

2. Public basic mental health care

3. Specialist mental health care

This primary care service is quickly and easily available to the public. Primary care providers are able to get advice from specialist mental health care institutions. The GP has the gatekeeper role and refers patients to public basic mental health care and specialist mental health care when needed. If the mental health problems are not resolved after treatment in basic mental health care, or if the problems are more complex or serious in nature, the GP can refer to specialised (specialist) mental health care. This type of care is intended for treatment of serious and complicated psychological disorders. These treatments are usually more intensive. There has to be a suspected DSM-classified psychological disorder for a patient to qualify for reimbursement for their treatment by mental health care services. Admissions, stays in a mental health care institution and crisis care also come under specialist mental health care.
Patients can be referred to highly specialist mental health care for very specialised diagnostic tests and treatment, innovative and experimental treatments and for a *second opinion*.

Alongside these organisational principles, the Netherlands has also been focusing on innovations.

Support by staff: practice mental health care support worker (POH-GGZ)

Since the reforms focusing on outpatient care and the role of basic mental health care there has been a systematic focus in the Netherlands on having a mental health practice support worker to support GPs (POH-GGZ). The role of the POH-GGZ is still very much under development. Not much is known so far about the effectiveness and efficiency of the assistance provided by the POH-GGZ, nor whether differences between practices in the way the role is organised play a part in this. A study is being carried out to find out more about this.

Programme to reduce stigma in the Gestel district of Eindhoven

The municipality of Eindhoven and GGzE together with *Mental Health First Aid* (MHFA Nederland), the Trimbos institute and the Phrenos Knowledge Centre have set up a project to deliver a course entitled 'First aid for mental health problems' to improve understanding and support for people with mental health problems. It is hoped that the course will also help to reduce the sense of a lack of safety in the Gestel district. The course is part of a wider programme to reduce stigma. During the October 2018 to October 2019 period, six MHFA courses have been run, with 76 attendees in total.

A participative project has also been implemented with support from a partner organisation, involving local residents, scientists and people with lived experience to develop a vision of 'a welcome community'. This participation progress has led to requests to focus on general inclusion ('Everyone belongs!') and not only activities aimed at reducing stigma around people with a psychological vulnerability.

The process resulted in a stepped plan entitled a 'Route map to reducing stigma in the Gestel district' and provides an overview of more than 55 interventions that can be used to build an inclusive community. These interventions include films, plays, theatre festivals, workshops, radio stations, gardens and restaurants, courses etc.

A number of lessons have been drawn from an evaluation of this.[1]

- Although a considerable effort was made to recruit residents and entrepreneurs for the courses, their reach was smaller than had previously been expected, and residents originating from other countries were under-represented. Possible explanations for this are that they are not being reached via the existing channels or that they do not take part because they do not have a good enough command of the language, since the course involves a lot of language. The other target group, local entrepreneurs, were hardly reached at all. Although they were interested in the course, they found the time investment too great to take part.
- Most of the attendees were satisfied with the structure and content of the course. The alternation between theory and exercises, film clips and role play was particularly appreciated. The attendees were also positive about the trainers. Although some of the attendees felt that the programme was quite 'full', they could not refer to specific components that they found less helpful. Most of the attendees would not have taken part if they had to pay for the course themselves. A number of points for improvement were put forward. It is not always clear to the attendees which organisations in the Eindhoven municipality people can contact to receive care or support. They also referred to the importance of follow-up to the MHFA course.

1 https://www.trimbos.nl/docs/5dd4ce69-db5f-4419-8124-b9c7df16a3ea.pdf

Examples of this include a (two-)yearly meeting with former attendees, making it possible to review the material, share experiences, practice skills and have more in-depth discussions.
– It emerged from the evaluation that the course helped the attendees to have a better understanding of (people with) mental health problems and to be more aware of their own prejudices. They were also given aids to recognising mental health problems and opening them up for discussion. Non-judgemental listening is particularly important. When asked whether they have (would) put what they have learned into practice, the attendees identified a difference between people they know (such as family and friends) and strangers. They said they would take action with people they know, but with strangers (for example on the street) it depends on the context: is it safe, are there others nearby etc.

Collaboration with a focus on social aspects: 'Well-being on prescription' (national knowledge network)

'Well-being on prescription' is an intervention that is closely related to what is described in the literature as *social prescribing/ prescription sociale*.

'Well-being on Prescription' (Dutch: WOR) is an approach put forward for people with psychosocial symptoms, in which the GP or other primary care professionals refer these patients to a well-being coach rather than treating them with drugs or medicalising the problem. The guiding principle is that symptoms like tiredness, stress, depression, anxiety and gloominess, and sleeping problems do not always have a medical cause but are linked to social or personal problems such as questions of identity, the death of a partner, loss of employment, loneliness and a limited social network etc. 'Well-being on prescription' is a form of integrated care in which primary care, social welfare and possibly mental health care all work together to deliver the right care.
A primary care provider can write a well-being prescription for patients with psychosocial problems that do not require any medical treatment or referral. The well-being coach works with the client to find out about their wishes, needs and opportunities. Since every individual is different And has different wishes and needs, this is always tailored to the individual.

