

adopt healthy behaviours, and they have poorer clinical outcomes than informed, activated patients.⁵

These failures are often due to the interaction between individual doctors and a dysfunctional system. Some doctors may simply be uncaring and paternalistic. Almost all become less collaborative when they are running two hours behind schedule. Given multiple competing demands, providing care that is consistent and compliant with guidelines in a 15 minute visit is beyond the reach of most primary care doctors, however well trained and well intentioned they may be.^{6 w4} Lack of time is a considerable barrier, preventing doctors from providing sufficient information to their patients and blocking their ability to share decisions in practice.^{7 w5-w7}

Numerous studies show the central role of nurses in implementing components of the chronic care model, most importantly planned chronic care visits. In Kaiser Permanente's trial of planned visits by groups of people with diabetes led by a nurse educator, participants had significantly lower glycated haemoglobin levels and lower use of hospitals than controls.⁸ Other work has shown that patients attending a clinic for planned visits led by nurses had improved glycated haemoglobin levels that were also lower than those of patients who got the usual care.^{9 10} In yet another study, patients attending a diabetes clinic with a nurse, compared with those getting the usual care, had lower mortality and a lower incidence of adverse clinical events (myocardial infarction, angina, revascularisation procedures, end stage renal disease) after a median follow up of seven years.¹¹ A Cochrane review found that planned nursing visits can improve healthy behaviours and patients' outcomes in diabetes; it concluded that nurses "can even replace physicians in delivering many aspects of diabetes care, if detailed management protocols are available, or if they receive training."¹²

Many of the positive outcomes seen in planned care visits with nurses may be due to better communication between nurse and patient. In a randomised controlled trial of people with diabetes in general practice, analysis of taped discussions showed that nurses covered more topics in the consultations, and more often mentioned diet, alcohol use, smoking, and weight, than did the doctors. Patients were more likely to take the lead in discussing behaviour change with nurses than with doctors.^{w8} In focus groups, patients preferred nurse led shared care for managing diabetes over doctor led care by a ratio of nearly 6 to 1.^{w9 w10}

Even though evidence and examples show the pivotal role played by nurses in improving chronic care, several barriers inhibit the spread of nurse led programmes in the United States (see bmj.com). The nursing shortage has made nurses difficult to recruit; few insurance plans pay for care provided by nurses; and nursing education in the United States does not emphasise the role that nurses can play in chronic illness care. In some health systems, nurses are under-used, taking blood pressures and putting patients into rooms rather than providing education for and encouraging self management by chronically ill patients. Until these barriers are overcome, the potential for nurses to lead a national effort in the United States to improve chronic illness care may be thwarted.

Thomas Bodenheimer *adjunct professor*

Kate MacGregor *research director*

Department of Family and Community Medicine, University of California at San Francisco, San Francisco General Hospital, San Francisco, CA 94110, USA (Tbodenheimer@medsch.ucsf.edu)

Nancy Stothart *clinical care specialist*

Whatcom County Pursuing Perfection Project, Bellingham, WA 98225, USA

Competing interests: None declared.

- 1 Wagner EH, Austin BT, Davis C, Hindmarsh M, Schaefer J, Bonomi A. Improving chronic illness care: translating evidence into action. *Health Affairs* 2001;20(6):64-78.
- 2 Marvel MK, Epstein RM, Flowers K, Beckman HB. Soliciting the patient's agenda. *JAMA* 1999;281:283-7.
- 3 Roter DL, Hall JA. Studies of doctor-patient interaction. *Annual Rev Public Health* 1989;10:163-80.
- 4 Braddock CH, Edwards KA, Hasenberg NM, Laidley TL, Levinson W. Informed decision making in outpatient practice. *JAMA* 1999;282:2313-20.
- 5 Heisler M, Bouknight RR, Hayward RA, Smith DM, Kerr EA. The relative importance of physician communication, participatory decision making, and patient understanding in diabetes self-management. *J Gen Intern Med* 2002;17:243-52.
- 6 Yarnell KSH, Pollak KI, Ostbye T, Krause KM, Michener JL. Primary care: is there enough time for prevention? *Am J Public Health* 2003;93:635-41.
- 7 Kaplan SH, Gandek B, Greenfield S, Rogers WH, Ware JE. Patient and visit characteristics related to physicians' participatory decision-making style. *Med Care* 1995;33:1176-87.
- 8 Sadur CN, Moline N, Costa M, Michalik D, Mendlowitz D, Roller S, et al. Diabetes management in a health maintenance organization. Efficacy of care management using cluster visits. *Diabetes Care* 1999;22:2011-7.
- 9 Peters AL, Davidson MB. Application of a diabetes managed care program. *Diabetes Care* 1998;21:1037-43.
- 10 Aubert RE, Herman WH, Waters J, Moore W, Sutton D, Peterson BL, et al. Nurse case management to improve glycemic control in diabetic patients in a health maintenance organization. *Ann Intern Med* 1998;129:605-12.
- 11 So WY, Tong PC, Ko GT, Leung WY, Chow CC, Yeung VT, et al. Effects of protocol-driven care versus usual outpatient clinic care on survival rates in patients with type 2 diabetes. *Am J Manag Care* 2003;9:606-15.
- 12 Renders CM, Valk GD, Griffin S, Wagner EH, Eijk JT, Assendelft WJ. Interventions to improve the management of diabetes mellitus in primary care, outpatient and community settings. *Cochrane Database Syst Rev* 2001;(1):CD001481.

