# *Introduction*

This issue of the Journal is devoted to mental disorders in primary care settings, and is divided into two parts. The first deals with how services can be improved, while the second consists of four reports from particular countries. We open with a paper from Peter Verhaak and his colleagues in NIVEL, who conducted a study of primary care in 10 European countries. They found clear differences between countries in the proportion of attenders reporting distress, and were unable to relate these differences to the system by which primary care is rewarded, but did find that countries where the GP had a "gate-keeper" function – so that patients could only seek mental health care if sent by their GP – patients were more likely to make psychological presentations and to receive mental disorder diagnoses. However, the strong finding that emerges from their survey is that patients who do not mention their distress to their doctor are unlikely to have their distress acknowledged. In the East European countries psychological distress is common, but patients do not mention it to their doctor abd receive no acknowledgment for it.

Linda Gask reviews the various attempts that have been made in the United Kingdom in the past few years to improve the quality of mental health care - by special training courses, by government sponsored frameworks for mental health care, by evidence based guidelines, by advice from the World Health Organisation contained in the ICD10-PHC system, by supplementing the primary care workforce with graduates dedicated to mental health work, and by various forms of collaboration between GP's and the mental health professions. In general, she is disappointed with the progress obtained, and p9ns her hopes in the system devised by the Medical Research Council for the assessment of what are termed "complex medical interventions".

Annet Smit and her colleagues agree with Professor Gask that so far training courses have been ineffective in improving the management of depression in primary care, but show that enhanced care & collaborative care may result in improved short-term outcomes, but do not appear to prevent recurrence. Quality improvement strategies do show improved outcomes at 6 months, and there is some evidence of longer term effectiveness. However, most studies have not demonstrated success in the prevention of chronicity, so more needs to be done.

Marianne Rosendal and her colleagues propose a new classification for patients who present with medically unexplained symptoms (MUS). She compares three diagnostic systems – the WHO's ICD-10, the American DSM-IV, and that proposed by the International Classification for Primary Care (ICPC), and finds the latter prefereable for this important group of patients.

The first part closes with a paper by Paul Walters and his colleagues, in which they sought to improve the detection of depression in young males in the UK by sending out a mail-shot which described the symptoms of depression, and invited young men these symptoms to consult their graduate mental health worker, or ask to see their GP. This resulted in a large

increase in numbers of young male depressives who attended for treatment, at a cost of about £297 (450 Euro) per patient detected.

The second part of this issue reviews developments in four different countries. Kathryn Magruder and Derek Yeager review developments that have occurred in the United States in recent years. Some of these, like the adoption of clinical guidelines for depression, have parallels in Europe, and others, like the adoption of non-physician facilitators as case managers seem similar to the "graduate mental health workers" in the UK. In the USA, problem drinking and depression have been identified as conditions which justify routine screening, and depression is seen as requiring chronic disease management in primary care. There has been a large increase in recognition of depression and prescribing anti-depressants, and there is greater use of telephone contacts with patients. As in other anglophone countries, there is also increasing use of the internet for the provision of computer-based psychotherapies.

Joanna Norton and her colleagues compare the system in French primary care with that in the UK on the one hand, and the Netherlands on the other. Despite record numbers of both GP's and psychiatrists, collaboration between the two services is generally poor, and predicted to deteriorate still further. She sees an urgent need for mental health training.

Antonio Lobo and his colleagues report a large study in Spain in which both physical diagnoses were made by the GP using ICPC and research psychiatric diagnoses were made simultaneously. The probability of psychiatric "caseness" was found to increase with each additional physical diagnosis made by the GP Although the depressed patients as a group were found to be more likely to be rated as severe, and also to have a higher disability score, than the anxious patients, there was no difference in disability between the two groups when severity of disorder was controlled.

Domenico Berardi and his colleagues describe three different ways in which the two services can relate together in Italy. These are a structured Consultation-Liaison Service, a model of Group Liaison, and patterns of spontaneous collaboration in small rural centers. The authors admit that these systems overlap to a considerable extent, and describe the pros and cons of each, without a clear winner emerging.

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