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COMPARING A COMMUNITY MENTAL HEALTH TEAM IN BEDFORD (UK) WITH COMMUNITY MENTAL HEALTH SERVICES IN PERUGIA (ITALY): DESCRIPTION OF TEAMS AND CASELOADS

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SUMMARY

Introduction: *The aim of our work is to evaluate and compare some of the key indicators that characterize one English Community Health team (Bedford), two Italian Mental Health Services, in Bastia and Magione, and one University Hospital Mental Health Service, in Perugia. Our work was conducted on the basis of a collaboration between Cambridge University (UK) and the University of Perugia (Italy).*

Subjects and methods: *We analyzed and described the teams supplying information about the number of psychiatrists, types of staff and populations in the catchment areas. Furthermore, we analyzed their caseloads, referring to the epidemiologic features and the diagnostic aspects. We considered the population that were referred to the services in February 2013.*

Results: *There are some differences between the organization of the teams and the caseloads of the Community Mental Health Services in Italy and in England and between the community health services and the hospital service. As for the diagnostic aspects, Mood Disorders seem to be the most frequent diagnosis in each service (Bedford 53.8%, Perugia 48%, Magione 45%, Bastia 38%).*

Conclusions: *The World Health Organisation identifies strong links between mental health status and development for individuals, communities and countries. In order to improve the mental health of the population, countries need effective and accessible treatment, prevention, and promotion programs. Achieving adequate support for mental health in any country requires a unified and shared approach. Little research has been done to describe the Mental Health Services in the different countries of the world, consequently more studies are needed to assess the improvements in the mental health system in relation to the services available for the population. In our study, according to the literature, we detected that mood disorders are the most frequent cause of referral to mental health services in all the populations studied.*

Key words: *Community Mental Health Team - Community Mental Health Service - Mental Health - Mood disorders*

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INTRODUCTION

Mental disorders are associated with significant negative consequences that affect society as a whole. The economic and social impact of mental disorders is observed in terms of human capital losses, reduction of qualified and educated manpower, impairment of the health and global development of children, workforce losses, violence, criminality, homelessness and poverty, premature death, health impairment, unemployment and out-of-pocket costs for family members (Knapp 2003, Patel et al. 1999, Patel et al. 2007).

Mental health is associated with positive development outcomes and it is fundamental for the development of adaptive coping strategies in the face of adversity, whereas poor mental health impedes an individual's capacity to realize his/her potential and make a contribution to the community. In order to improve the mental health of the population, countries need to make effective treatment, prevention, and promotion programs available to all who need them (WHO 2012).

A consortium of researchers, advocates and clinicians supported by the US National Institute of Mental Health (NIMH) in Bethesda, Maryland, and by the Global Alliance for Chronic Diseases (GACD) highlighted the grand challenges in global mental health (Collins et al. 2011). The first challenge is to invest in research that uses a life-course approach (Hermann 2013).

The World Health Organization states “1 in 4 get mental illness during their lifetime’’ (Boseley 2001) and ‘‘during their entire lifetime, more than 25% of individuals develop one or more mental or behavioural disorders’’ (Sayers 2001).

Consequently, increased emphasis on mental health, improved resources and enhanced monitoring of the situation in countries is called for to advance global mental health (Jacob 2007). In order to investigate the mental health situation in the Mental Health Services in two different countries in Europe, we created a collaboration between the Cambridge University, with Doctor Mark Agius (South Essex Partnership University Foundation Trust, Bedfordshire Centre for Mental Health Research in association with the University of Cambridge; Department of Psychiatry University of Cambridge; UK) and the University of Perugia (Division of Psychiatry, Clinical Psychology and Rehabilitation, Department of Clinical and Experimental Medicine - Santa Maria della Misericordia Hospital, Perugia, Italy) in order to evaluate and compare some of the key indicators that characterize one English Community Health team (Bedford), two Italian Mental Health Services, in Bastia and Magione, and one University Hospital Mental Health Service, in Perugia.

In fact, this paper reflects on the needs for close interaction between psychiatry and all partners in international mental health for the improvement of mental health and the advancement of the profession. (Herrman 2013).

