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(Análisis Socio-Económico)

EL ACCESO A LA SALUD MENTAL Y LA ATENCIÓN PRIMARIA: GESTIÓN Y ESTRATEGIAS DE MANEJO EN ESPAÑA E ITALIA

ROBERTO GIOSA

Oviedo, Noviembre 2024

Universidad de Oviedo

Ph.D. Dissertation

Doctoral Programme in Economics and Enterprise

(Socio-Economic Analysis)

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RESUMEN (en español)

Los trastornos de salud mental son un importante desafío para la salud pública, afectando a millones de personas a nivel mundial y ejerciendo una fuerte presión sobre los sistemas sanitarios. La prevalencia de trastornos mentales sigue siendo crítica junto con el aumento de las tasas de suicidio, particularmente entre los jóvenes. Además, el envejecimiento de la población mundial incrementa la carga de los trastornos cognitivos, lo que requiere estrategias sanitarias más sólidas. El aumento del uso de medicamentos para el tratamiento de la salud mental refleja un cambio hacia el control de los síntomas en detrimento del bienestar a largo plazo, a menudo a expensas de la autonomía del paciente. Los médicos de atención primaria, como primer punto de contacto con el sistema de salud, juegan un papel crucial en la identificación y gestión de estos trastornos.

Esta tesis tiene como objetivo investigar las dinámicas entre los médicos de Atención Primaria (AP) y los pacientes con trastornos mentales, destacando su importancia para el acceso a servicios especializados, a través de un análisis comparativo entre Italia y España. La investigación aplica la teoría de la Burocracia a Nivel de Calle (BNC) para examinar cómo los médicos de AP navegan entre las necesidades de los pacientes y las restricciones institucionales, y cómo su capacidad de agencia puede influir en las estructuras sanitarias. A través de una comparación narrativa cualitativa, el estudio se basa en entrevistas en profundidad con 20 médicos de AP, 22 pacientes con trastornos mentales y 6 coordinadores de Centros de Salud.

Los resultados revelan que, aunque los sistemas sanitarios en Italia y España son distintos, ambos enfrentan desafíos similares relacionados con la escasez de recursos, el aumento de la carga de pacientes y las presiones sistémicas que a menudo empujan a los médicos hacia soluciones farmacológicas. A pesar de estos desafíos, el estudio destaca el poder discrecional que los médicos de AP ejercen en su práctica diaria, lo que impacta directamente en la implementación práctica de la universalidad de los sistemas de salud a nivel de calle. Muchos médicos buscan activamente equilibrar la presión institucional con las necesidades de los

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pacientes, explorando a menudo intervenciones alternativas no farmacológicas. Por ejemplo, con pacientes jóvenes, los médicos a menudo optan más por estrategias de atención colaborativa, las cuales incluyen apoyo psicológico y formación del paciente, para reducir la dependencia de los medicamentos. La investigación sugiere que, aunque las presiones institucionales siguen siendo sustanciales, muchos médicos de AP se esfuerzan por mantener un enfoque en la atención individualizada que promueve la autonomía del paciente y el bienestar a largo plazo.

En Italia, los médicos de AP tienen una elevada independencia siendo trabajadores autónomos, lo que les permite adoptar prácticas innovadoras, formar grupos colaborativos y utilizar nuevas tecnologías para ofrecer una atención de salud mental personalizada y centrada en el paciente. En cambio, los médicos de AP en España operan dentro de un sistema más centralizado y burocrático, lo que limita su capacidad de innovar de manera independiente. Sin embargo, tanto los médicos italianos como los españoles disfrutan de una considerable autonomía en su práctica clínica, lo que les permite elegir de manera discrecional estrategias de gestión alternativas más allá de la medicación, fomentando un enfoque más participativo con los pacientes.

