Provision of mental health care in general practice in Italy

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SUMMARY. The main features of the psychiatric system and of the general practice system in Italy since the psychiatric reform and the introduction of a national health service are briefly described. Research conducted in Italy confirms that a large proportion of patients seen by general practitioners have psychological disorders and that only some of those patients whose psychological problems are identified by general practitioners are referred to specialist psychiatric care. Thus, the need to identify the best model of collaboration between psychiatric services and general practice services is becoming increasingly urgent. The chances of improving links between the two services and of developing a satisfactory liaison model are probably greater in countries such as Italy where psychiatric services are highly decentralized and community-based, than in countries where the psychiatric services are hospital-based.

Introduction

WITH the promotion of decentralized psychiatric practice in the community, the Italian psychiatric reform has increased the likelihood of improved links between psychiatric services and the primary health care system, especially general practitioners. This paper briefly describes the main features of the psychiatric reform and the characteristics of the general practice system in Italy; summarizes the results of studies recently conducted in Italy evaluating psychiatric morbidity in general practice and its management; and discusses how the liaison between community psychiatric services and general practice services in Italy can be promoted and evaluated.

Italian health reform and the introduction of a national health service

In December 1978 the health reform in Italy (law 883) introduced changes in the delivery of health care and introduced a national health service (*Servizio Sanitario Nazionale*). This national health service is intended to promote health, prevent sickness, provide care and rehabilitation, and improve the environment both for the individual and the general population. The three levels controlling the service are the state, region and municipality. The 20 Italian regions are divided in 670 local social health units (*unitá locale socio-sanitaria)*. Each local social health unit provides services for a population of 50 000–200 000 and is subdivided into health districts which provide all basic services for a population of 10 000–20 000. All services, whether hospital or community, are integrated and coordinated by the local social health unit. The state and the regions coordinate those health activities which are more appropriately coordinated nationally or regionally.

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Since January 1979, most health care has been provided free of charge to patients. However, charges are made for certain drugs and diagnostic tests. The patient must pay the full price for all drugs not included in the Italian national formulary, while drugs included in the national formulary are divided into three categories. Drugs in the first category are free of charge to the patient. For drugs in the second category the patient must pay 30% of the cost and for drugs in the third category (including many antipsychotic and antidepressant drugs) 40% of the cost. Benzodiazepines classed as anxiolytics have never been included in the formulary, while benzodiazepine hypnotics were excluded in September 1984. Thus, all prescriptions for benzodiazepines, together with those for some antipsychotic and antidepressant drugs not included in the formulary, must now be paid for by the patient. Health insurance is compulsory for all Italian citizens and has been dealt with through one organization since January 1980.

Italian psychiatric reform

The psychiatric legislation (law 180), which in May 1978 introduced the psychiatric reform in Italy, was later incorporated into law 833 and is therefore now part of the health reform. The main features of the Italian psychiatric reform have been described extensively elsewhere[1-3] but the main features are as follows:

- There were to be no first admissions to mental hospitals after May 1978 and no admissions at all after December 1981.
- Psychiatric units, with up to 15 beds, were to be established in general hospitals, to which all patients requiring hospitalization — voluntary or compulsory — were to be admitted.
- Community psychiatric services were to be set up, each providing care for a specified geographical area and working closely with the inpatient unit so as to ensure continuity of care.
- In cases of urgent therapeutic need and refusal of treatment, compulsory admission could be authorized by the mayor on the basis of two medical recommendations. Such detention would be subject to review at two and seven days and there would be extensive rights of appeal.
- The new facilities in general hospitals and in the community were to be staffed by existing mental health personnel.