SUBJECTS AND METHODS

In our paper we initially described the teams of one English Community Health team (Bedford), two Italian Mental Health Services, in Bastia and Magione, and one University Hospital Mental Health Service, in Perugia, supplying information about the types of staff and populations in the catchment areas.

Furthermore, we analyzed the caseloads, referring to the epidemiologic features (such as total outpatients examinations, sex, age, number of first examinations of patients) and diagnostic aspects (in terms of ICD-10 codes).

We considered the population that reached the services in February 2013.

Statistical analysis was performed by the means of Microsoft Office Excel 2007 program.

RESULTS

Epidemiological and diagnostic aspects

Mental Health Service in Bastia

Total patients using the service: 412.

Total outpatients examinations 678; sex: males 285, females 410, age: 0-14 =0, 15-18 =6 (0.9%), 19-65 =612 (90.3%), over 65 =60 (8.8%), number of first outpatient examinations 17.

Table 1. Illustrates the diagnostic aspects in Bastia

Diagnosis	Percentage (%)
F00-09	9.0
F10-19	2.0
F20-29	12.0
F30-39	38.0
F40-49	28.0
F50-59	1.0
F60-69	4.5
F70-79	2.0
F80-89	1.5
F90-98	2.0
F99	-

Description of codes for diagnosis– see table 9

Table 2. Refers to the diagnostic aspects of first outpatient examinations in Bastia

Diagnosis	Percentage (%)
F00-09	-
F10-19	-
F20-29	2.0
F30-39	4.0
F40-49	4.0
F50-59	2.0
F60-69	2.0
F70-79	1.0
F80-89	-
F90-98	2.0
F99	-

Description of codes for diagnosis– see table 9

Mental Health Service in Magione

Total patients using the service: 270.

Total outpatients examinations 316; sex: males 120, females 150; age: 0-14 =1 (0.4%), 15-18 =7 (2.6 %), 19-65 =219 (81.1%), over 65 = 43 (15.9%); number of first outpatient examinations 19.

Table 3. Illustrates the diagnostic aspects in Magione

Diagnosis	Percentage (%)
F00-09	1.5
F10-19	2.2
F20-29	22.6
F30-39	45.2
F40-49	21.1
F50-59	0.4
F60-69	3.7
F70-79	1.5
F80-89	0.4
F90-98	-
F99	-
No diagnosis	1.5

Description of codes for diagnosis– see table 9

Table 4. Refers to the diagnostic aspects of first outpatient examinations in Magione

Diagnosis	Percentage (%)
F00-09	-
F10-19	5.3
F20-29	31.6
F30-39	47.4
F40-49	-
F50-59	-
F60-69	15.7
F70-79	-
F80-89	-
F90-98	-
F99	-

Description of codes for diagnosis– see table 9

University Hospital Mental Health Service in Perugia

Total patients using the service: 145.

Total outpatients' examinations 154; sex: males 50, females 104; age: 0-14 = 0, 15-18 = 3 (1.9%), 19-65 = 138 (89.6%), over 65 =13 (8.5%); number of first outpatient examinations: 40.

Table 5. Illustrates the diagnostic aspects in Perugia

Diagnosis	Percentage (%)
F00-09	8.4
F10-19	0.6
F20-29	0.6
F30-39	48.0
F40-49	25.3
F50-59	8.4
F60-69	20.8
F70-79	-
F80-89	-
F90-98	-
F99	7.4

Description of codes for diagnosis– see table 9

Table 6. Refers to the diagnostic aspects of first outpatient examinations in Perugia

Diagnosis	Percentage (%)
F00-09	15.0
F10-19	-
F20-29	2.5
F30-39	45.0
F40-49	12.5
F50-59	7.5
F60-69	-
F70-79	-
F80-89	-
F90-98	-
No diagnosis	10.0

Description of codes for diagnosis– see table 9

Community Mental Health Service in Bedford East

Total outpatients examinations in February, 200. Total number of patients who use the service 564 this number refers to all patients on the caseload who are seen in outpatients on a relatively regular basis, however, some of the patients may be seen monthly or even more frequently, consequently, some of them may be seen every two, three, or six months rather than monthly. sex: males 258, females 288; age: 0-14 =1 (0.2%), 15-18 =21 (3.7%), 19-65 =476 (84.4%), over 65 =36 (6.4%); number of first outpatient examinations: 46.