There are a number of preconditions for taking part in this. The patient must give their consent, must have insight into themselves and basic insight into what they want and need, and needs to have adequate communication skills.
The referrer must clearly know the reason for referral and what the patient needs and must supply all relevant information. Processes must be agreed between the referrer and the well-being coach: it must be clear how the referrer expects to receive feedback and tasks must be agreed so that it is clear which tasks are the responsibility of the well-being coach. It also needs to be clear what 'Welfare on prescription' does or does not include. Activities must also be delivered locally and patients must be willing to join the local groups.

The well-being coach also considers together with the client whether any other service is required prior to or concurrently with the 'Well-being on prescription" pathway. This may include resolving financial problems, problems relating to safety and housing, or providing skills that are needed for the pathway. Active involvement shifts the participant's attention from the symptom or limitation to the activity that the participant enjoys. This has a direct influence on enjoyment of life, self-image and well-being in the broad sense.

Originally this was a pilot project, but it has now been rolled out further. It receives funding and support with its content from the National Institute for Public Health and the Environment. The well-being coach is funded by local authorities. In practice it is not yet clear how primary care staff should be funded for the extra work involved in this collaboration.

There is now a national 'Well-being on prescription' (WOR) network that allows for sharing of experiences.
In 2019 a *quick scan* of the programme was carried out.[1]
Since July 2019 WOR has been one of the focus areas within the preventive health policy of the Ministry of Health, Welfare and Sport.[2]

By 2020, Well-being On Prescription had been implemented in 83 municipalities in the Netherlands.
It is important to note, however, that the intervention has not been implemented in a standardised or uniform way in the various municipalities and it is not known which components of the 'Well-being on prescription' programme are essential to ensure that it is effective and efficient. A number of key points have been identified as success factors for collaboration. These can be recognised on the basis of findings from the scientific literature:

- Distinct roles and tasks for all the professionals involved, with clarity about their various responsibilities;
- A declaration of intent and/or collaboration agreement with the parties involved to safeguard collaboration;
- Low thresholds for contact, regular contacts and short lines of communication with well-being coaches;
- Personal collaboration with a known and trusted well-being coach;
- Prompt, well-organised exchange of information (e.g. also using a secure website);
- Feeding back and sharing experiences;
- Timely, consistent feedback;
- Structural consultation to discuss participants' progress on a case by case level.

The *quick scan* in 2019 also showed that it is not easy to sustain this way of working together. After an initial enthusiastic start-up, the approach is not developed further into a structural, intensive collaboration. Possible explanations for this are the workload of the GP practice, a fall in the municipality's motivation to continue investing in 'Well-being on Prescription' or the limited capacity of the well-being coach. One salient observation was that those referred to the Well-being on Prescription programme were mostly over 65 years old, and that very few municipalities have an active policy of focusing on younger age groups.

Mothers as a target group: Breakthrough project: Preventing Post-Natal Depression 2019-2020

A national project aiming to prevent depression among mothers, both prenatally and in the immediate post-natal period (2019-2021). This project is part of the 'Multi-year programme to prevent depression' (Dutch: MJP) run by the Ministry of Health, Welfare and Sport (VWS).
The aim is to improve awareness, reporting, discussion, referral and signposting to (preventive) interventions.
The purpose of this project is to improve collaboration between those involved in the perinatal period.

1 https://welzijnoprecept.nl/wp-content/uploads/2020/01/Quickscan_WelzijnopRecept_VWS_FINAL-1.pdf
2 https://welzijnoprecept.nl/wp-content/uploads/2020/10/Essentiele-bestanddelen-van-WOR.pdf

Symptoms of depression among mothers in the prenatal and immediate post-natal period must be reported in a timely way. Women with symptoms of depression must also be signposted and supported to receive the correct treatment or guidance. The project explicitly allows professionals to be supported through the creation of a care pathway. This care pathway involves a multidisciplinary team consisting of a doctor and a nurse both specialising in young people, midwives, maternity assistants, GPs and/or practice support staff.
A team is led by a coordinator. He or she is the project leader of the multidisciplinary team and is responsible in that role for providing guidance, encouragement, action and follow-up.

Teams from different organisation aim to use an improvement method (breakthrough method) in the context of a (temporary) collaboration to bring about concrete improvements.

This approach includes a focus on e-learning for patients via apps. The *WellMom* app is intended to enhance mental resilience and prevent and reduce symptoms of depression among mothers during the prenatal and postnatal periods. The *Loss* app is intended to increase the mental resilience of parents who have lost a child during or soon after pregnancy.

The programme is currently being fully rolled out and an evaluation study is not yet available.

Rapid access to support without taboos: @ease walk-in centres for young people

In the Netherlands *@ease* walk-in centres have been created in a number of cities. These are freely accessible for young people aged 12 and 25 years. *@ease* is the Dutch variant of the Australian *Headspace* initiative, which offers free low-threshold help and psychological support for young people. By recognising problems more quickly and working towards a solution, *@ease* aims to prevent the need for long-term care at a later stage. The walk-in centres are presented as a complementary service, intended to fill existing gaps in the care system and working according to different principles. Young people can walk in without an appointment, they do not have to pay and no records are kept. The organisation uses volunteers (often these are students during their training) and health care professionals (psychiatrists, paediatricians and psychologists) if the conversations reveal more serious mental health problems. The health care professional is physically present in the walk-in centre. The volunteers have all received training.

Similar initiatives have also been rolled out in other countries (such as Belgium, Denmark etc.)


