

EUR/ICP/PSF 010

THE DEVELOPMENT OF MENTAL HEALTH CARE  
IN PRIMARY HEALTH CARE SETTINGS  
IN THE EUROPEAN REGION



WORLD HEALTH ORGANIZATION  
Regional Office for Europe  
COPENHAGEN

## TARGET 4

### Reducing disease and disability

By the year 2000, the average number of years that people live free from major disease and disability should be increased by at least 10%.

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THE DEVELOPMENT OF MENTAL HEALTH CARE  
IN PRIMARY HEALTH CARE SETTINGS  
IN THE EUROPEAN REGION

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Note

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the 1990s, the number of people in the UK who are aged 65 and over has increased from 10.5 million to 13.5 million, and the number of people aged 75 and over has increased from 4.5 million to 6.5 million (Office for National Statistics 2000).

There is a growing awareness of the need to address the needs of older people, and the need to ensure that the health care system is able to meet the needs of older people. The Department of Health (2000) has published a strategy for older people, which sets out the government's commitment to improve the health and well-being of older people, and to ensure that the health care system is able to meet the needs of older people.

The strategy for older people is based on three main principles: (1) to improve the health and well-being of older people; (2) to ensure that the health care system is able to meet the needs of older people; and (3) to ensure that older people are able to live independently and actively. The strategy for older people is a key document in the development of health care for older people, and it is essential that health care professionals are able to understand and implement the strategy.

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## Introduction

A Working Group on the Development of Mental Health Care in Primary Health Care Settings met in Lisbon on 15-18 November 1989. The meeting was organized by the WHO Regional Office for Europe in collaboration with the National School of Public Health, Lisbon (a WHO collaborating centre for primary health care) and the Portuguese Directorate of Mental Health Care, General Directorate of Primary Health Care.

The Working Group consisted of 16 temporary advisers from 11 European countries, five observers from Portugal, five from Portuguese-speaking countries of the African Region, five representatives of other international organizations, five from WHO collaborating centres for training and research in mental health, two from WHO headquarters and two from the Regional Office for Europe.

The main aims of the Working Group were:

- to review the extent to which health policies and their mental health components have actually fostered the development of mental health care in primary health care (PHC) settings at district and local level throughout the Region;
- to identify the major trends and to make recommendations for the further strengthening of the integration and development of mental health care in PHC settings as an essential element of truly comprehensive PHC systems oriented towards health for all (HFA);
- to discuss and draft indicators for monitoring and evaluating these developments.

## Background

The activity generated by the Regional Office in the field of community-based mental health care has been intense for the last two decades. In 1971, a working group on comprehensive psychiatric services and the community examined not only the services needed by patients but also the special problems the community has to face in suicide, alcoholism and drug dependence. In 1972, a conference was held on the development of comprehensive mental health services in the community at which the WHO programme's principles in relation to service development were laid down. In 1973, a working group discussed psychiatry and primary medical care, stating that the primary care team is the keystone of community psychiatry. In 1978, a working group reported on changing patterns in mental health care in the European Region. A working group convened in 1983 established the principle of first-contact mental health care, reviewed the tasks and responsibilities of PHC workers in mental health care, and discussed the relationship of specialist mental health services, self-help groups and voluntary organizations with PHC. In 1986, a working group on mental health services in southern countries of the European Region reviewed mental health policies, and recommended that WHO should facilitate the exchange of experience and information concerning the development of community-based mental health programmes that conform to the objectives of HFA.

## Discussion

In recent years, Member States in the Region have given increasing attention to the development and organization of a comprehensive network of PHC services within the scope of their respective health systems. These developments - which in several Member States have actually become a major component of national health policy - are making it possible for an increasing number

of population groups to gain access to community-based care, preventive measures, health promotion, and support for those affected by long-standing chronic or disabling disorders. The extent to which those population groups at risk or affected by severe and less severe forms of mental disorders are actually benefiting from the development of PHC services in the Region is not fully known. Moreover, the full potential and limitations of the different liaison schemes now being established between PHC systems and the network of community-based mental health services are neither fully known nor understood.