La presente tesis doctoral proporciona una relevancia tanto teórica como práctica a la teoría de la BNC, al examinar cómo los médicos de AP gestionan los trastornos mentales dentro de específicos contextos institucionales y organizativos. La investigación ofrece un análisis exhaustivo de cómo las prácticas discrecionales de los médicos en Italia y España moldean las interacciones con los pacientes y los resultados sanitarios. El estudio identifica carencias en la formación en salud mental y destaca cómo la experiencia profesional influye en la toma de decisiones. Esta investigación se enfoca en los contextos poco estudiados y con recursos limitados del sur de Europa, ampliando el alcance comparativo de la teoría de la BNC. Muestra cómo las estrategias de gestión de los médicos de AP, condicionadas por factores institucionales y organizativos, pueden generar cambios sistémicos desde la base de los sistemas de salud. Asimismo, las diferencias en dichas estrategias, influenciadas por factores individuales y contextuales, cuestionan la noción de universalidad de los sistemas sanitarios.

RESUMEN (en Inglés)

Mental health disorders are a major public health challenge, affecting millions globally and placing immense pressure on healthcare systems. The prevalence of mental disorders remains a critical concern, alongside rising suicide rates, particularly among young people. Moreover, the ageing global population increases the burden of cognitive impairments, necessitating more robust healthcare strategies. The rising use of pharmaceuticals for mental health treatment reflects a shift towards symptom control over long-term well-being, often at the expense of patient autonomy. General practitioners (GPs), as the first point of contact in primary care, play a crucial role in identifying and managing these disorders.

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Thus, this thesis aims to investigate the dynamics between GPs and patients with mental disorders, highlighting their significance for access to specialised services, through a comparative analysis of Italy and Spain. The research applies the Street-Level Bureaucracy (SLB) theory to examine how GPs navigate the tension between patient needs and institutional constraints, and how their agentic power may influence healthcare structures. Using a qualitative, narrative cross-case comparison, the study draws on in-depth interviews with 20 GPs, 22 patients with mental disorders, and 6 first-line supervisors.

The results reveal that while the healthcare systems in Italy and Spain are distinct, both face similar challenges related to resource shortages, increasing patient loads and systemic pressures that often push GPs toward pharmacological solutions. Despite these challenges, the study highlights the significant discretionary power that GPs exercise in their daily practice, directly impacting the practical implementation of the healthcare systems' universality at the street level. Many GPs actively seek to balance institutional demands with patient needs, often exploring alternative, non-pharmacological interventions. For example, GPs frequently opt for more collaborative care strategies with younger patients, including psychological support and patient training, to reduce the reliance on medication. The research suggests that while institutional pressures remain substantial, many GPs strive to maintain a focus on individualised care that promotes patient autonomy and long-term well-being.

In Italy, GPs have greater autonomy as self-employed practitioners, which allows them to adopt innovative practices, form collaborative groups, and utilise new technologies to deliver personalised, patient-centred mental health care. Conversely, Spanish GPs operate within a more centralised, bureaucratic system, limiting their ability to innovate independently. However, both Italian and Spanish GPs enjoy considerable autonomy in their clinical practice, enabling them to discretionarily choose alternative management strategies beyond medication, promoting a more participative approach to health management with patients.

This dissertation provides both theoretical and practical analytical relevance to the SLB Theory by examining how GPs manage mental health disorders within institutional and organisational contexts. It offers a comprehensive analysis of how GPs' discretionary practices in Italy and Spain shape patient interactions and healthcare outcomes, enhancing the understanding of SLB Theory in real-world healthcare settings. The study identifies gaps in mental health training and highlights how professional expertise impacts decision-making. This research focuses on the under-explored, resource-limited contexts of Southern Europe, broadening the comparative scope of the SLB Theory. It demonstrates how GPs' management strategies, shaped by institutional and organisational factors, can drive systemic changes from the ground level of health systems. Moreover, the variations in GPs' management strategies, influenced by individual and contextual factors, challenge the notion of universality in healthcare systems.