ITALY

In Italy, the importance of integrating primary care and mental health care was added to the policy agenda quite recently. This may be because there were not many GP group practices and outpatient mental health care centres are highly structured and developed (although there are differences between regions) in the context of de-institutionalisation.
Historically GPs have worked on a very individualistic basis and made almost no use of support networks. There were also few government policies aimed at improving collaboration between primary care and mental health care.
Two regions stand out because active programmes have been created: the Emilia-Romagna region in 1999, and Liguria, where there has been a regional working group since 2010 strategically addressing collaboration between primary care and mental health care based on the principles of stepped care.

The way GPs operate in Italy is similar to Belgium. Patients are free to choose their GP and the majority of GPs work in solo practices.
Only younger GPs organise themselves into group practices.
Mental health care is provided by mental health care centres that work with multidisciplinary teams (psychiatrists, psychologists, nurses, social workers, physiotherapists etc.). These facilities are mainly responsible for treatment, care and support of people with serious psychiatric problems.
They are also designed as direct-access primary care facilities, and as a result GPs and primary care have not always had an important role in mental health care.

Consultation liaison function in Emilia Romagna

The consultation-liaison function is an initiative to improve collaboration between GPs and specialist care providers in mental health care and psychiatry, with the aim of allowing people with common and/or complex problems to be supported by primary care as well.

The Emilia Romagna regional health service was one of the first regions to encourage the implementation of psychiatric consultation services, including a focus on developing a collaboration model. In practice, three models of collaboration are identified in the region:

- Structured consultation-liaison service. Within the local CMHC a specific and specialist liaison service is set up for primary care, and staff are assigned specific roles for this purpose. This service acts as an interface with GPs (and primary care), supports GPs who provide psychiatric services and focuses on working with them to treat common, non-complicated psychiatric disorders. The model emphasises written information and the exchange of information by telephone, with face-to-face meetings when necessary. The model is mainly used in larger cities such as Reggio and Bologna. This way of working has contributed towards a clearer allocation of tasks between primary care and specialist mental health facilities such as CMHCs. The model is valued because it supports primary care providers in their work with non-complex, frequently occurring psychiatric disorders. The weak points are the cost of the service and the risk of bureaucracy due to the complexity of the model. When implementing this way of working there were major concerns around increasing bureaucracy and formality, which the interaction did not always promote.
- Group liaison/multidisciplinary team: direct contact between a psychiatric consultant and a GP to discuss treatment plans for patients with mental health problems, very often in a team context. In some situations the mental health care team appoints a 'liaison psychiatrist' for a specific region, who is supported by a liaison nurse. This way of working is intended to improve interaction and integrate different ways of working, through collaboration and consultation. Staff on both sides can learn through sharing problems within a team. Discussing patient cases collectively generates added value. In practice, however, this model of team-oriented collaboration is not developed very often. This is thought to be because of the effort and time that are required to develop it on a long-term basis.
- Spontaneous ad-hoc collaboration in small centres. This way of working is mainly seen in rural areas, and it is strongly reliant on personal, rather informal contacts between GPs and primary care. Consultation and liaison activities are not formalised, but these take place when needed.

The consultation-liaison function is delivered from mental health care centres: the team consists of various professionals (psychiatrists, psychologists and nurses). The aim is to provide specialist consultations in primary care at the request of the GP. The team then provides diagnostic and treatment advice, which is communicated (either in writing or by telephone) to the GP.
There is a built-in option for regular physical meetings between the liaison person and the GP for reflection and discussion on clinical cases (also providing opportunities for support and teaching). From experience, GPs are using this liaison function more and more, and they have retained ultimate responsibility for the care and treatment of the person with a psychological vulnerability.
It has also meant that the previous influx of clients (referred) to mental health care centres has reduced.

Experience in the region has also shown that it is not always easy in practice to organise these meetings on a permanent basis, because systematic and ongoing collaboration demands a large investment of time and commitment.

In addition to the consultation-liaison function, work has also been done on training and a *train the trainer* approach. Trainers were selected from primary care doctors (PCPs) and primary care professionals with knowledge and experience of mental health care. Psychiatrists were also selected with practical experience of collaboration with primary care.

The consultation-liaison function in Bologna is an integrated entity within the local CMHC and is intended to improve collaboration with GPs in the area around Bologna. The liaison function consists of a multidisciplinary team: consultant psychiatrists, psychiatry registrars, psychologists and nurses, who have all taken a specific training course to allow them to work together. Their explicit goal is to spend an average of five hours per week on their liaison work. The liaison person helps with diagnosis, recognition and clarification of symptoms, clarification of possible dysfunctional behaviour and support in formulating a treatment plan. For patients with more serious disorders, the liaison person can also provide a direct *counselling function* for individual patients.

Most of this activity is done by telephone, with face-to-face meetings only when necessary. Suggestions and reports are drafted by the liaison person and passed on to GPs in the form of written reports. Initially, patients and their families are not always actively involved in the liaison consultation. An advisory committee consisting of representatives of the CMHC and GPs has also been created by the city authorities to monitor the collaboration.

One interesting aspect is that some group practices in primary care have formed an active alliance with psychiatrists to provide consultations in primary care facilities for people with psychological problems (in other words, a variant of co-location).

Raising awareness: Radio Fragola

Radio Fragola is a radio station that has been running in San Giovanni since 1984, and which is accredited by the Ministry. As part of social communication and prevention programmes, radio is used to promote campaigns to combat stigma and social exclusion, testimonials are collected and there are initiatives to encourage collaboration with a wide range of actors in the area.