For WHO the definition of PHC incorporates the principles of equity, community participation, health promotion and self-reliance. It does not, however, imply a preference for one particular type of organizational infrastructure or in any way suggest that a given method of service provision is more suitable or superior to any other. The emphasis has shifted to the psychosocial aspects of health care and of economic and social development, and WHO's concern has been to raise the status of mental health in the scale of human values. The development of strategies at the central level and the pursuit of their implementation at the periphery has given way to a process of monitoring local developments and streamlining them into an overall WHO policy in the field of mental health.

The Working Group heard a resumé of PHC developments in mental health care in the European Region over the past few years based on reports from Bulgaria, Finland, Italy, Netherlands, Portugal, Spain, Turkey, USSR, United Kingdom and the Scandinavian countries. There were a number of reasons for the variations noted, such as the existing national patterns of general and mental health care before the new developments took place, differences in the individual countries' administrative methods (e.g. local/central budgeting and planning) and national

health priorities, and sociodemographic, sociocultural and sociopolitical factors (e.g. scattered/compact populations, illness behaviour, private/state medicine).

However, there were several common features, one of them being the new PHC tasks with a mental health orientation assigned to professional groups such as general practitioners, public health officers, psychiatrists, psychiatric nurses and clinical psychologists and the increase in their potential contribution.

As the Portuguese experience indicates, public health officers could successfully act as a bridge between the members of health teams and between the community and various health agencies and so spearhead a concerted effort to revamp hospital-based services and programmes.

In the United Kingdom community psychiatric nurses have established a place for themselves in primary care. This has raised questions about the possible implications of the fact that they work in isolation from specialist psychiatric teams, and has also made it clear that they need to specialize in a particular area of mental illness.

Countries such as the United Kingdom, where patients are referred to specialists by general practitioners, have tried various approaches to identifying psychiatric cases at the point of first contact (e.g. screening questionnaires, computerized self-administered interviews, better interviewing techniques for general practitioners), and have tested various methods of increasing the participation of specialist psychiatric services in the community management of mental illness (e.g. the replacement model, the liaison model, the referral model).

Training - closely related to this question of changes in professional patterns and roles - was another recurrent feature of the national reports. In countries such as Turkey where community mental health is a fairly recent development, sensitization of various categories of staff, mainly through in-service training programmes, has become the order of the day. In countries such as Bulgaria, Portugal, Spain and the USSR the introduction of therapeutic modalities appropriate to PHC and community care has highlighted the scarcity of staff in certain professions (e.g. social workers, occupational therapists, clinical psychologists). Elsewhere, in countries (such as Netherlands, United Kingdom and the Scandinavian countries) with long-established traditions of involvement of the helping professions in mental health care, an important issue has been the question of the professional credentials needed for work in the new settings.

A third feature of most of the national reports is the question of filtering mechanisms (to use Goldberg's and Huxley's term) at various entry and transition points in the patient's progress through the health services. While in some settings (e.g. in the United Kingdom) the long-established tradition of the "second filter" (i.e. recognition rate/sensitivity of general practitioners) is now being bypassed as a result of new opportunities for direct contact with specialist psychiatric services (e.g. mental health centres), it seems that in other countries (e.g. Bulgaria, Finland, Italy, Spain) administrators are trying to introduce and strengthen this filter by devising links and referral channels between existing services and laying down rules for their operation.

The various reports create the general impression that in virtually every European country a significant change has been set in motion over the past decade.

However, it is impossible at this stage to make any quantitative comparison because of the wide divergences of approach in the various Member States.

After being introduced to PHC's relevance to the WHO mental health programme, and the major trends in the development of PHC systems in the WHO European Region, the Working Group discussed the progress achieved in Member States regarding mental health care in PHC settings. The discussions were organized around the following themes.

