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# Mental healthcare professionals' perspectives on optimal mental healthcare:

## A focus group study in six European countries

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*Pilot Projects is an initiative „of an experimental nature designed to test the feasibility of an action and its usefulness" and permits appropriations for it to be entered in the EU budget for more than two consecutive financial years.

## The European MentALLY project

Mental health problems in adults are of great concern as they are highly prevalent and significantly impact health, social welfare, and the economy. Psychological treatment – whether in combination with medication or otherwise – is effective, but has not been able to nullify the disparities that exist within mental health care. Suboptimal or undertreatment and overtreatment of people seeking services have been reported. MentALLY's strategic aim is to gather the necessary empirical evidence to accelerate the evolution towards European mental healthcare that provides effective treatment to all adults who are in need. A carefully designed implementation and dissemination strategy will translate the empirical evidence in ways that will strengthen existing networks and improve practices.

## The issue

We currently lack data on the current situation in MHC across Europe and on the practices required to overcome barriers in access to services and in assessing and referring clients, especially clients who are vulnerable in terms of their socioeconomic status and/or ethnic background. We also lack European data on the competencies applied, required, and deemed effective by health professionals working in primary and specialized mental healthcare and how these practices yield positive treatment outcomes.

## Research questions

- What are **health professionals' perspectives** on accessible and effective mental healthcare?
- What practices and skills do health professionals working in MHS consider important and necessary in facilitating accessibility, referral practices, collaboration, and positive treatment outcomes?

## Method

Local **focus groups** with 3–11 participants in 6 countries

- A focus group is a qualitative research method whereby various participants have a discussion on a particular topic. The discussion is led by a facilitator (or multiple facilitators) who provides a list of topics concerning the main research questions.

- Ethical approval from four Review Boards: Ghent University, University of Gothenburg, the University of Crete, and Regional Committees for Medical and Health Research Ethics Norway

- Research process in each country: **recruitment of participants → informed consent → audio-recorded focus group → verbatim transcript → translation to English → thematic analysis**

- Participants were recruited according to the following criteria: age – gender - professional background (e.g. psychologists, psychiatrists, general practitioners) – work setting (e.g. public or private sector, working as part of an interdisciplinary team or independently).

## Thematic analysis

The thematic analysis followed the step-by-step instructions presented in Braun & Clarke (2006)[1] with the goal of identifying patterns that are relevant to our research questions. The analysis resulted in a series of main themes and subthemes for each country. The resulting themes and subthemes were woven together to summarize, interpret, and make sense of the data in a narrative representing the six MentALLY partners' engagement in sharing and recounting the mental healthcare stories in their countries. In this fact sheet, we present five overarching themes that refer to patterns that were present in various focus groups across the six countries.(*)

(*) The findings in this fact sheet are the result of a first analysis of the focus groups across all countries. For a more extensive description of the thematic analysis within each country, the resulting themes, and an analysis between countries, we would like to refer to the academic paper that will be published in a later phase of the project. More information on this paper will be shared on the MentALLY website: http://mentally-project.eu.

[1] Braun, V., & Clarke, V. (2006). Using thematic analysis in psychology. *Qualitative research in psychology, 3*(2), 77-101.

## Presentation of the five overarching themes

### (1) Availability and accessibility of mental health services: barriers and obstacles to obtaining the necessary care

MHPs in the 6 countries stated that Mental Health Services (MHS) have been increasingly utilized in the past few years. They stressed the barriers and obstacles to obtaining the necessary care, especially with the increasing need for services. In Norway access to MHS is described as ***a process of accessing a "castle surrounded by a moat",*** whereas in Cyprus MHS have managed to ***survive a severe economic crisis to the detriment of quality and equitable accessibility***, since the preponderance of services are in the private sector. In Greece ***a long process of de-institutionalization and expansion of community services is still in progress***. Hence, publicly funded services are available (especially for severe psychiatric problems) but are not always accessible due to understaffing. In the Netherlands there are ***capacity problems for chronic as well as crisis care***. Finally, in both Belgium and Sweden MH professionals stressed that ***people seeking MHS do not get the help they need, the moment they need it*** due to waiting lists. Adequate ***funding and staffing shortages*** are seen as common barriers to providing quality services in all the countries. Growing inequality fueled by inaccessibility, long waiting lists, and a lack of specialized care was underscored in all six countries.