Three distinctive features of the Italian model of community psychiatry are worthy of note. First, the phasing out of mental hospitals was intended to be a gradual process rather than the abrupt deinstitutionalization of chronic patients, characteristic of the American community mental health experience.[4,5] Secondly, the new services were designed to be alternative, rather than additional to mental hospitals. Furthermore, it is hospital psychiatry, increasingly located in general hospitals rather than in mental hospitals, that is considered complementary to community care, and not vice versa as in most European programmes of community psychiatry.[6] Thirdly, in one geographical area the same team should provide domiciliary, outpatient and inpatient care, thus facilitating continuity of care and long-term support. Emphasis is placed on multidisciplinary teamwork, domiciliary visits and crisis intervention, on easy access to the community mental health centres, and on close liaison with other

medical and social community services and, in particular, with general practitioners.[6,7]

There is considerable controversy over the outcome of the Italian psychiatric reform[7,8] and its application has not been heterogenous across the country.[8,9]

Italian general practice system

In Italy there is a high number of doctors per head of population (on 31 December 1988 there was one doctor per 219 people) with a large regional variation (Lazio: one doctor per 165 people; Val d'Aosta: one doctor per 315 people) (Federazione Nazionale Ordine dei Medici, Rome, personal communication, 1989). The corresponding rate for general practitioners alone on the same date was one general practitioner per 867 people.[10]

The main characteristics of the Italian general practice system are, first, that all residents must register with a local general practitioner and are free to choose their doctor. Each general practitioner is in charge of no more than 1500 patients. General practitioners are not employees of the national health service but have a three year contract thus retaining their self-employed status. They are funded by the local social health units with a fixed allowance per patient registered, regardless of the number of consultations, prescriptions and other care that they provide. Secondly, general practitioners do not have a specific postgraduate training curriculum, although many have postgraduate training in internal medicine or other specialties. However, in the last few years, an increasing number of junior physicians have entered general practice without postgraduate training. Thirdly, the majority of general practitioners are in single handed practice, only a minority working in partnership with one or more other doctors, generally without the support of other health care professionals. Fourthly, it is necessary for patients to see the general practitioner before seeing a specialist or attending hospital or community health departments. Patients with psychiatric symptoms, however, may be referred or may refer themselves directly to psychiatric services. Finally, there are few epidemiological data on mental disorders in the primary care setting, and therefore planning and service organization have so far been based mainly on empirical and political decisions.

The need for a close liaison between psychiatrists and primary health services has been repeatedly stressed.[11,12] Unfortunately, this goal has not yet been fully achieved in Italy. However, with the implementation of the health reform, psychiatrists working in community psychiatric services and general practitioners operating in the same geographical area have an increased chance of establishing close collaboration.

Research on psychiatric morbidity in Italian general practice

Most of the studies on psychiatric morbidity in general practice in Italy have been conducted by our department in Verona, but relevant research is also in progress in Milan, Florence, Bologna and Padua.

Development and assessment of instruments

The general health questionnaire and the clinical interview schedule are probably the most widely used instruments for the detection of psychiatric morbidity in primary care. The 28 and 30 item versions of the general health questionnaire and the clinical interview schedule have been translated into Italian and the accuracy of the translation checked by two independent Italian psychiatrists who were familiar with the English version. The performance of the 30 item general health questionnaire and clinical interview schedule was tested in three studies which concurred in finding the clinical interview schedule to be a useful and reliable instrument for case identification and the 30 item general health questionnaire to be valid as a screening instrument in general practice[13,14] as well as in community settings.[15] The performance of the 12 item general health questionnaire (derived from the 30 item version) and of the 28 item general health questionaire in general practice are currently being assessed.

A simple instrument to standardize general practitioners' assessment of psychiatric morbidity, the general practitioner recording schedule, was developed in our department and has proved to be an acceptable, efficient and economic means of collecting patient information. It covers physical illness, psychiatric problems and social problems as perceived by the general practitioner and also allows the collection of information about drug prescription and referral.[16,17]

Assessment of total and conspicuous psychiatric morbidity

Data were collected from patients attending 32 general practitioners in south Verona on one day. Of the 505 patients who attended, 404 (80%) completed the 30 item general health questionnaire and 211 of the respondents (52%) were high scorers (total score five or more). Application of predictive values obtained in a pilot validation study[14] gave an estimate of 41% for the prevalence of total psychiatric morbidity among consulters.[18] A subsequent study conducted in 92 general practices in Verona estimated the extent to which general practitioners themselves identified psychiatric problems in the patients who presented to their practices (conspicuous psychiatric morbidity). Of the 2559 patients who were seen on one day 32% were rated by their doctors as presenting psychiatric problems.[19] Two other smaller studies confirmed the rates of approximately 41% and 32% for total and conspicuous psychiatric morbidity in general practice, respectively.[20,21] Factors significantly increasing the relative risk of being identified by the general practitioner as a psychiatric case were the presence of social problems, previous psychiatric illness known to the doctor and, to a lesser extent, female sex.[18]