Mental health in Europe

New action plan will help improve care, especially in eastern Europe

In January 2005 the *Mental Health Declaration for Europe* and the *Mental Health Action Plan for Europe* were endorsed by the ministers of health of the 52 member states in the European region of the World Health Organization at a meeting in Helsinki.^{1 2} An unprecedented array of organisations of service users, non-governmental organisations, and professionals had been consulted in preparing these statements, which now set a clear policy direction for the development of mental health services in the wider Europe for

at least the next decade. In which direction is the new policy going and how far is it wise?

The background to these new policies is a clear divide between the countries of western Europe, which have largely completed the process of deinstitutionalisation, and the position in most central and east European states, in which the transition from institutional care to a



Figures 1 and 2 are on bmj.com

more balanced mix of services is starting only now (figures 1 and 2 are on bmj.com).^{3,6} At its worst, the challenges of institutional practices (persisting from totalitarian times), very low funding, and remote locations have led to severe abuses of human rights at mental hospitals in several east European countries.^{7,8}

The WHO declaration is quite clear that in future mental health services in Europe should no longer be in isolated and large institutions but should be provided in a wide range of community based settings. Interestingly, going beyond the location of services, the policy refers repeatedly to the need to achieve the social inclusion of people with mental illness (for example, in the labour market), and to reduce discrimination.⁹ It also specifically encourages the role of non-governmental organisations as the “yeast,” bringing innovation into mental health care.

The Mental Health Action Plan is somewhat more specific in its content. It recommends a series of actions under five key headings—to foster awareness of mental wellbeing, to tackle stigma, to implement comprehensive mental health services, to provide a competent workforce, and to recognise the experience and importance of service users and carers in planning and developing services.

From the perspective of a service user or consumer what is the importance of these recommendations? That a consumer role is given such prominence is both overdue and welcome, although these documents are noticeably vague on such details as how funding should be provided to initiate and consolidate service user groups, at the same time as respecting their autonomy.¹⁰ Further, no attention is given here to more complex questions of how the views of children, or those who lack capacity, can be represented. Little emphasis is placed in these documents on the mental health of the younger and older segments of the European population. On the positive side, the action plan actively encourages the use of legislation about disability rights in each member state of the European WHO region on an equal basis for people with disabilities related to physical illness or to mental illness.¹¹

But do these policies go far enough? They tread a broad but often uneasy path between advocating for mental health promotion and prevention strategies for the whole populations (the focus of the European Commission), emphasising the need to respect human rights (the domain of the Council of Europe), and targeting services towards people with established mental illnesses in proportion to their degree of disability (a prime interest of WHO). These policies therefore do not state clearly whether or not treatment and care should take precedence over promotion and prevention. Most European countries cannot afford to do both of these activi-

ties well, and in some states few mentally ill people receive any effective treatment. A recent comparative international study of depression found that none of the patients in St Petersburg received evidence based treatment in primary care, and only 3% were referred on to specialist mental health care.¹² The inability of patients to afford out of pocket costs was the primary barrier to care for 75% of the depressed patients studied.

This core issue of finance is dealt with well in these documents. WHO calls on European nations to make investment in mental health an identifiable part of health expenditure to achieve parity with investment in other areas of health. This has very important implications since mental disorders contribute about 12% to the global burden of disease, whereas European countries spend on average about 5% of their health budget on mental health care.⁶ The lowest reported budgets, at less than 2%, are all in the countries of the former Soviet Union.⁶ Such parity of expenditure is therefore a necessary ingredient to redress historical neglect of mental health, both East and West, for example within European Union Research and Development budgets. WHO is to be congratulated on stating the principle of parity in funding so unequivocally.

Graham Thornicroft *professor of community psychiatry*

Health Service Research Department, Institute of Psychiatry, King's College London, London SE5 8AF
(g.thornicroft@iop.kcl.ac.uk)

Diana Rose *co-director*

Service User Research Enterprise (SURE), Health Service Research Department, Institute of Psychiatry, King's College London, London SE5 8AF

Competing interests: GT attended the WHO European Ministerial Conference as a temporary adviser to the World Health Organization.

- 1 World Health Organization. *Mental health declaration for Europe*. Copenhagen: WHO, 2005.
- 2 World Health Organization. *Mental health action plan for Europe*. Copenhagen: WHO, 2005.
- 3 Tomov T. Central and eastern European countries. In: Thornicroft G, Tansella M, eds. *The mental health matrix: A manual to improve services*. Cambridge: Cambridge University Press, 2001:216-27.
- 4 World Health Organization. *Mental health in Europe. Country reports from the WHO European network on mental health*. Copenhagen: WHO, 2001.
- 5 Thornicroft G, Tansella M. Components of a modern mental health service: a pragmatic balance of community and hospital care: overview of systematic evidence. *Br J Psychiatry* 2004;185:283-90.
- 6 Knapp MJ, McDaid D, Mossialos E, Thornicroft G. *Mental health policy and practice across Europe*. Buckingham: Open University Press, 2005.
- 7 Amnesty International. *Memorandum to the Romanian government concerning inpatient psychiatric treatment*. London: Amnesty International, 2004.
- 8 Mental Disability Advocacy Center. *Cage beds*. Budapest: Mental Disability Advocacy Centre, 2003.
- 9 Social Exclusion Unit. *Mental health and social exclusion*. London: Office of the Deputy Prime Minister, 2004.
- 10 Chamberlin J. User/consumer involvement in mental health service delivery. *Epidemiol Psychiatr Soc* 2005 (in press).
- 11 Sayce L. *From psychiatric patient to citizen. Overcoming discrimination and social exclusion*. Basingstoke: Palgrave, 2000.
- 12 Simon GE, Fleck M, Lucas R, Bushnell DM. Prevalence and predictors of depression treatment in an international primary care study. *Am J Psychiatry* 2004;161:1626-34.