The team does not limit its activities to (web) radio. It is also involved in development of audiovisual and multimedia products and in the organisation of events such as *Frontiere dei Lunatici* in the Lunatico Festival. The organisation works with the *Nottingham Museum of Contemporary Art* and the *Reina Sofia Museum* in Madrid, to share discussions and experiences on reducing institutionalisation and on the relationship between art, culture and mental health. The organisation behind the radio station and the events also manages the archives of the former psychiatric hospital and helps to manage a sports school.

As part of the *La Piazzetta* social cooperative, it promotes integration for young people.

GERMANY

Historically Germany has had a highly fragmented health care system, with integration and harmonisation between sectors arriving on the policy agenda relatively recently. The system was very hospital-centric. There are explicit references in policy documents to the importance of GPs and primary care, including in day-to-day management of mental health problems. GPs are expected to identify patients with mental health problems, diagnose and treatment problems and refer to a specialist if necessary. In addition to primary care, patients can seek help from psychiatrists, approved clinical psychologists (for psychotherapy) or specialists in psychosomatic medicine (doctors who deliver psychotherapy).

For serious disorders, the majority of patients still end up in hospital, despite the pressure from policymakers to treat them as outpatients where possible. The way that facilities are currently funded does not really promote integration or collaboration. One example is the *Hamburger Modell für Menschen mit schweren psychischen Erkrankungen [Hamburg model for people with severe mental health problems]* which does involve working in an integrated approach. The Hamburg model is an integrated care model for people with serious psychotic disorders, people with schizophrenia, bipolar disorder and severe depression with psychotic symptoms. The core element is so-called *Therapeutic Assertive Community Treatment Team* (TACT). TACT is a variant of *Assertive Community Treatment* (ACT) which specialises in severe psychotic disorders. Generally there is relatively little focus on innovative approaches involving primary care.

Support for primary care: Nuremberg Alliance against Depression

In 2001 the *Nuremberg Alliance against Depression* (NAAD) was initiated as a trial project in the city of Nuremberg. The programme involves:

1 / collaboration with GPs to optimise diagnosis and treatment;
2 / public campaigns to inform the public about depression (through posters, leaflets and community events);
3 / collaboration with actors in the community (such as teachers, counsellors, priests, nurses, police officers and the media;
4 / and support for self-help groups and people with lived experience.

Evaluation studies have shown that integrated approaches of this kind have a significant impact on the management of depression and suicide. The insight gained from this includes the emphasis on an 'integrated' approach in which various different actors from different sectors are all actively involved.

The project has grown (partly thanks to initial European financing) to become the *European Alliance against Depression (EAAD) programme,* which has developed concrete guidelines and recommendations[1] on how to implement a similar programme.

Specific target groups: Heidelberg: walk-in centre for refugees with mental health problems

In Heidelberg a walk-in centre specifically for refugees has been opened within the reception centres for refugees and asylum seekers. Refugees with a mental health problem are its target group. The walk-in centre offers psychosocial support for refugees. The team consists of six professionals with expertise in psychiatry and psychotherapy from the department at Heidelberg University Hospital and the Institute for Medical Psychology. In its activities the centre also makes use of inter-cultural mediators. Since June 2019 the centre has been offering a surgery three times a week; previously this was only twice a week. The centre is able to offer consultations for about fifteen to twenty refugees each week. Each of these involves two members from the psychosocial walk-in clinic. The activities include clinical diagnostic tests, updating case documentation, counselling, providing treatment recommendations and making adjustments to psychiatric medication.

One major problem for this walk-in centre is that it is not sufficiently integrated with other facilities to allow it to organise follow-up care. While its way of working does make it possible to build a degree of trust and intercultural expertise, it is not certain what form the follow-up mental health care should take, although clients do say this is needed.

1 European Alliance Against Depression: How to implement a 4-level community-based intervention targeting depression and suicidal behaviour. Leipzig: European Alliance Against Depression (EAAD); 2016. http://www.eaad.net)

Support and cross-sectoral collaboration: Berlin: Versorgungsnetz der Psychiatrie Initiative Berlin Brandenburg (PIBB)

In Berlin (for Berlin and Brandenburg) there is an active network accredited in 2008 that coordinated care for people with psychiatric problems. It has come into being and works within the activities of the *Verein für Psychiatrie und seelische Gesundheit* (Psychiatry and Mental Health Association - VPSG). The staff of the PIBB include psychiatry and neurology registrars, paediatric and youth psychiatrists, psychotherapists, GPs, psychological psychotherapists and sociotherapists, occupational therapists and psychiatric nurses. The network works with hospitals to provide cross-sectoral care to the clients who use the service. It also works to improve communication and coordination between the members of the network and has the explicit goal of maintaining quality, for example by working on treatment pathways, setting up transition management, providing joint consultations on cases, providing uniform IT structures and documentation standards (for example an Internet-based communication, prescribing and accounting system), standardised quality management systems and (inter-disciplinary) quality circles (www.pi-bb.de).

Digital support for GPs: PREMA – e-Health-supported case management in primary health care (Hessen region)

The goal of the PREMA pilot project [2] is to support GPs to recognise depression and panic disorders sooner and more reliably, and to develop an appropriate treatment strategy quickly. This approach is intended to make GPs more effective in their role as a trusted person alongside patients with psychiatric disorders. Digital tools are made available for this, to support both diagnosis and treatment, including an *e-Health*-supported case management programme. The system is intended to support GPs so that they can make decisions on whether or not to refer.