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The doctoral thesis is often described as a long journey, a voyage in search of knowledge that sheds light on an unclear or unknown phenomenon. In this journey, the guidance of my supervisors has been essential. Modern Virgil in the Inferno that scientific research often appears to be, they have helped me grow in a discipline that is now part of my scientific and cultural background. I therefore thank Professor Ana Marta Guillén Rodríguez for her always timely, sharp, and precise advice. I thank Professor David Luque Balbona for his effective direction, constant availability, and meticulous attention to my progress.

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Thanks to Isabel, for being there, for encouraging and helping me in difficult moments, and for being a solid shoulder always by my side. A thought for Luck, a soul of love that passed through this world too quickly.

Finally, heartfelt thanks to all the interviewees, without whose availability this research would not have been possible.

OSLOMET

Oslo, 18 October 2024

Review of doctoral thesis

Thesis title: *Access to mental health and the primary care: Management and handling strategies in Spain and Italy*
Doctoral candidate: *Roberto Giosa*

This letter is written in my capacity as external reviewer of Roberto Giosa's doctoral thesis, which I have read with great interest.

The thesis addresses a theoretically interesting and empirically very important topic. It provides an investigation of "the dynamics between general practitioners (GPs) and patients with mental disorders". More specifically, Giosa studies how modes of organisation and the broader institutional configurations of primary care in the public health system impact how GPs approach patients with mental challenges and whether these practices of GP-patient interactions, in turn, may lead to organisational and systemic changes. Hence, beyond its empirical focus on GPs' management of patients with mental health problems, the thesis also offers a theoretical argument about how institutional change might unfold in modern welfare states.

Theoretically, the thesis builds on and further develops the concept of street level bureaucracy (SLB). Drawing on the SLB perspective, Giosa outlines an analytical framework that underscores the importance of factors belonging to the macro, meso and micro level respectively in shaping the primary care given to patients with mental disorders in different health systems. An emphasis on the ongoing interplay and interactions across the three levels underpins his argument that behaviour at the micro level may eventually lead to changes in the broader institutional and organisational architecture. The analytical framework appropriately employs the work of Michael Lipsky on street level bureaucrats as its starting point and integrates this with the perspective of Deborah Rice, who in her micro-institutionalist approach combines Giddens' structuration theory and Lipsky's street level bureaucracy perspective. Giosa presents his theoretical framework with impressive clarity, demonstrating extensive knowledge and a deep understanding of relevant theoretical debates as well as strong writing skills. He defines and discusses the key conceptual building blocks of the framework in a commendable manner.

Empirically, the thesis offers new knowledge about how patients with mental health challenges are met by general practitioners (GPs) in Italy and Spain, which exemplify two Southern European, universal national health systems. Thus, the justification of the case selection is sound and the study represents a valuable addition to the existing body of empirical knowledge of Southern European health systems in particular but also of their welfare states more generally. Moreover, the thesis contributes to existing scholarly literature with regard to GPs use of discretion and what factors influence this. In general,

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differences in management practices are explained with variation in institutional and organisational structures across the two countries.

The methodological approach is explained in an exemplary way. I was impressed by the rigorous and very systematic research design and the thorough discussion of the qualitative approach adopted in the thesis. I appreciated the author's critical reflections on the strengths and weaknesses of qualitative methods when contrasted with quantitative approaches. Furthermore, the methods chapter of the thesis outlines not only the research design and methods employed to collect and analyse data but also details the ontological and epistemological underpinnings of the study as justification for the chosen methods.

The empirical chapters are supported by primary data in the form of 48 in-depth biographical interviews with GPs, first-line supervisors and patients. This approach is appropriate for the research questions at hand. The quality of data management appears adequate and the data is rigorously analysed with the help of a sound scientific approach and, thereby, meeting the expectations of a strong PhD thesis.

Overall, Giosa has produced an excellent piece of research. The thesis is very well written, addresses a topic of high societal relevance, and is of very high academic quality. Therefore, I recommend that Roberto Giosa is awarded the doctoral degree in sociology.