Prescription of psychotropic drugs

Psychotropic drug prescribing was studied among patients attending the 92 general practitioners on one day.[17] It was found that 14.2% of the patients surveyed received a prescription for a psychotropic drug, about three-quarters of the drugs being benzodiazepines. The prevalence of prescription was higher in women than in men. Patients aged 45–64 years were the most likely to receive a prescription for a psychotropic drug.

A strong association was found between psychotropic drug prescription and conspicuous psychiatric morbidity. This association was independent of the sex, age and occupational status of the patient. However, social problems and patients' sex were found to have an interactive effect on psychotropic drug prescribing: the perception of the general practitioner of a social problem doubled the likelihood that a psychotropic drug would be prescribed in women, but not in men.[17] A follow-up study showed that 26% of recipients of a new prescription for a psychotropic drug (in most cases a benzodiazepine) were still taking the drug six months later.[22]

Another research strategy was to collect information on psychotropic drugs prescribed in general practice using a drug information system (*sistema informativo farmaci*) implemented in the Verona local social health unit by the department of pharmacy. The drug information system is based on intensive computerized monitoring of all drugs included in the Italian national formulary, prescribed by general practitioners working in the area of Verona and collected by the pharmacies in the same area.

In an initial study we used the drug information system to analyse the psychotropic drugs prescribed by 68 general practitioners and collected by the community pharmacists in south Verona during 1983 and 1984.[23] On average the doctors issued 0.42 prescriptions for psychotropic drugs per registered patient in 1983 and 0.36 per patient in 1984. In both years, benzodiazepine hypnotics were the most commonly prescribed drugs, followed by antidepressant and antipsychotic drugs. As expected, there was wide variation between the general practitioners with respect to their prescribing rates.

Two limitations of the drug information system are that it only covers drugs listed in the Italian national formulary and a prescription is only included if it is dispensed by a pharmacist. Thus, prescriptions for benzodiazepine anxiolytics are not recorded and benzodiazepine hypnotics have been excluded since September 1984.

In a later study using the drug information system the prescription ratios (defined daily dose per 1000 patients per day) for antidepressant drugs of all general practitioners (mean 295) working in the area of Verona over a six-year period (1983–88) were analysed.[24] The defined daily dose was calculated and it was found that the prescription ratios increased over the six-year period, mainly because of a rise in the use of 'second generation' antidepressants and of 'non-tricyclic' antidepressant drugs. The correlation between prescribing antidepressant drugs and general practitioners' age, sex and list size was low. Analysis revealed substantial seasonality in prescribing which was interpreted as being due to the seasonal holiday pattern and not to seasonality in the onset of depressive disorders.[24]

Referral to psychiatric services

Information relating to 'filter three' of Goldberg and Huxley's model — the referral by general practitioners to specialist psychiatric services — may be collected from both the general practitioner and the psychiatric service.[25]

In the study conducted in 92 general practices it was shown that 23% of the patients identified by general practitioners as having conspicuous psychiatric morbidity were referred to specialist psychiatric care. This proportion was the same for general practitioners working in an area with a community-based, comprehensive district service (south Verona) and those working in an area with an hospital-based system of care (north Verona). However, the proportion of patients referred by general practitioners to private psychiatric services or clinics was significantly lower in south Verona than north Verona (29% and 51% of those referred, respectively). This confirms that, among other variables affecting the 'quality' of general practitioners' referrals to psychiatric services, the structure and the characteristics of the available specialist services play a central role.[26] These referral rates to specialist psychiatric care are higher than those found elsewhere,[27,28] and this may be due to the availability and the visibility of community psychiatric services in Verona.