> *"The different institutions are too isolated, and a bit too much either of this or that. It is like trying to reach a fortress surrounded by a moat! Then there is the problem with the organization of the health services. The structuring, coordination and patient flow ... There are too many areas where we fall short." (Norwegian participant)*

The impediments mentioned above go along with ***waiting lists and lack of availability of comprehensive treatment,*** especially in rural areas.

> *"Accessibility also means follow-up of the patient's progress, attendance frequency, why people do not seek services, what problems a person had and did not come to see how we will solve it. If the person misses an appointment, to immediately schedule the next one. (To have) continuity in therapy, that is, some reference persons that are consistently available and not to change providers all the time." (Greek participant)*

MH professionals fear that these obstacles in accessibility and in the availability of comprehensive services compromise the MHS offered. They described how they are not only failing to provide adequate treatment for patients with enduring MH problems, but are also wasting funds by not providing suitable, timely, and effective services. Mobile mental health services and the application of mental healthcare (e-MHC) in the delivery of services were mentioned as positive developments in all MentALLY countries.

## (2) Complications and dilemmas in assessment and diagnosis: required, needed, and overbearing

The MH professionals who participated in the focus groups expressed concern that they ***often have to work beyond their professional competencies in diagnostic procedures*** (Belgium, Greece, Cyprus) or they ***lack the appropriate tools to provide the best care*** (lack of standardized assessment tools in Cyprus or evidence-based protocols for diagnosis in Greece). The lack of ***state support in continuing training and education*** (Cyprus) and the ***lack of Europe-wide licensing, credentialing, privileging, and accreditation procedures for MHP*** create diagnostic or treatment problems and ethical dilemmas (Greece). The ***chase for diagnosis*** (Sweden) and ***working in predetermined and inflexible frameworks*** where only a specific model of care can be provided (Norway) were other issues cited.

> *"We are usually based on our subjective evaluation as to whether the outcomes we get are good or bad" (Cypriot participant )*

Participants working in primary care in Sweden described feeling ***trapped in the financial compensation system they have to implement which leads to a chase in diagnoses.*** They dubbed this required labelling 'devastating', because it can be overbearing for people and their lives.

> *"Last week I was going to write some papers that were to be distributed, and there was one of the junior doctors who had written 'generalised anxiety', and the patient had seen this and hit the roof. He had also been given a diagnosis that was completely wrong, so that he would sue everybody now. And this poor junior doctor had done it, I can't just write UNS, or something ... he had to write a diagnosis, so you are forced to write a diagnosis." (Swedish participant)*

According to the MH professionals in all countries involved in the MentALLY project, mental health problems are also often complex problems where several life domains are involved. This complexity and ambivalence is often a barrier to accurate diagnosis, requiring continuous training, experience, and flexibility as diagnosis can lead to labelling and stigmatization.

### (3) Facilitating referrals: processes, efficiency, and identifying and providing a broad spectrum of mental health services

MHPs underlined ***the importance of Primary Care in referral*** and the need for well-outlined guidelines for such practices. There appear to be gray areas, and MHPs are often hard-pressed to draw the line regarding the scope of their practice in managing clients' concerns versus making a referral. Moreover, ***referrals are often lost between different services*** (e.g., primary care and specialized care in Sweden). MHPs have difficulty ***in identifying mental health providers and the available services*** (Belgium, Cyprus).

MHPs stated that MHS should operate as ***"a chain of care"*** by ***"blind trust"*** (Belgium). Such a chain does not seem to exist (Cyprus, Greece). In Norway, referrals and ***the movement of service users*** between different branches in mental healthcare were described as ***halted by heavy bureaucratic processes***. Difficulties in referral between the diverse forms of care that exist in different countries (Sweden, Cyprus, and Greece) were also discussed.