Table 7. Illustrates the diagnostic aspects in Bedford East

Diagnosis	Percentage (%)
F00-09	0.3
F10-19	3.2
F20-29	25.0
F30-39	53.8
F40-49	22.0
F50-59	2.5
F60-69	8.9
F70-79	-
F80-89	-
F90-98	1.7
F99	3.0

Description of codes for diagnosis– see table 9

Table 8. Refers to the diagnostic aspects of first outpatient examinations in Bedford East

Diagnosis	Percentage (%)
F00-09	1.9
F10-19	-
F20-29	3.9
F30-39	23.1
F40-49	11.5
F50-59	1.9
F60-69	5.8
F70-79	-
F80-89	-
F90-98	-
No diagnosis	51.9

Description of codes for diagnosis– see table 9

DISCUSSION

Description of the Mental Health System in Italy

In Italy, starting from the end of the last century, the care of people with mental illnesses has undergone a profound change, both at the organizational level and at the legislative one. This change has firstly seen the management of the psychiatric patients pass from the old asylums to the Departments of Mental Health (Dipartimenti di Salute Mentale – DSMs).

Tables 9. Codes of diagnosis in the tables 1-8

Code	Diagnosis
F00-09	Organic, including symptomatic, mental disorders
F10-19	Mental and behavioural disorders due to psychoactive substance use
F20-29	Schizophrenia, schizotypal and delusional disorders
F30-39	Mood (affective) disorders
F40-49	Neurotic, stress-related and somatoform disorders
F50-59	Behavioural syndromes associated with physiological disturbances and physical factors
F60-69	Disorders of adult personality and behaviour
F70-79	Mental retardation
F80-89	Disorders of psychological development
F90-98	Behavioural and emotional disorders with onset usually occurring in childhood and adolescence
F99	Unspecified mental disorder; mental disorder, not otherwise specified

Law 180/78 provided for the abolition of psychiatric asylums, included psychiatry in the health care, integrating psychiatric wards in general hospitals (mental health services for the diagnosis and the treatment - servizi psichiatrici di diagnosi e cura - SPDC), and featured compulsory interventions as exceptional, short-term measures, allowed only in the case of therapeutic needs that cannot be addressed in any other way.

As shown by the latest census of the Italian population, dating back to 2001, all regions and provinces have set up the DSMs, mainly within the local health units (Aziende Sanitarie Locali – ASL). These structures - 211 distributed throughout the national territory - play a fundamental role in the prevention, treatment, rehabilitation and reintegration of mentally ill persons.

To better respond to the multiple needs, each department is organized into a diverse network of services that offer four basic types of assistance:

- Mental Health Services (Centri di Salute Mentale - CSMs) and outpatient clinics for community care and home care;
- Mental health Services for the Diagnosis and the Treatment (servizi psichiatrici di diagnosi e cura – SPDC) and Day hospitals for in-patient care;
- Community Centres for social and rehabilitative interventions in semi-residential regime;
- Residential facilities for therapeutic and rehabilitative interventions in residential regime.

The DSM is the organizational structure and the operational tool that ensures the coordination and standardization of activities aimed to deal with mental health throughout the territory that belongs to the local unit. The task of the DSM is to ensure the promotion of mental health and the prevention, the treatment and the rehabilitation of mental illness, the training and the updating of the personnel assigned and of scientific research. The DSM designs specific responses to the emerging issues in a perspective of social integration of the mentally ill patient and of prevention of stigma.

The CSMs provide psychiatric outpatient care and are available 12 hours a day, 6 days a week. The team is composed of doctors, psychologists, sociologists, social workers, health care assistants and psychiatric nurses. In particular the service provides: evaluation of the requests coming from patients, family members, social services and general practitioners; outpatient visits and home visits; social and welfare interventions for patients admitted to the service; psychological support; individual and group psychotherapy; psychopharmacological therapy; rehabilitative and social activities and other variables according to the regional plan.