#### Trends in the organization of care

The present trend in the organization of mental health care in PHC settings has been set by the anti-institutional movements in the care of psychiatric patients that began in the 1950s and by the considerable amount of mental health work already carried out by first-contact doctors, either explicitly or less obviously, as part of their routine medical consultations. A closer linking of formal mental health services to primary care will therefore bring mental health personnel into contact with this area of psychiatric morbidity. The development of a credible psychiatric service that is comprehensive, flexible, decentralized and dynamic is a prerequisite if primary health care is to maintain a mental health orientation. Under such conditions:

- mental health is seen as coming high on the scale of human values;
- the psychology-mindedness of the public and of care consumers and providers is increased;

- psychological problems are more readily brought to medical attention and general practitioners become more motivated to improve their mental health expertise;
- the resulting rise in the rate of referral of common mental illness to psychiatric attention does not precipitate a tendency for the "walking worried" to displace psychotics from the psychiatrist's list;
- rather, psychiatrists tend to respond by developing programmes targeted to this broader spectrum of needs and also tend to liaise and integrate their specialist services with primary care;
- this is in fact a further step in the development of the psychiatric service towards comprehensiveness, flexibility, and so on.

If it is not acknowledged at the time of policy-making and resource allocation (and all too often it is not!) that development and growth take this pattern, circular rather than linear, it may be wrongly concluded from later evaluation that things have gone out of control. A finger should be kept continuously on the pulse of development, and planning should be kept sufficiently flexible to be able to take into account trends and situations that could not have possibly been predicted at the time a policy or programme was launched.

In view of the above, the importance of a national policy cannot be overstressed. When needs are spelled out, a clearly defined national policy becomes indispensable, since decisions on how to meet the needs have to be made in the face of limited funds and resources. A good national policy takes into account the needs as perceived by various groups of the public, the professionals and the consumers, and balances them in

order to attain harmony in the existing situation. For example, with regard to a curative versus a preventive orientation of mental health, a balanced national policy would consider the scientific arguments (e.g. knowledge of causes, technologies for bringing this knowledge to bear, cost analysis), the profession's potential to absorb new knowledge and skills and to translate it into health action, the demands and the perceived needs of the consumers, and the attitudes of the public as determined by the prevailing values in the society.

In the absence of such a framework, practical issues that require immediate attention may stagnate into ineffective solutions determined purely by the power balance. Examples of such issues are: Should family doctors be involved in preventive work? How should this involvement be encouraged, and who should decide on it (the family doctors or the health planners)? What training should the various categories of staff receive to equip them better for community mental health work? Who should do the teaching, and who should decide on this (the professional groups themselves or the academics)?

#### The primary health care team

Compared with institutional settings, PHC settings are much closer to the natural human environment: they are less rigidly structured, have more permeable boundaries and more varied and flexible norms, rules and definitions. In institutions, physical structures and regulations implicitly contribute to the constancy of roles and the uniformity of tasks, whereas mental health practice in the fluid context of PHC creates the need to attend explicitly and continuously to maintaining the team as a system. The renegotiation of roles and boundaries, redefinition of professional tasks according to the needs of each case, the development of a common language between members from different professional backgrounds and a host of similar tasks take on a key importance.

The "mechanics" of teamwork are far from fully understood. On the one hand the diversity of professions represented on the team extends its capacity with regard to both the range of problems it can handle and the richness of approaches and points of view it can apply to a case; on the other hand, the inevitable blurring of roles can give rise to problems of professional identity, power struggles and time-consuming, nonproductive preoccupation with the team's difficulties as a group. Attempts to ensure the functional fitness of the team by administrative means (e.g. by defining leadership and spheres of responsibility in terms of professions) should be complemented by an openness to innovative organizational solutions, prompted by the team's experience as a functioning unit. One such solution could be to introduce training programmes intended to produce a new type of professional equipped to handle the whole range of mental health tasks in the PHC context, rather than attempting to secure the required expertise for the team by composing it according to the present-day spheres of competence of the helping professions.

The performance of the PHC team as a unit is closely linked to the ways in which it relates to the formal and informal helping networks of the community. On the one hand a well functioning team is capable of incorporating outside professionals and nonprofessionals for specified periods and reasons as the clients' needs dictate, without going beyond a certain limit to this openness, which might endanger its identity as a team. This implies the acceptance of alternative ways of defining, interpreting and handling problems and the ability to accommodate them in an overall framework. On the other hand, a well functioning team is capable of absorbing inputs from second-line professions by incorporating new skills in its work, rather than restricting itself to a limited list of services and simply referring the problems not included on that list. On-the-job training

and continuing medical education programmes should take into account (in terms of both content and methods) the significant reframing of one's professional role to which teamwork leads.