This is a recent project that has only just started up and has not yet been evaluated.

2 PREMA – eHealth gestütztes Case-Management für psychisch Erkrankte in der hausärztlichen Primärversorgung - G-BA Innovationsfonds (g-ba.de)

Interdisciplinary collaboration: Netzwerk psychische Gesundheit (NWpG) [Mental Health Network]

Although this is not strictly an example of integration of mental health care in primary care, this initiative focuses on intersectoral and interprofessional collaboration. It is controlled by insurance companies and has been designed as a *managed care* approach. The purpose of the network is to provide people with psychiatric disorders and their family members with a comprehensive, high-quality range of outpatient treatment and care options ('treatment at home') to foster self-reliance and independence, as well as social participation on the part of those insured, increase their capacity for self-help, relieve the burden on family members and replace or at least significantly reduce the duration of stays in residential care. The intention is that those who are insured should be able to remain in their own social and professional context and should be stabilised there. The project works on the basis of *recovery* principles. It aims to deploy a network of professionals around the patient to provide treatment, care and support (GPs, neurologists, psychiatrists and psychotherapists, outpatient care, social therapists, home and family assistants, service providers and outpatient clinics of psychiatric institutions (PIAs) and hospitals). A coordination point is provided as a kind of variant of case management.

There are no evaluations available so far on the impact of this way of working.

GERMANY

SPAIN

In 2006 a new policy framework was introduced for the organisation of mental health care, with a strong focus on outpatient care and integration in society. In view of the country's specific history (combination of dictatorship and a history of anti-psychiatry), the situation there is not perfectly comparable with developments in other European countries.
Briefly, there has already been a focus on primary care, continuity of care and integration for many years. In 2007 a strategic policy framework was developed for primary care. Later this was further emphasised in a policy framework for chronic disorders (2012) which confirmed the role of primary care.
Work is being done in a number of regions on so-called integrated care regions, where collaboration and harmonisation are the main focus (the Basque region and Andalucia are frequently cited as examples).

At the same time, however, the country is facing significant regional differences in terms of organisation and available resources. Collaboration and integration between different sectors have also been developed in very diverse ways in the different regions.

Collaborative care for depression in primary care (the INDI·i project)

INDI is a complex intervention programme that is being tested in Catalonia. It is based on the chronic care model and has been adapted to suit the characteristic way in which primary care is organised in Catalonia. The programme includes teaching and training of primary care professionals, clinical and organisational ways of working and activities relating to health education and training for patients. The purpose of the programme for guidance and management of depression to be provided by a primary care team, but based on an approach of collaboration with different levels of care.

An initial eight-hour course is provided on the NICE clinical guidelines for the treatment of depression, the knowledge and skills of doctors in diagnosing depression, suicide risk assessment, clinical treatment, monitoring depression and adapting treatment to achieve remission. The training emphasises the care procedure, active clinical follow-up and the options that are available if the predefined goals are not reached (short-term remission and no relapse in the longer term). Basic training and follow-up training are both provided.

In the programme, the participating doctors are given a 'Depression Management Toolkit' that includes a treatment algorithm allowing them to optimise prescribing of antidepressants.

Case managers are also being introduced. The case managers are nurses from the participating primary care centres, who receive training (an initial eight hour course plus periodical updates) on depression, treatment with antidepressants, side-effects, compliance with treatment and methods to ensure it, warning signs for worsening depression etc.

The case manager is responsible for identifying the individual, family and community factors for planning of individualised care. They have to provide health education and support in the search for appropriate help and support, so that the patient can continue to live independently. The minimum number of nurse visits is defined, divided between: 'in the acute phase' and 'in the follow-up and maintenance phase' but follow-up visits are scheduled in an individualised way based on the patient's characteristics and the course of their depressive illness. The visits are structured and the patient receives information and education on their condition and treatment, including 'self-help' and health advice for both the patient and their family members.

Patients are given appropriate information (leaflets, audiovisual materials etc.) to improve their insight and self-care. During the consultations, their compliance with the treatment plan is systematically assessed. Any problems are identified and adjusted as actively possible, but the aim is to guarantee the treatment and the care plan.

The GP remains clinically responsible for diagnosis And treatment of patients with depression. A care manager (who is often a nurse) helps the GP with the patient's proactive follow-up and compliance with treatment. The care manager shares responsibility for 'empowering' the patient and continuing to play an active part in the 'therapeutic' process. Psychiatrists can be involved in various different ways, but their basic role is to guide primary care professionals and support them in the management of depression. Patients, and by extension their family members, are viewed as part of the therapeutic team. The programme also includes an online-supported interactive tool that provides management guidelines.

Complex intervention: Basque country

A pilot project has been set up in the Basque country to improve collaboration between primary care and mental health care: this is a programmed intervention that combines a number of different elements[1]. The pilot project focuses on improving communication and knowledge between primary care and mental health staff, using a shared diagnostic record that can be used in both settings, training programmes with meetings and shared clinical practice guidelines, and monitoring and evaluation of this way of working. The key lessons learned from the project are that these are complex change processes that require ongoing effort and adjustment, but can contribute towards better care for clients and improve the primary care sector.