Inside the SPDC, short-term intensive therapeutic activities are carried out in the case of voluntary admissions (when expressly accepted by the patient) or of compulsory admissions (according to the Law 180 of 1978).

The SPDC deals with the diagnosis and the treatment of acute psychiatric disorders when these ones cannot be treated at home or in an outpatient service. The ward's activity consists in daily medical-psychiatric visits and clinical, laboratory or instrumental evaluations.

Noteworthily, the operators of the ward act in close collaboration with those of the Mental Health Service.

Sometimes in the ward Day-Hospital admissions are carried out for further diagnostic and therapeutic investtigations.

The community centre is a semi-residential territorial structure, belonging to the network of intermediate structures, directly related to mental health departments, along with residential facilities.

The community centre carries out therapeutic-rehabilitative programs, in conjunction with other units of mental health departments, creating partnerships with individuals and institutions involved in the health care and social network outside the departments themselves.

These structures are involved in:

- the design and implementation of customized rehabilitation programs, coordinated with programs of both psychopharmacological and psychotherapeutic individual therapies, carried out at the referring service;

- reception activities as an alternative to hospitallization, both in the sense of avoidance of such a measure and in the sense of an abbreviation of the length of stay of patients taken in care, in collaboration with the SPDC;
- reception activities, in collaboration with residential facilities for the implementation of specific programs, that support the integration of patients in the residential facility.

The goal of treatment is the recovery of individual skills and functional levels of autonomy, in close integration with individualized programs of care that are also integrated with daytime activities carried out in the semi-residential centres, as well as specific treatments at the mental health services. The "Unità di Convivenza" (i.e. unit of cohabitation) is an intermediate residential structure intended for patients who do not need continuously support over the 24 hours.

The presence of the staff is aimed at supporting the patient in the management of the significant daily activities, such as meals, daily startup of outdoor activities, both as working activities and activities within semi-residential departmental structures.

The "Gruppo Appartamento" (i.e. apartment group) is an intermediate residential structure intended for patients with chronic disorders, but with preserved or recovered individual self-management skills. The presence of the staff, without specific psychiatric skills, is not continuous in the 24 hours and is aimed at supporting the patients in particular situations of the day, to meet specific needs, related to the moments of community life in the residence.

The main function/activity is re-socialization.

Mental health in Umbria

The mental health system in Umbria depends on the Department of Mental Health to which the different Mental Health Services refer.

Table 10 and table 11 show the distribution of the Mental Health Services, divided according to the various ASL.

Table 10. The distribution of the Mental Health Services, divided according to the various ASL part 1

ASL n. 1
Mental health service of Gubbio - Gualdo Tadino
Mental health service of Città di Castello - Umbertide
Perugia District:
- Mental health service of Perugia Centro
- Mental health service of Bellocchio
- Mental health service of Ponte S. Giovanni
Mental health service of Bastia
Mental health service of Marsciano - Todi
Mental health service of Magione

Table 11. The distribution of the Mental Health Services, divided according to the various ASL part 2

ASL n. 2
Mental health service of Foligno
Mental health service of Valnerina
Mental health service of Spoleto
Mental health service of Terni
Mental health service of Narni/Amelia
Mental health service of Orvieto

In Umbria SPDCs are located in Perugia, Terni e Foligno.

In reference to our study, here are the description of the Italian team of the 3 services with their catchment areas.

Division of Psychiatry, Clinical Psychology and Rehabilitation

The Division of Psychiatry, Clinical Psychology and Rehabilitation in the Department of Clinical and Experimental Medicine of the University of Perugia, works in the Santa Maria della Misericordia Hospital in Perugia.

Every consultant carries out the ambulatory activity one day in a week and has the possibility to see two first ambulatory visits and the outpatients that need a follow-up visit (generally monthly).

The first ambulatory visit can be booked with a General Practitioner's request at the Unified Booking Service of the Hospital.

The first ambulatory visit consists of a clinical diagnostic conversation with a psychodynamic approach and a diagnosis is defined also by the means of diagnostic tools such as MMPI-2 and SCID-II.