In view of the special significance of the first contact in setting the pattern of the relationship between the care provider and the consumer, training for this contact should be a major concern of the team. A pattern of cooperation, partnership and shared responsibility between consumer and provider is the style that nonprofessional helpers tend to adopt as mediators, and it also facilitates collaboration with volunteers.

Coordination of mental health action in the field of PHC needs to be ensured by extensive horizontal links between the agencies involved, the setting up of information networks, the placing of mental health and general health under the same administration, and local control over budgeting.

Quality assurance in mental health teamwork raises the difficult and practically untouched question of standards of mental health care in PHC settings. The evaluation of community mental health programmes for their effectiveness as compared to other existing programmes needs to be done on a much larger scale than is now the case.

#### Primary prevention

It is practically impossible and scientifically superficial to split primary prevention from secondary prevention and treatment. In the field of mental health, particularly where the desired changes concern lifestyles and patterns of cultural behaviour, primary preventive action may lead to raised expectations and increased demands for treatment services. For example, an

anti-alcohol programme that raises awareness of the risks involved in drinking, if successful, will result in more people asking for advice on how to reduce their drinking.

In the field of mental handicap (e.g. prenatal detection through amniocentesis) effective technologies are increasingly available but, once again, for a population to benefit from them it should be motivated and informed on how to act in times of illness; an organizational infrastructure to make the new technology available should be identified and prepared for the job; and funds for launching and maintaining a collective effort should be secured.

In the field of mental illness "at-risk" groups can be identified and targeted (e.g. the recently bereaved, or single mothers with young children). In these cases, preventive action will basically be concerned with quality-of-life issues and will make use of psychosocial interventions. Research evidence as to the effectiveness of existing programmes is slowly accumulating. Primary health networks seem to be the ideal vehicle for such action.

The public health profession is involved in an important process of finding a new identity vis-à-vis mental health. Having been traditionally concerned with environmental health and service planning, this discipline is now slowly incorporating the psychological aspects of the human environment into its framework of concern and is on the look-out for an alliance between public health action and economic interests. A direct corollary of this reorientation is the growing interest in consumers' sentiments about health and illness, their satisfaction with existing services and care, and their preferences as to what services should be provided and how.

### Training

The core content of training for mental health action in the community includes skills in human communication (e.g. the ability to listen), knowledge of psychosocial matters and mental health (e.g. the family life cycle), and attitudes that underlie therapeutic behaviour. Much of what makes a health worker competent in this field, though, is of an experiential rather than cognitive nature and training methods have to be selected accordingly. Since learning through experience is demanding and requires personal dedication, self-selection for such training is an important step in the selection procedure.

The development of a career in general or family practice should emphasize teaching through practical work outside hospital settings. The training programmes should be flexible in that they take into account the perceived needs of the trainees, they should be problem-oriented and trainers should always receive feedback on how far the training objectives have been met.

Training for teamwork should start early in the formative process by exposing the professional to working with members of other professions. Continuing medical education should make use of discussion groups, Balint groups and audiovisual programmes.

The training of psychiatrists, public health officers and clinical psychologists should ensure that each knows enough about the others' fields and professional identities for them to have realistic expectations of each other.

### Monitoring and evaluation

Monitoring of developments in the field of mental health in PHC is linked to the setting up and maintenance of case registers. Data from registers are indispensable

in establishing long-term trends and in providing statistical arguments in situations where mental health has to compete for limited resources with other sectors. Case registers are a tool, and sometimes a very flexible one, that health administrators and planners should know how to use. Too often, however, their potential is not fully utilized or they are expected to produce answers to questions they were not designed to answer.

By virtue of being anchored in the community, mental health in PHC settings addresses local needs and resources, and this has important implications for evaluation. Data from registers which make perfect sense when questions are asked at a more global level often prove not to be specific enough on matters of local concern, such as the evaluation of intervention programmes. Carefully planned studies designed to test specific hypotheses and using validated and simple instruments are needed in such cases. A good example is Mann's study on neurotic patients in general practice.<sup>a</sup>

There was a general feeling in the Working Group that as mental health skills penetrate PHC the satisfaction of both consumers and providers with services is growing. This leads into the issue of how indicators of satisfaction should be incorporated in a more comprehensive approach to evaluation. However, the Group did not feel prepared at this stage to suggest a list of indicators for an overall monitoring of developments in the mental health field.