Training and support model based on interaction and liaison: El Departamento de Salud La Ribera Valencia

The project was implemented in Valencia[2]. This initiative focuses on providing mutual information sharing through regular contact and communication between actors in primary care and mental health care. The content and approach are very similar to other liaison initiatives in other countries. This model and the actions were institutionally supported, however, in the sense that resources and time were made available to take part in the training and joint communication and meetings.

1 Calderón C, Balagué L, Iruin Á, Retolaza A, Belaunzaran J, Basterrechea J, Mosquera I. Colaboración atención primaria-salud mental en la asistencia a pacientes con depresión: evaluación de una experiencia piloto [Primary care and mental health care collaboration in patients with depression: Evaluation of a pilot experience]. Aten Primaria. 2016 Jun-Jul;48(6):356-65. Spanish. doi: 10.1016/j.aprim.2015.06.013. Epub 2015 Nov 11. PMID: 26522782; PMCID: PMC6877855.

2 Morera-Llorca M, Romeu-Climent JE, Lera-Calatayud G, Folch-Marín B, Palop-Larrea V, Vidal-Rubio S. Experiencia de colaboración entre atención primaria y salud mental en el Departamento de Salud La Ribera, 7 años después [An experience of collaboration between primary health care and mental health care in La Ribera Department of Health (Valencia, Spain)]. Gac Sanit. 2014 Sep-Oct;28(5):405-7. Spanish. doi: 10.1016/j.gaceta.2014.02.014. Epub 2014 Mar 29. PMID: 24690535.

NORWAY

The Norwegian mental health care system[1] is organised as a public service and is characterised by extensive decentralisation of both outpatient and inpatient care. Municipalities organise primary health care, while the national government is responsible for special care, including hospital services, provided through government regional health authorities. GPs act as gatekeepers. A referral from the GP is required for specialist treatment.

Mental health care is delivered in municipalities by GPs, psychologists, psychiatric nurses and social workers. Many municipalities have multidisciplinary *outreach teams* for mental health care. Local authorities (*municipalities*) organise primary health care, which includes GPs, primary mental health teams and substance misuse services. Hospitals are organised by 19 *health trusts* which are managed by four regional administrations. The current policy in Norway is strongly focused on empowering the primary care sector, which includes taking on work in mental health.

Familiens hus [Family centres] are multidisciplinary centres that are available in about half the municipalities. These centres can provide help to children, young people and their families and support their mental and physical well-being, without requiring a referral or having to be placed on a waiting list.

More than half of the municipalities and districts in Norway have a 'Healthy Living Centre' (*frisklivssentral*) that focuses on lifestyle (a much wider concept than mental health problems) but also on dealing with depression and stress, sleeping problems and alcohol misuse.

In about 45 municipalities (districts) there are also low-threshold community facilities *Rask psykisk helsehjelp* [Rapid mental health assistance] for adults over 18 years (or over 16 years in some municipalities) suffering from various types of anxiety and mild or moderate problems with depression - possibly linked with sleeping problems due to starting medication or drugs problems. The service is free of charge and provides direct support without referral from a doctor for two weeks.

1 https://www.regjeringen.no/globalassets/upload/kilde/hod/red/2005/0011/ddd/pdfv/233840-mentalhealthweb.pdf et https://www.consortium-psy.com/jour/article/view/43

District psychiatric centres (DPCs) still represent the cornerstone of outpatient mental health care and work closely with the general primary care sector (although there are major differences between regions). The DPCs have a care coordination role in certain well-defined geographical areas, between specialist intramural psychiatric provision and primary care.

Doctors working in the DPCs are responsible for liaison with GPs and primary care teams, either regularly or on an ad-hoc basis. Consultations also take place with patients, where people from different departments have a meeting with a patient to plan and coordinate his or her care and treatment. It has been noted, however, that working practices in the centres and individual care providers are not entirely focused on a recovery-oriented approach and that there is still a lot of work to be done in this area.

There are major differences between the ways DPCs work. Some mainly provide outpatient services and depend on the presence of inpatient units, others have both outpatient and inpatient services integrated in small local institutions.

Policymakers have suggested fully integrating the DPCs and primary care services. There is also guidance to merge certain facilities so that they are managed by multiple municipalities, to ensure an adequate size and bank of skills. There are concerns, however, that for DPCs and the mental health care sector, the primary care sector will not be able to offer mental health care of sufficiently high quality due to a lack of knowledge and expertise. There is a need for further debate in this area.

Access to primary psychological assistance: Prompt Mental Health Care, the Norwegian version of Improving Access to Psychological Therapies

PMHC[1] has been implemented in 49 locations (municipalities and urban districts) (PMHC) is inspired on the English *Improving Access to Psychological Therapy* (IAPT), which focuses on low-threshold access to primary treatment with short waiting times for people with symptoms of anxiety or depression, so that people do not depend on referral by GPs to receive help. In Norway the roll-out of PMHC is supported by the Norwegian Public Health Ministry. In PMHC, cognitive behavioural therapy (CBT) is provided, with both low-intensity (guided self-help and group-oriented psycho-education) and high-intensity (face-to-face) treatment. PMHC is organised according to a *matched care* model. This is different from the *stepped care* model used in IAPT, since the client does not necessarily begin with a low-intensity treatment. While stepped care is based on low-intensity interventions where possible, followed by more intensive interventions where necessary, *matched care* does not focus as much on rigidly or formally following sequential steps, but is more about matching the treatment to the patient's needs, and also to the severity of the problems, mental and social skills, environmental factors and the patient's wishes and needs. In *matched care* the right care provider to carry out the right interventions is found as quickly as possible, to prevent under-treatment or over-treatment.