After that, the doctors suggest a psychopharmacological therapy or conduct longitudinal psychological support.

Doctors: 1 chief of department, 3 consultants, 14 junior doctors (trainees) residents of the School of Specialization in Psychiatry.

Catchment area: generally people refer to the Division from the territory of Perugia (about 600.000 inhabitants), but the service is open to people from all the country.

Activities:

- Clinical Psychopharmacology Unit
- Eating Disorders Unit
- Psychogeriatric Unit

Mental Health Service of Bastia

- Catchment area: 70000 inhabitants;
- Doctors: 3 consultant;
- Psychologists: 2;
- Community Psychiatric Nurses: 9;
- Social Workers: 1.

Mental Health Service of Magione

- Catchment area: 58000 inhabitants:
- Doctors: 4 consultants:
- Psychologist: 1:
- Community Psychiatric Nurses: 8;
- Social Worker: 1.

Description of the Mental Health System in England

A Community Mental Health Team (CMHT) is a multidisciplinary team offering specialist assessment, treatment and care to people with mental health problems in their own homes and the community. CMHTs may provide a whole range of community-based services themselves or be complemented by one or more teams providing specific functions.

The CMHT usually provides support and advice to primary care services including: provision of joint educational facilities; regular meeting to discuss the management of patients; shared clinical governance; assessment of mental health problems; provision of mental health treatments; assistance to patients and carers in accessing a range of support, advice and information.

CMHTs, in some places known as Primary Care Liaison Teams, will continue to be a mainstay of the system. CMHTs have an important, indeed integral, role to play in supporting service users and families in community settings. The responsibilities of CMHTs may change over time with the advent of new services, however they will retain an important role. They, alongside primary care, will provide the key source of referrals to the newer teams. They will also continue to care for the majority of people with mental illness in the community.

The Mental Health System in England provides the following new specialized services:

CRISIS RESOLUTION/HOME TREATMENT TEAMS

Commonly it works with adults (16 to 65 years old) with severe mental illness (e.g. schizophrenia, manic depressive disorders, severe depressive disorder) with an acute psychiatric crisis of such severity that, without the involvement of a crisis resolution/home treatment team, hospitalization would be necessary.

ASSERTIVE OUTREACH

It works with adults aged between 18 and approximately 65 with the following:

1. A severe and persistent mental disorder (e.g. schizophrenia, major affective disorders) associated with a high level of disability;
2. A history of high use of inpatient or intensive home based care (for example, more than two admissions or more than 6 months inpatient care in the past two years);
3. Difficulty in maintaining lasting and consenting contact with services;
4. Multiple, complex needs including a number of the following:

- History of violence or persistent offending;
- Significant risk of persistent self-harm or neglect;
- Poor response to previous treatment;
- Dual diagnosis of substance misuse and serious mental illness;
- Detained under Mental Health Act (1983) on at least one occasion in the past 2 years;
- Unstable accommodation or homelessness.

EARLY INTERVENTION IN PSYCHOSIS

This service is offered for:

- People aged between 14 and 35 with a first presentation of psychotic symptoms;
- People aged 14 to 35 during the first three years of psychotic illness.

An early intervention service should be able to:

- reduce the stigma associated with psychosis and improve professional and lay awareness of the symptoms of psychosis and the need for early assessment;
- reduce the length of time young people remain undiagnosed and untreated;
- develop meaningful engagement, provide evidence-based interventions and promote recovery during the early phase of illness;
- increase stability in the lives of service users, facilitate development and provide opportunities for personal fulfillment;
- provide a user centred service i.e. a seamless service available for those from age 14 to 35 that effectively integrates child, adolescent and adult mental health services and works in partnership with primary care, education, social services, youth and other services;
- at the end of the treatment period, ensure that the care is transferred thoughtfully and effectively.

Mental Health in Bedfordshire and Luton

A Trust such as South Essex Partnership University Foundation Trust (SEPT) is an autonomous institution with a board of directors and a chief executive who provide mental health service to a County of England and is responsible to a larger ‘regional’ structure such as ‘East of England’.

South Essex Partnership University Foundation Trust (SEPT) provide the following specialist services.