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<sup>a</sup> Mann, A.H. et al. The twelve-month outcome of patients with neurotic illness in general practice. Psychological medicine, 11: 535-550 (1981).

## Conclusions

### Trends in the organization of care

1. As PHC systems and the network of community-based mental health care resources are progressively developed, a timely opportunity arises in Member States not only to improve the care given to the mentally ill but also to extend mental health expertise to the prevention of mental disorders and the promotion of mental health, especially in vulnerable groups of the population.
2. The Working Group recognized that at present collaboration and functional integration between the systems of PHC and mental health care at community level are still incipient. They are mainly developed through the use of a great variety of mostly invalidated intervention technologies, and without sufficient consideration for the organizational implications of these liaison schemes in the functioning of primary care and mental health services.
3. The further development of a comprehensive community-based network of mental health and psychiatric services in Member States was considered to be an indispensable precondition for the overall improvement of mental health care in PHC settings. The Group recognized that health policies should incorporate strong mental health components which foster the development of community-based mental health care systems.

### Mental health care development in PHC settings

4. As a consequence of the growing number of agencies and different categories of personnel operating in community settings, mental health technologies are being used increasingly by health care providers without professional qualifications. In this context, special consideration should be given to:

- quality assurance;
- issues of confidentiality; and
- the accreditation of training and professional qualifications for service operation and work in community settings.

5. Teamwork was considered essential for effective intervention in PHC settings. It was recognized that training in teamwork should be introduced at pre- and postgraduate levels and should be applied in community health care settings.

6. Team leadership was seen as a key tool for full utilization of the team's potential. The selection and training of personnel for this leadership role was considered fundamental.

7. Given the mental health technology available for intervention in community settings, the Group agreed that it was both necessary and desirable for the psychiatric profession to assume responsibility for the full range of mental health problems in the framework of mental health services. Clinical psychologists should make an increasing contribution to the psychological aspects of mental health practice.

8. As the number of agencies providing mental health care increases and public health services tend to become further fragmented, it was pointed out that there is a need for stronger leadership and for coordination between these agencies and services in order to ensure comprehensiveness and continuity of care.

9. The present trends towards the decentralization of health management and control over the health budget were seen by the Group as an opportunity for strengthening and stimulating the development of community-based mental health services and programmes. Decentralization should

also be closely linked with the adequate training of community health workers, and health authorities should contemplate the integration of mental health care and general health care under the same administration.

10. It was stressed that the development of adequate standards of mental health care in PHC settings is largely dependent on a correct and much more equal quantitative balance than at present exists between mental health and general health care resources.

11. Community-oriented mental health care plans and programmes should be adapted to local conditions, should be efficiently coordinated with the work of self-help and voluntary organizations, and should take into account the interests of both consumers and their social networks.

12. Concerning the functions of PHC, special emphasis was given to the concept and practice of first-contact mental health care. The identification of need and of available resources, as well as the provision of professional help and support when resources are inadequate, were considered to be the basic requirements.

13. As the first contact is a unique occasion for both helper and helped to interact in a mutually satisfactory way and is likely to shape all their subsequent contacts, special training is required for the large numbers of both professional and non-professional or agency personnel who work together in the field of mental health in community health settings.

#### Prevention of mental, psychosocial and neurological disorders

14. The Group considered that preventive technologies are available and that preventive action in PHC settings should be strengthened in consequence. Examples of possible preventive measures can be found, for instance, in the Report and Resolution on the Prevention of Mental,

Psychosocial and Neurological Disorders in the European Region adopted in 1988 by the Regional Committee for Europe. Techniques for implementing these preventive measures need to be developed at local level.

15. Programmes aimed at raising the community's awareness with regard to preventive action (especially where lifestyles are concerned) should always precede the planning and implementation of actual preventive measures. Planning should be seen as a joint endeavour between professionals and consumers which carries benefits for all the parties involved.

16. The role of public health services in the prevention of mental disorders and in the promotion of mental health should be enhanced. This development requires a much stronger liaison between the mental health and PHC sectors and the public health sector.