1 https://bmcpsychiatry.biomedcentral.com/articles/10.1186/s12888-018-1838-0 et https://www.karger.com/Article/FullText/504453

Implementing PMHC is viewed in Norway as a complex process, certainly in the start-up phase which required a number of different procedures, forms, information material and websites, staff training and support and development or adaptation of course material, treatment and symptom measurements, as well as structuring the collaboration with different services.

INSPIRATION FOR CHANGE

This study provides 'sources of inspiration' on ways of improving the management of mental health in primary care. None of the examples or approaches that have been used can be 'simply' copied or transferred to a different context. Local circumstances and the health and welfare system in each country have fundamental impacts on the way an initiative is developed. At the same time the study does show that the underlying rationale behind the way of working is quite similar and it is definitely possible to learn from this.

The literature helps to classify different types of initiatives and reflect on the aspects that a project could focus on. The examples also show that not all initiatives are easily covered by the typology used in the literature: examples of this are walk-in centres and 'initiatives to reduce stigma'.

In the 'initiatives to reduce stigma' category it is noticeable that we found no examples in Europe that focus on improving interaction between people with mental health problems or a psychological disorder and people without health problems, nor on stigma among health professionals (examples of this can be found in countries that are still developing their health care systems). The literature describes how interventions that focus on teaching and training, maintaining contacts and collaboration between groups, awareness campaigns in (mass) media can make a major contribution towards overcoming the barriers to the use of facilities.

It also helps to have a focus on the fact that mental health problems can also be discussed and addressed in a 'general' health care system and not only in a specialist niche. It is known from the scientific literature that initiatives to reduce stigma that focus on contact, collaboration and action can contribute significantly towards disarming the idea of 'us' ('normal' people) against 'them' (people with mental health problems). In that way this social factor helps to bring about recovery for people with psychological vulnerabilities or breaks through taboos so that they can seek help. We also found no specific practices focusing on the image of patients with psychiatric disorders, although the literature teaches that this group of people make lower than average use of somatic health care, probably because primary (and other) care providers do not assess the situation in the same way as they do for other patients.[1] The reason why we do not include examples of this type may be linked to the search strategy that was used.

The typology in the literature also does not focus on target groups. The examples, however, illustrate that specific models can focus on very vulnerable groups in society (socio-economically vulnerable people, refugees etc.).

1 see e.g. Corrigan PW, Mittal D, Reaves CM, Haynes TF, Han X, Morris S, Sullivan G. Mental health stigma and primary health care decisions. Psychiatry Res. 2014 Aug 15;218(1-2):35-8. doi: 10.1016/j.psychres.2014.04.028. Epub 2014 Apr 18. PMID: 24774076; PMCID: PMC4363991.
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This study does not focus strongly on the walk-in centre model (*Family of mental health walk in centers*, except for the project for young people in the Netherlands) although these are quite significant for primary care (and in many cases for specific vulnerable groups). For example, there is a focus on these *walk in (counseling) centres* in Canada and Australia[1]. In England (Manchester) the *walk-in model* is being introduced for crisis situations, and in the USA *walk in clinics* are mainly used in a hospital context to deal with the problem of (missed) appointments and compliance with treatment.

We also did not look closely at initiatives targeting the general public (i.e. those who are not actors in primary care). One interesting initiative in Scotland is *Health in mind*[2] which has been running since 1982. The aim is to *empower* the public in the area of mental health without medicalising mental health. It provides various forms of support and a portal site to guide people through a spectrum of activities. The activities that are mentioned are definitely not only therapeutic but also have a social-preventive aspect.

In summary: this international inventory does not seek to be comprehensive or to look in full detail at every aspect involved in implementing each initiative. From the overview, however, a number of aspects do come up when efforts are being made to focus on sustainable change and on the management of mental health in primary care.

Introducing a project or intervention to change something about the way assistance or services are provided in the health care sector is never a temporary, isolated activity. It is a stepped process in which various different activities are emphasised more or less. So there is a major difference between the idea, the plan, and the process of implementing the plan. That implementation process involves many different activities and there may need to be space and willingness to make adjustments in comparison with the initial plan. Working out initiatives in reality depends a lot on the context and it is necessary to leave room for a learning process. A flexible attitude is needed. The way in which ideas and models are implemented in practice is not always standardised, but is often adapted to local circumstances. Nevertheless, the important lessons and insights can still be drawn from these, and the insights in relation to evaluation and monitoring are particularly important.

We can also see a common theme that initiatives are built on and around collaboration (between individual, organisations, sectors or policymakers). Many different actors are involved in change in the health and care sectors, and projects or initiatives depend on the way a variety of actors engage with, understand and give meaning to a particular initiative. Every project has a need to be based on a distinct vision, with a clear explanation of the way in which that vision can take concrete shape. All too often the narrative is too implicit. When this happens, despite good intentions and strong engagement, actors do not always see their implicit expectations being realised.