- •Adult Mental Health
- •Older Peoples Mental Health
- •Child and Adolescent Mental Health
- •Learning Disability
- •Drug & Alcohol Misuse

Hence, older persons will go to the Older Peoples Mental Health service, so that Bedford East will see very few persons with Dementia, and children will go to the Child and Adolescent Mental Health while Learning disabled patients will go to the specific Learning Disability service, and the Drug & Alcohol Misuse clients have their specific service with whom the CMHTs co-operate. This accounts for the differences in caseload composition between a UK CMHT and an Italian CSM.

These services are designed to meet the needs of a diverse population of around 600,000 people and are delivered to over 60 sites across Bedfordshire and Luton.

The Community Mental Health Teams in Bedfordshire and Luton provide the core services to People of Working Age with more complex common or severe and enduring Mental Health problems within an Integrated Service that also includes Assertive Outreach (AO) Crisis Resolution and Home Treatment (CRHT) in-patient services and Day Services. CMHT's will work closely with primary care, users and carers and develop key partnerships which will include voluntary organizations.

Community Mental Health Teams will work with the wider system for providing mental health care by managing referrals and care plans with primary care other statutory and non statutory services, service users and carers through a single point of access.

They work according to locally developed recovery orientated values and principles in order to stabilize social functioning and facilitate service users to live independently in the community.

Services will be accessible, relevant, non discriminatory and will respect the cultural values of service users and their carers.

The service is aimed at reducing the stigma linked to mental health ensuring that care is delivered in the least restrictive and disruptive manner possible.

As for the organization, Community Mental Health Services in Bedfordshire and Luton will be delivered by 6 CMHT's. Each team is linked to primary care with weighted populations of equal size based on Mental Illness Index (MIN) Services.

Each CMHT unites specialist medical, nursing, psychology, occupational therapy, social work and care management skills in a team with an adequate skill mix and a single management structure.

As for Community Mental Health Service in Bedford East, the staff is composed by:

- *Doctors:* 1 consultant, 1 associate specialist, 1 junior doctor (trainee);
- Community Psychiatric Nurse: 5;
- Social Worker: 3;
- Occupational Therapist: 1;
- Support Workers: 4.

The CMHT will provide individualized, effective, evidence-based treatments to reduce and shorten distress and suffering, these should include:

- Psychological therapies and counseling;
- Psychosocial Interventions;
- Medication management and concordance;
- Relapse prevention therapy;
- Treatment to achieve Recovery, Function and Inclusion;
- Psycho-education and health promotion;
- Coping strategies;
- Management of associated substance misuse;
- Support with housing and finance;
- Day time activity (including education, employment and leisure):
- Monitoring physical health;
- Support and advice to families and carers.

Generally, the patients are referred to the Service by the GP or the crisis team; they are then seen for the first 3 months by a 'subteam' called the ASPA (Assessment and Single Point of Access) team which works with the patients to assess whether there is an important mental health problem which needs treatment in our team or whether after some work the patients can be discharged back to the GP. A diagnosis is made, and the patients are seen by a care co-ordinator and a doctor. At the end of this, a decision is made as to whether the patient can be discharged back to the GP or whether he/she needs further longer term treatment, in which case he/she is transferred to the 'Recovery' subteam, which works with patients over a much longer period of time. Here the patient has the same doctor but a different care co-ordinator.

Comparison of the caseloads

Referring to the caseloads of the different Services considered in our work, we have detected that there are some differences between the organization of the teams and the caseloads of the Community Mental Health Services in Italy and in England and between the community health services and the hospital service.

Analyzing the differences between Italy and England, we can see that CMHT in Bedfordshire- is faced with a similar catchment area (60.000 inhabitants) to that of the Italian services (Bastia 70.0000 e Magione 50.000 inhabitants).

Despite this, we see that in the month of February 2013 the CSM of Bastia had to face a greater demand for psychiatric visits than the other services (Bastia 678 visits, Magione 270 visits, Bedfordshire 200 visits , and 564 patients use the service).