17. The involvement of sectors other than health at community level is imperative for the formulation and implementation of effective comprehensive prevention programmes to reduce mental disorders and to improve the mental wellbeing of vulnerable groups of the population.

18. Decisions regarding preventive interventions should be systematically preceded by the collection of as much scientific evidence as possible.

#### Training for mental health care in PHC settings

19. The Group recognized that there is a need for a mental health training core curriculum and stressed the value of peer groups, the problem-centred approach and multiprofessional involvement in learning.

20. In the training of family doctors, particular attention should be given to the relationship between

doctors and their clients, to the learning of appropriate technologies and practical teamwork, and to developing the ability to listen to and communicate with service users.

21. The practice of psychiatry in PHC settings requires not only the teaching of appropriate technologies but also the development of a common language and of a classification of disorders which takes the views of PHC professionals into account.

22. Mental health training in schools of public health and in departments of social medicine in medical schools should be strengthened, as there is evidence that the mental health training component is still too weak.

23. Continuous training and education is essential for maintaining adequate standards in community-based mental health work.

24. The postgraduate training of psychiatrists and other categories of mental health professionals should include public health subjects and a basic education in PHC.

25. Training in teamwork should begin during undergraduate education and there should be as much direct involvement as possible in multiprofessional field work.

#### Monitoring and evaluation of mental health care in PHC settings

26. The Group recognized that in general very little progress has been made in identifying and drafting good indicators for the monitoring and evaluation of mental health care in PHC settings. One difficulty is that there has been too little experience with the implementation of clearly targeted mental health programmes.

27. Psychiatric case registers were considered to be an indispensable tool for monitoring and evaluating mental health care in community settings. Administrators and consumers should take more advantage of them.

28. Evaluation should be comprehensive and should encompass all aspects of community health care, such as management, epidemiology, clinical effectiveness, providers' and users' satisfaction, training, and so on. Mental health programmes should systematically include an in-built evaluation component, and the training of professionals should stress evaluation.

29. Information systems can only produce answers when specific questions have been formulated and data have been collected accordingly. Moreover, mental health monitoring was considered to be largely dependent on the quality of registration, the adequacy of the classification system and the care provided.

30. As more competition and cost-containment policies are being introduced in the health care system, monitoring and evaluation of the economic costs and benefits of community-based mental health care was considered by the Group to be essential.

31. Monitoring and evaluation data should be disseminated to all the parties involved in the supervision and implementation of community mental health programmes.

32. The Group made special reference to the need to validate and further simplify rating instruments and to ensure an adequate comparison with previously obtained baseline data in evaluation projects.

## Recommendations

### Member States

1. Mental health and PHC policies and plans in Member States should state the need for closer collaboration and more effective functional integration between the systems of primary health care and mental health care, and should specify ways of implementing this collaboration.
2. As the development of functionally integrated PHC systems is highly relevant to the strengthening of mental health care in community settings, mental health workers at all levels of administration and service delivery should help improve cooperation between the two systems in Member States.

### WHO

3. WHO should fill in the gaps in information regarding the provision of mental health care in PHC settings, including preventive action and the promotion of mental health.
4. WHO should disseminate a set of available and assessed techniques and programmes for the prevention of mental disorders and the promotion of mental health in community settings.
5. Collaboration between the WHO Regional Office for Europe's primary health care and mental health programmes in promoting the development of mental health care in community settings should be increased and given adequate support.
6. In collaboration with interested parties in Member States and other international organizations, WHO should sensitize decision-makers and the population at large to

the value of mental health and to the contribution this discipline can make to changes in health policies, services and approaches to health development.

7. As a follow-up to this Working Group, the PHC programme at the Regional Office should call a meeting in the next biennium to review the prospects of extending mental health care in PHC settings to the prevention of mental disorders and the promotion of mental health. The participants should include representatives of general practice, public health, sectors other than health and other interested parties.