> *"I do not always get a response to the referrals I send, so I do not know if these people receive an offer or if they're now in nowhere-land. This makes me a bit uncertain about referrals, and it might raise the threshold for referring. I always try to refer of course, as I do not want to rob them of any rights, but it is challenging." (Norwegian participant)*

> *"Referrals become a game between primary and psychiatric care to the detriment of the patients." (Swedish participant)*

In Greece, the MHPs described how within the same MHC unit there is ***no referral system for different MHS or other health services that service users may need***. In Cyprus, referrals are almost exclusively ***self- or family-initiated***. Adequate coordination and meaningful communication between the GPs, MHPs, the service user, and the consultant to whom they are referred maximize efficiency and effectiveness in care provision. According to the participants, such referral processes are not systematically implemented.

Universal and well-organized frameworks for referrals can facilitate diverse service provision, which can in turn facilitate adequate coordination and meaningful communication between MHPs and service users. On the positive side, MHPs referred to the incorporation of new information technology in MHC and described how it can be used to improve communication and networking among the people involved.

## (4) Forms of care and the quandaries involved

A broad spectrum of MHS is provided in the countries involved in the MentALLY project. The services include MH promotion, prevention, early identification of MH concerns, referrals for specialized treatment, and different forms of therapy in public and private settings. Nevertheless, MHPs emphasized the ***fragmentation of existing forms of care*** (Belgium, Norway) and the ***parallel and conflicting operation of different forms of care*** (i.e., between primary care and specialized care in Sweden).

In the Netherlands, participants stated that ***MHC is influenced by private market mechanisms*** (insurance companies who only reimburse only specific forms of treatment). Due to this, healthcare providers ***pick the "easy" people to treat***, and people with more complex problems that need specialized and long-term care are consequently left untreated.

> *"All the private institutes cherry-pick their patients. Like, oh that patient is good, because I can do short DBCs (diagnosis-treatment-circuits) and have good results. I'll take them. I hear from several general practitioners that certain patients are denied care by certain bigger institutes. The caregivers refer them and the institutes say, "No, we won't take this patient." (Dutch participant)*

In Greece, Cyprus, and the Netherlands MHPs proposed ***linking prevention and treatment within an integrated framework***. Diverse approaches to ***prevention and the promotion of mental health*** were discussed, including ***psychoeducation of the general public*** on mental health problems at the primary level. Secondary prevention, additional treatment, or wrap-around services designed to strengthen the therapeutic gains for individuals who did not fully benefit from the standard program or whose recovery seems fragile are not always available. ***Continuity in care***, which encompasses an array of strategies used in an ongoing way over extended periods to support those individuals diagnosed with persistent, long-term conditions, is considered necessary and not readily offered.

> "*This is what I am thinking (as the ideal MH care service): prevention, treatment, stabilization, psycho-education, de-stigmatization, and in general the improvement of the quality of life of the recipients of mental health services." (Greek participant)*

In Norway, participants described the ***flexibility of choosing an appropriate treatment for each patient*** as an essential aspect of their job, which in turn facilitates their ability to deliver quality services. In Sweden, participants explained that continuity in care is of utmost importance for service users diagnosed with psychosis. Therefore, a model for continuity in care was incorporated into the treatment plan for such cases.

> *"As an example, our clinic ... psychosis psychiatry ... no one decides to sort of follow and take care of individual patients, but there are people who are responsible for each patient and there are people who organise the care and collaboration around the patients. And that works well, and in some clinics it works ... very well." (Swedish participant)*

The focus group participants championed comprehensive services that include a holistic understanding of peoples' lives and continuity in care. They discussed the need for MH promotion strategies and for building the capacity of MHS to respond to mental healthcare needs with increased and more purposeful attention to people's unique lives.

### (5) Collaboration arrangements: making therapeutic practice relevant

According to the MHPs, therapy practices have to be relevant to people's everyday lives, and collaboration at different levels is crucial in achieving this. Participants stressed how positive collaborative relationships are indispensable when an MHP wants to tailor care practices to each person's circumstances and to enhance therapeutic outcomes.

***Shared responsibility of both service users and the MH professionals*** is far-reaching for the provision of quality services (The Netherlands). Furthermore, ***collaboration with service users*** is considered integral in order to ensure therapy compliance and an effective therapy outcome (Cyprus, Belgium). Co-production mandated by policies was also deemed necessary in all the countries that took part in the research. Accordingly, quality care is based on a trusting and mutually positive relationship between professionals and individuals seeking MH services.