To evaluate the specialist side of the filter we examined the records of the south Verona community psychiatric service (the agency in charge of providing psychiatric care for all those living in the area). The proportion of patients who contacted the service for the first time, having been referred by a general practitioner increased from 11% in 1982 to 26% in 1989. It should be noted that in south Verona, even though filter three is becoming progressively more permeable, only a quarter of first-ever referrals are from general practice and a substantial proportion of patients refer themselves or are referred by their relatives. We believe that this is true in many areas in Italy and arises from the fact that patients can be referred directly to community psychiatric services. These services, therefore, function at the primary as well as the secondary level of care.

Developing and evaluating liaison between community psychiatric and general practice services

In Italy, the community psychiatric services developed after the psychiatric reform are decentralized and have their focus in the mental health centre. The mental health centre is a multipurpose facility based in the community, which ensures that patients have easy access to the service, as well as providing continuity of care for long-term patients, extensive home support and home visiting, and prompt crisis intervention. Therefore, in principle, the community psychiatric services are in a particularly good position to develop liaison with other community services, including general practitioners, primary care services, social services and voluntary organizations. The extent to which this goal has been achieved varies between different areas. However, we believe that in Italy the methods of developing a well structured interface between community psychiatric services and other district services operating in the same area will be a topic of great interest in the years to come. A preliminary requirement for stimulating such a development is the provision of more resources to psychiatric services, as most of them are currently suffering from a shortage of personnel, especially nurses.

In order to evaluate the progress achieved in developing liaison between community psychiatric and general practice services it is first necessary to identify the characteristics of the interface between the two services. These characteristics may be different in different countries and areas, and depend to a large extent on the structure and the style of working of both the general practice and the psychiatric services in the area. David Goldberg recently emphasized that 'the nature of the health care system exerts a profound effect on the way in which psychiatrists have worked in primary care' (paper presented at the 18th European Conference on Psychosomatic Research, Helsinki, August 1990).

We believe that in areas with a well-developed psychiatric service which is community-based it is important for general practitioners to refer their patients freely to the specialist service when they want advice concerning not only diagnosis but also management and pharmacological and psychological therapy. However, it should be remembered that filter three — the referral by general practitioners to psychiatric services — is a two-way filter and that referral back from psychiatric services to general practice should also be possible when necessary. This is particularly important for patients, including those with long-term psychoses, who may benefit from treatment provided in non-specialist settings or would more willingly accept such treatment.

Measurement of the progress achieved in developing liaison between the two services should therefore include:

- Monitoring admission rates to psychiatric beds and, in general, use of psychiatric facilities before and after the introduction of the collaborative model between specialist and general practice services.[28]
- Evaluation of referrals to and from community psychiatric services, over a relatively long period. This evaluation should include the following elements: the intention of the referral, for example, whether the general practitioner wanted advice or was requesting the psychiatrist to take full responsibility for the psychiatric component of patient care; whether the request concerned an identified problem or symptoms and disorders; and whether the referral was made to the appropriate psychiatric facility, for example, in areas with an integrated community-based psychiatric service, the referral should be made to the coordinating facility, that is the mental health centre and not to a hospital ward.
- Evaluation of the proportion of cases in which the psychiatric

service and the primary care team are sharing the continuing burden of chronically disabled, demanding and dependent psychiatric patients and their relatives.

- Evaluation of the extent to which various agencies and services providing care to the resident population are coordinated and integrated.
- Comparison of the outcome for patients with psychiatric problems treated in general practices which are well coordinated with the local community psychiatric service and in those without such a liaison.
- Completion of satisfaction measures by general practitioners, psychiatrists and other members of both the general practice and the psychiatric team.

We are aware that these suggestions for monitoring liaison are not sufficiently specific. In order to transfer these intentions into practice, detailed research protocols will have to be prepared, taking into account the general characteristics of the area and the resources and the facilities available.

Conclusion

The evidence shows that there is enormous potential in the adoption of a close relationship between mental health services and primary care (Goldberg D, 18th European Conference on Psychosomatic Research, 1990). The World Health Organization has long stressed the need for mental health care to be decentralized and integrated into primary health care and has detailed the infrastructure necessary to support such services and the training in the additional skills that would be required of health personnel at all levels.[12] However, further research is needed to identify the best model of collaboration between general practitioners and psychiatrists, psychologists and their co-workers.

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