## Annex 1

### PARTICIPANTS

#### Temporary Advisers

- Dr E. Aydiner  
General Director of Primary Health Care, Ministry of Health, Ankara, Turkey
- Mr G. Bingöl  
Director of External Relations, Ministry of Health, Ankara, Turkey
- Professor J.M. Caldas de Almeida  
Direccao Servicos de Saude Mental, Lisbon, Portugal  
(Chairperson)
- Dr V. Corces Pando  
Comunidad de Madrid, Consejeria de Salud y Bienestar Social, Gerente del Hospital Psiquiatrico, Madrid, Spain
- Dr B. Coskun  
Director of Psychology Department, Ministry of Health, Ankara, Turkey
- Dr J.H. Henderson  
Medical Director, St Andrew's Hospital, Northampton, United Kingdom

- Professor A. Mann  
Institute of Psychiatry, London, United Kingdom  
(Co-Rapporteur)
- Dr A.R.K. Mitchell  
Consultant Psychiatrist, Young People's Psychiatric  
Service, Cambridge, United Kingdom
- Dr P. Munk-Joergensen  
Institute of Psychiatric Demography, Aarhus  
Psychiatric Hospital, Risskov, Denmark
- Dr T. Ozçam  
General Directorate of Preventive Psychology,  
Ministry of Health, Ankara, Turkey
- Dr K. Pylkkanen  
Deputy Director, Department of Hospital Care,  
National Board of Health, Helsinki, Finland
- Dr G. Rumyantseva  
Head, Department of Services for Outpatients,  
All-Union Scientific Centre on Borderline  
Psychiatry, Moscow, USSR
- Dr J. Shanks  
Medical Officer, Mental Health and Illness Division,  
Department of Health, United Kingdom
- Professor J. Sennfelt  
National School of Public Health, Lisbon, Portugal
- Professor M. Tansella  
University of Verona, Istituto di Psichiatria,  
Verona, Italy
- Dr T. Tomov  
WHO collaborating centre for research and training  
in mental health, Medical Academy, Sofia, Bulgaria  
(Co-Rapporteur)

## Representatives of Other Organizations

### *Association of Schools of Public Health in the European Region (ASPHER)*

Dr Idalmiro Carraca  
National School of Public Health, Cadeira de Saude  
Mental, Lisbon, Portugal

### *Council of Europe*

Mrs C. Thayer  
Administrative Officer, Health Division, Strasbourg,  
France

### *European Federation of Professional Psychologists Associations (EFPPA)*

Dr F.M. McPherson  
President (EFPPA), Tayside Area Clinical Psychology  
Department, Royal Dundee Liff Hospital, Dundee,  
United Kingdom

### *World Association of Social Psychiatry (WASP)*

Dr A. Guilherme Ferreira  
President, Av. Mousinho de Albuquerque, Lisbon,  
Portugal

### *World Federation for Mental Health (WFMH)*

Dr S. Flache  
President (WFMH), WFMH Representative to WHO,  
Geneva, Switzerland

*International Council of Nurses (ICN)*

Ms M. do Carmo Caviedo  
Rua Monte Oliveti 39, Lisbon 1200, Portugal

WHO Collaborating Centres

*WHO collaborating centre for research and training in  
mental health, Groningen*

Dr J. Jenner  
Department of Social Psychiatry, University  
Hospital, Groningen, Netherlands

*WHO collaborating centre for research and training in  
primary health care, Lisbon*

Dr Teodoro Briz  
National School of Public Health, Lisbon, Portugal

Observers

Dr D. Cardoso  
Centro de Saude Mangualde, Portugal

Dr Medeiros Paiva  
Departamento de Saude Mental, Faculdade de medicina,  
Hospital de S. Joao, Porto, Portugal

Dr J.F. de Freitas  
Estrada Nacional-2, N<sup>o</sup> 2000, 2<sup>o</sup> Esq., Abraveses,  
3500 Viseu, Portugal

Dr H. Meireles  
Director, Mental Health Services, Direcçao Servicos  
de Saude Mental, Lisbon, Portugal

## World Health Organization

### *Regional Office for Europe*

Dr J.G. Sampaio Faria  
Regional Officer for Mental Health

Dr W. Hubrich  
Regional Officer for Primary Health Care

Mrs Heideh Shabsavan  
Acting Secretary, Mental Health unit

### *Headquarters*

Dr N. Sartorius  
Director, Division of Mental Health

Dr J.M. Bertolote  
Division of Mental Health