However, in reference to the number of new visits, the CMHT of Bedfordshire seems to present a greater turnover of patients compared to the Italian CSMs (Bedfordshire 46 new referals, Magione 16, Bastia 17). This could be due to two factors, the first of which is that in England there is a particularly close interaction between the GPs and the CMHT.

In fact, General Medical Practitioners play a central role in the care and treatment of people with mental illness. Just under half of all GPs complete a mental health training placement as part of their vocational training. This inevitably improves the referral of patients with mental problems to specialist psychiatrists, increasing the number of first contacts at the level of outpatient mental health services, as it was detected by A. Grassi (Grassi 1998) in Italy, who noted that the origin of the demands reaching the district services is related to an increasing extent to general medicine.

The second factor to consider is that the CMHT is integrated in the city context with an industrial reality of Bedfordshire, which differs from to the rural and craftsmanship reality of the CSMs in Umbria and this seems to be a protective factor with respect to the onset of mental disorders.

The context of the Section of University Psychiatry that operates in the general hospital of Perugia is even more different.

In fact, what emerges is that, despite the hospital of Perugia represents the regional referral hospital, the total number of contacts per month seems to be lower than those of the other 3 services (154); however it is worthy to note the high numbers of first visits (40). This is due to the type of work carried out in this section. In fact, three different activities are carried out for three days a week (Clinical Psychopharmacology Unit, Psychogeriatric Unit and Eating Disorders Unit) where patients are sent mainly by GPs.

Therefore the team performs diagnostic and therapeutic outcome evaluations, taking in care the patient or referring him/her to the community mental health services.

This Section provides a service in close cooperation with the CSMs, which deal with much of the primary mental health care at a territorial level.

The differences are also visible at the most purely diagnostic level, where we can see a higher percentage of patients suffering from elderly disorders (8.4%) and from eating disorders (8.4%), compared to community mental health services, in line with the specialized activities carried out by the different operating units of the Section of Psychiatry.

It is important to note that Bedford East is a working age CMHT hence the doctors do not visit over 65 age patients unless they are already known to our service before the age of 65, when they stay with us till age 70. Hence Bedford East will not usually have many dementia patients.

Noteworthy both the community mental health services in Italy and in England, and the Hospital University Section in Perugia (Italy), are characterized by a high percentage of people suffering from mood disorders (see tables 1, 3 , 5, 7).

This is in line with what WHO observed, namely, that in 2030 depression will be the most important and critical disease worldwide. In fact, to date, mood disorders are the most prevalent psychiatric disorders, as they contribute to 5% of patients in public mental health services, 65% of psychiatric outpatients, and 10% of all patients seen in non-psychiatric medical facilities (Merk manual 2012). This makes much more sense if we consider that European regions had a higher rate of suicide than other regions (Jacob 2007).

Further the most frequent diagnosis are anxiety disorders and psychosis (see tables 1, 3, 5, 7).

Not by chance in Italy it had already been observed that if we analyze the psychopathological distribution between 1977 and 1985, the disorders that become increasingly frequent among the district service users are anxiety states (from 18.4% to 50%), affective psychoses (from 8.3% to 21.7%) and depressive psychoses (from 0 to 14.3%) (Carucci 1987).

CONCLUSIONS

WHO outlined the need and rationale for building community-based mental health systems and services.5 It identified the following key components for improving mental health services: provide treatment for mental disorders in primary care; ensure increased accessibility to essential psychotropic medication, and provide care in the community; educate the public; involve communities, families, and consumers; establish national policies, programs, and legislation on mental health; develop human resources; link with other sectors; monitor community mental health; and support relevant research (Jacob 2007).

In order to promote mental health primary care the Division of Mental Health should develop standardized epidemiological tools and supervise mental health services in data collection for Mental Health Services, day-hospitals, psychiatric wards in general hospitals and out-patient units. It would be important to have indicators such as the number of new cases seen in the systems and the number of persons being reached. These epidemiological instruments can be developed by universities and be available to all mental health services in the countries (Mateus 2008).

Furthermore, it is important to develop mental health guidelines for primary care health professionals and to train health workers acting in primary care. Training alone is not sufficient to guarantee sustainability of actions so it is important to develop long term follow-up of teams.

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