> *"It is extremely important to plan treatment primarily in consultation with the patient. Teamwork is critical for this." (Swedish participant)*

> *"People may leave the hospital thinking: 'I have received compulsory therapy, I am ok now, and I am leaving, and I do not want to see any MH professional in my life!' Thus, the patient is lost for the system." (Cypriot participant)*

Participants in all the countries described quality care as ***"being authentically there"*** and developing a positive and unique long-term relationship or 'bond' with the service users. MHC can only be adequate when care providers treat people not as objects (diagnoses or parts of their problem), but as people with dignity. Moreover, care should not be hindered by administrative constraints.

> *"I think it is an added value, that you can leave all that labelling behind and just go into a conversation with that person and move on with his question…" (Belgian participant)*

Contrary to quality care, ***compulsory hospitalizations*** are counter to therapeutic goals and constitute a significant issue in MHC in Cyprus and Greece, according to the participants. They are related to dropouts and relapses and add to the mistrust of MHPs.

Inter-sectoral ***collaboration with other organizations or institutions*** in order to work on MH related policies (The Netherlands) and in providing the needed services is essential (Greece) for the provision of proper care. Nevertheless, in some countries ***collaboration between different services***, such as public and private (Cyprus and Greece), is difficult due to legislative obstacles. Moreover, collaboration between primary healthcare and specialized healthcare (Sweden, Norway) enhances treatment outcomes but is not always feasible (Sweden, Cyprus, and Greece). Participants therefore made compelling arguments for effective **teamwork** fostered through collaboration and networking processes aimed at achieving a service user-centered approach to service provision.

As participants in Belgium described:

> *"You know that some doctors you can call and that you are always welcome, other doctors find it disturbing ... I'm talking about doctors now ... yes, with other people you have to mail or some prefer a letter or ... that alone, communication has struggles, and I experience it as a real problem." (Belgian participant)*

***Collaboration between MH professionals*** also entails the sharing of expertise and mentoring of inexperienced personnel (The Netherlands). Collaboration assumes that ***MH professionals know their limitations and the boundaries of their competencies*** (The Netherlands, Cyprus, Greece) and do not practice beyond them. ***Conflicts*** (Cyprus) and ***mistrust*** (Belgium and Greece) between MH professionals and MHC providers were also underscored in the focus group discussions.

> *"As a psychologist/psychiatrist, like every caregiver, you should be able to say I can or cannot do this. And say to the patient, I am going to send you to a specialist and you are going to be treated by them. The first step to do this is being able to say; I do not treat this, it isn't my expertise. This needs a different mindset." (Dutch participant)*

Collaboration is considered a key ingredient in providing quality mental healthcare by the participants in this research. They recounted that collaboration is not a simple process. Service users benefit from respectful listening, responsiveness to their expressed needs, and from taking part in decision-making regarding their lives. According to the MHPs who contributed to the focus group discussions, service users are not numbers or labels and certainly do not want their humanity debased nor their freedom suppressed.

## Conclusion

MHPs in all countries involved in the MentALLY project propose comprehensive models of care where service users have a say in their treatment and receive the needed support, and where services are organized, equitable, and tailored to users' needs. Participants emphasized the barriers in accessibility and availability of services, which include waiting lists, inadequate funding, and staffing shortages in most countries, along with the lack of continuing education, specialization, and training of primary care personnel. They also underscored the complexities involved in assessing and treating mental health issues and the fine lines that exist between diagnosis, labelling, and stigmatization.

MHPs are interested and motivated to provide optimal mental healthcare that is appropriate, effective, and available for all who need it. MHPs highlighted collaborative models of primary, secondary, and prevention-oriented mental healthcare, which were deemed positive and vital. Teamwork in providing care was considered a more effective and efficient use of resources. Another positive development, according to the MHPs, is the use of e-mental health, mobile and electronic filing systems, which enhance collaboration and can be more widely applied in rural and hard-to-reach areas of the participating countries.