1 e.g. https://walkincounselling.com/ et https://www.whatsupwalkin.ca/

2 https://www.health-in-mind.org.uk/

Disappointment or tensions can then emerge between the different rationales driving the various actors. Developing and implementing change definitely does not mean that all those involved have to have a 'homogenous' way of thinking, but there is a need for those involved to have a shared starting point that should not be too vague. It is known from the scientific literature that this is one of the factors that helps to build mutual trust.

Developing and starting up an initiative and changing working processes demands leadership; a driving force that will encourage and facilitate action and the development of activities and interventions. Leadership is also the ability to encourage actors to engage in concrete action and work towards clear agreements on tasks and roles. That definitely does not need to be formal and procedural, but the way people work together should be based on mutual trust among the partners. This is particularly important because not all the parties involved are working on the basis of the same 'rationale'.

Every project or initiative has to take into account that there will be some engaged enthusiasts who want to be active and make rapid progress, while some people and organisations are more cautious and that not everyone necessarily wants to get on board at the beginning. That insight is vitally important because most initiatives are strongly dependent on human engagement as one of their key resources.

In addition to people's availability and effort, it is also important to give sufficient thought to the financial, logistical and infrastructural resources available, whether there is enough time, how the various people involved will find the time, and in particular whether that time and those resources can still be made available in the long term.

Well-organised communication to and with all those involved is an important area for attention. Communication is a process that needs to be shaped throughout the period of implementation and a balance has to be found between informing people efficiently and having a working methodology for dialogue and participation during implementation. Attention needs to be paid to the nature and content of communication (what is communicated with whom and when) since these help to shape the project.

Systematic monitoring of the roll-out of the project and the subsequent experiences, possibly linked to formal evaluation (process and impact evaluation) are significant ways of driving forward a newly introduced way of working. Monitoring can easily be organised in the context of consultations and dialogue with the actors involved, but that is not the same as having more unstructured dialogues on a regular basis. It helps if monitoring (as a simple variant of process evaluation) is based on criteria and focus points, partly to preserve the coherence and consistency of the initiative.

The learning points from this international summary are as follows:

- The ways in which mental health and primary health care are integrated depends on the local context and the health care system;
- Starting with a person-centred approach and striving towards an integrated, holistic understanding of the target group, including a strong focus on empowering the individual person;
- Making time to listen, consult people and give advice;
- Primary care will also need to focus on acquiring a mix of knowledge, competencies and skills (skill mix): knowledge and skills can be improved through teaching and training, but it is also necessary to be aware and make use of external expertise (cf. liaison consultations) or to extend practice to encompass multiple disciplines;
- It is not only knowledge and skills that are important: interventions and training also need to address attitudes, prejudices and possible discrimination against people with a psychological vulnerability by health care professionals in primary care;
- It seems to be essential to use supervision and support to improve knowledge and competencies in the area of mental health;
- Working in an interdisciplinary way and in a team context seems to be essential, and this includes integrating knowledge based on experience and the informal care system;
- Co-location seems to offer a number of important benefits both for patients and in helping the actors involved to learn from each other. Co-location fosters direct contact and communication and improves accessibility for care users;
- The importance of harmonising the different 'rationales' and priorities of others when working together: showing respect for the different rationales found in different disciplines, organisations and sectors;
- Ensuring that care and continuity are accessible: coordination between care providers and sharing information are both vital;
- Supporting people in the field of mental health requires a pathway perspective: it is not a one shot acute intervention, even where the problems are mild;
- Most cases can be coordinated by primary care staff, provided they have and take enough time to complete the whole pathway. Clearly defining tasks and roles is an essential component, but flexibility is needed too;
- Some target groups require selective interventions (young people, homeless or insecurely housed, refugees) but efforts must be made to achieve integration with the whole health and social care system;
- An approach and initiatives involving active collective involvement (from the neighbourhood or local community) seem to be extremely valuable. Many mental health problems can be understood and treated based on the characteristics of the local community where the primary care function is delivered, and not solely from an individualistic perspective. Actions and guidance can be tailored to this (but should be evidence informed);
- Social prescribing / 'Well-being on prescription' is a promising technique in which primary care can play an important role together with other sectors and above all with the community. It prevents mental well-being and mental health problems being medicalised too quickly;

- There is potential for digital innovations: both to support self-care by the public and patients both online and through e-consultations, and for knowledge and competency support for primary care workers to help them to identify and manage mental health. It is necessary to think carefully about the digital skills of the target group, particularly since these are certainly not evenly distributed in a diverse society;
- Addressing mental well-being and health in primary care demands engagement and hard work, as well as the 'courage' to refer to specialist services when the needs are too complex. Steps towards integration should make efficient and active use of the expertise and knowledge that are available. Primary care cannot keep hold of everything. There are many possible variants of collaboration (shared consultations, liaison and referral when it is really necessary, while continuing to monitor the coordination);
- There will continue to be a need to focus on new roles in primary care. A number of the examples integrate new 'roles' in primary care, for coordination and support work (cf. case managers, consultation etc.). These are not only new functions, but the content and role of primary care workers can also shift from an individualistic professional approach to an interdisciplinary group and shared care approach that makes room for the patient, client and his/her network (family, or household);
- Not all initiatives relating to mental well-being and vulnerability in primary care have to take place under the auspices of institutional health care. There is definitely scope and space for more informal initiatives focusing on social support, awareness, empowerment, reducing stigma and helping target groups who have difficulty accessing the regular health care system.

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