Mi Ah Schoyen

Research professor
Oslo Metropolitan University

Review of Roberto Giosa doctoral thesis "Access to mental health and the primary care: management and handling strategies in Spain and Italy"

Roberto Giosa doctoral thesis is an interesting study on the interactions between GPs and patients with mental health disorders. It examines how institutional and organizational factors affect these relationships. Moreover, mental health is framed in the research as a case study in order to seeking to understand how GPs operate in general adopting a specific lens to draw broader conclusions about health management practices.
The thesis adopts a nuanced and interesting theoretical framework, primarily based on Michael Lipsky's street level bureaucracy (SLB) theory and complemented by Deborah Rice's micro-institutionalist theory of policy implementation.
In relation to methods, Roberto Giosa utilizes two tools: a cross-national narrative comparison and primary data collection. The empirical research is based on a most-similar cases approach: Spain and Italy are countries that transitioned from occupation-focused to universal healthcare models.
The findings of Roberto Giosa doctoral thesis are valuable and insightful both in terms of empirical findings and theoretical ones.
The comparison between the two countries shows the ongoing presence of different approaches within similar welfare models. Differences in management practices between Italy and Spain can be traced back to variations in these institutional and organizational factors, while similarities also appear. The research highlights that Italian GPs, as self-employed practitioners, enjoy considerable organizational autonomy. This independence enables them to adopt innovative practices, such as forming collaborative groups and utilizing technology to manage patient care more efficiently. In contrast, Spanish GPs, constrained by their dependent employment status, face greater limitations in implementing organizational changes independently. They must navigate through more layers of bureaucracy, which can stifle innovation. At the same time, the study finds that the systemic pressures and constraints GPs face are counterbalanced by their capacity to exercise discretion effectively. The convergence of practices between Italian and Spanish GPs highlights a universal trend in GP management of mental health disorders that transcends national boundaries.
From a theoretical perspective, the Giosa study finds that GPs tailor their interventions to meet individual patient needs, reflecting a deep understanding of the complexities inherent in mental health care. This practice not only supports the SLB theory's assertion of the autonomy of front-line public service workers but also aligns with Rice's observation of the dynamic interaction between macro-structural elements and individual agency within institutional settings. At the same time, the study did not only find confirmation of previous SLB theory (and Rice approach), but it also developed a further understanding of how SLB work. In particular, the study offers a comprehensive analysis, providing a nuanced understanding of the interplay between macro-level structures and micro-level interactions. The study further developed SLB Theory by demonstrating how professional frameworks influence the discretionary practices of GPs. It also explored how GPs' management of patients with mental health disorders can initiate policy-making processes that, in turn, shape broader institutional and organizational frameworks.
Finally, the dissertation provides valuable suggestions for policies, and supplies insights for further research in the field.
Overall, Roberto Giosa doctoral thesis contributes to our understanding of important social phenomena and helps to sharpen our analysis of such phenomena thanks to a well-design theoretical approach that mixes macro-, meso-, and micro-factors. Therefore, the thesis by Roberto Giosa fulfils all the conditions and is acceptable for the doctoral degree in sociology.

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LIST OF ABBREVIATIONS

AP	[*Atención Primaria*]
FFS	Fee-for-service
FL	First-line
FLS	First-line supervisor
GP	General Practitioner
GPs	General Practitioners
GDP	Gross Domestic Product
NHS	National Health Service [*Sistema Nacional de Salud*, SNS]
NICE	National Institute for Health and Care Excellence
OOP	Out-of-pocket
SLB	Street-Level Bureaucracy
SLBs	Street-Level Bureaucrats
SPHs	Schools of Public Health
WHO	World Health Organization

ACCESS TO MENTAL HEALTH AND THE PRIMARY CARE: MANAGEMENT AND HANDLING STRATEGIES IN SPAIN AND ITALY

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KEYWORDS: Mental health management, Primary care, Street-level bureaucracy theory, Institutional and organisational constraints, Healthcare systems

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investigación sugiere que, aunque las presiones institucionales siguen siendo sustanciales, muchos médicos de AP se esfuerzan por mantener un enfoque en la atención individualizada que promueve la autonomía del paciente y el bienestar a largo plazo.

En Italia, los médicos de AP tienen una elevada independencia siendo trabajadores autónomos, lo que les permite adoptar prácticas innovadoras, formar grupos colaborativos y utilizar nuevas tecnologías para ofrecer una atención de salud mental personalizada y centrada en el paciente. En cambio, los médicos de AP en España operan dentro de un sistema más centralizado y burocrático, lo que limita su capacidad de innovar de manera independiente. Sin embargo, tanto los médicos italianos como los españoles disfrutan de una considerable autonomía en su práctica clínica, lo que les permite elegir de manera discrecional estrategias de gestión alternativas más allá de la medicación, fomentando un enfoque más participativo con los pacientes.

La presente tesis doctoral proporciona una relevancia tanto teórica como práctica a la teoría de la BNC, al examinar cómo los médicos de AP gestionan los trastornos mentales dentro de específicos contextos institucionales y organizativos. La investigación ofrece un análisis exhaustivo de cómo las prácticas discrecionales de los médicos en Italia y España moldean las interacciones con los pacientes y los resultados sanitarios. El estudio identifica carencias en la formación en salud mental y destaca cómo la experiencia profesional influye en la toma de decisiones. Esta investigación se enfoca en los contextos poco estudiados y con recursos limitados del sur de Europa, ampliando el alcance comparativo de la teoría de la BNC. Muestra cómo las estrategias de gestión de los médicos de AP, condicionadas por factores institucionales y organizativos, pueden generar cambios sistémicos desde la base de los sistemas de salud. Asimismo, las diferencias en dichas estrategias, influenciadas por factores individuales y contextuales, cuestionan la noción de universalidad de los sistemas sanitarios.

CHAPTER 1
INTRODUCTION

This doctoral dissertation investigates the dynamics between general practitioners (GPs) and patients with mental disorders, highlighting their significance for access to specialised services. In this thesis, mental disorders are understood according to the definition provided by the World Health Organization (WHO) (2022), which considers both mental health conditions as a wide category, where mental disorders are specific settings of significant impairment in an individual's social and psychosocial functioning.

> A mental disorder is characterized by a clinically significant disturbance in an individual's cognition, emotional regulation, or behaviour. It is usually associated with distress or impairment in important areas of functioning. There are many different types of mental disorders. Mental disorders may also be referred to as mental health conditions. The latter is a broader term covering mental disorders, psychosocial disabilities and (other) mental states associated with significant distress, impairment in functioning, or risk of self-harm.

More in detail, this thesis examines how institutional and organisational factors impact the daily work of GPs and their potential to effect changes within these contexts. Mental health is considered a specific case study, aiming to comprehend the general operations of GPs, thus employing a particular perspective to formulate wider conclusions about health management practices.

This chapter begins with a concise overview of the historical evolution of "health". Further, the justification for the research is presented, highlighting the critical role of primary care in the early detection and management of mental health disorders. After, the research design of the thesis is presented. Finally, the introduction concludes with the structure of the thesis.

1.1 A brief presentation of the historical evolution of "health"

The concept of health has evolved significantly over the centuries, reflecting shifts in philosophical, medical, and societal perspectives. In ancient Greece, health was perceived through a holistic lens, integrating physical well-being with mental and spiritual harmony. Ancient physicians, such as Hippocrates, wanted not merely to treat physical illness but to understand the balance of the body's humours. They recognised that health encompassed a state of equilibrium within the individual's body and environment, marking an early appreciation for the interconnectedness of the human condition.

The philosophy of Stoicism further expanded on the concept of well-being by advocating for the cure of the soul as a pathway to health. Stoicism suggested that health could be achieved through the practice of reflexivity, engagement in political and social life, and care for the body (as the residence of the soul). Seneca highlighted the significance of friendship for well-being in his work *De tranquillitate animi* [Of Peace of Mind] (1900, Chapter VII), stating:

> Yet nothing delights the mind so much as faithful and pleasant friendship: what a blessing it is when there is one whose breast is ready to receive all your secrets with safety, whose knowledge of your actions you fear less than

> your own conscience, whose conversation removes your anxieties, whose advice assists your plans, whose cheerfulness dispels your gloom, whose very sight delights you!

It was widely recognised that well-being is a multifaceted concept, incorporating biological, psychological, social, and spiritual elements. However, during the centuries, the approach to health took a decidedly more biological turn. The human body started to be seen through a mechanistic perspective, with health being defined as the absence of illness and the focus shifting towards merely resolving symptoms. This period saw a diminution of the holistic understanding of health, favouring instead a reductionist approach that sought to treat symptoms and diseases through direct intervention, often overlooking the mental and emotional dimensions of health.

It was not until the 20th century that the biomedical model of health began to be challenged by the emergence of the biopsychosocial model (Engel, 1981). This model marked a return to a more holistic understanding of health, acknowledging the complex interplay between biological, psychological, and social factors. In practical terms, as Engel states:

> This means that the physician identifies and evaluates the stabilizing and destabilizing potential of events and relationships in the patient's social environment, not neglecting how the destabilizing effects of the patient's illness on others may feed back as a further destabilizing influence on the patient […] For the biopsychosocially oriented physician this is not merely a matter of compassion and humanity, as some would have us believe, but one of rigorous application of the principles and practices of science, a human science (p. 543).

This model roots in the WHO "health" definition in which physical, social, and spiritual well-beings were included (1946). With the new definition, "health" underscores not just the absence of disease but the general presence of well-being.

It was therefore expected that medicine would become more "social". However, it seems that it was society that was "medicalised". On page 97 of her manual "Sociology of Health and Illness", Sarah Nettleton (2021) presents the results of a study on medicalisation. Observing the evolution of the number of mental disorders listed in the "Diagnostic and Statistical Manual of Mental Disorders" (DSM), from the first to the fifth, the latest edition, one can notice a change from 106 disorders in the first edition, which had 130 pages, to 295 disorders with more than 500 pages in the DSM-III, up to the current DSM-5 with 541 disorders and over 947 pages (Whooley, 2017).

The medicalisation of society can also be evidenced by the globally increasing in the consumption of pharmaceuticals for the treatment of mental health issues (Diaz-Camal *et al.*, 2022). While factors such as the pandemic may play a role, the New Public Management approach has prioritised symptom control and quick outcomes over long-term well-being (Nettleton, 2021). Moreover, pharmaceutical companies may have a vested interest in increasing and modulating drug consumption, as favouring anxiolytics over traditional benzodiazepines (Fava, 2016). In fact, the consumption of benzodiazepines has shown fluctuations without a considerable increase (Sarangi *et al.*, 2021), while the consumption of anxiolytics continues to rise (Diaz-Camal *et al.*, 2022).

Patients with mental health issues have moved from the paternalistic management typical of the asylum period to being considered as consumers of treatment. Doctors act more as dispensers of medication than as counsellors for therapy based on well-being and aimed at improving the lifestyle of patients (Fava, 2023). Despite being consumers, patients are deprived of the ability to implement decision-making strategies, with those who best adapt to the doctor's management being rewarded (Fava, 2023; Stacey, 1974). This change potentially restricts patient autonomy in treatment decisions, favouring a system where conformity to prescribed medical management is incentivised, possibly at the expense of exploring individualised and potentially more beneficial therapeutic options.

1.2 Research justification

In this thesis, the focus is on mental health and the crucial role that primary care plays in its management and early detection. The considerable prevalence of untreated mental disorders, as highlighted by Kessler *et al.* (2005) and Wittchen *et al.* (2011),

coupled with widespread stigma and escalating healthcare costs (Doran *et al.*, 2017), underscores the urgency of addressing this issue.

Suicide, considered a critical indicator of mental health challenges worldwide, is identified by the WHO as the fourth leading cause of death among young individuals aged 15–29 years, after road injuries, tuberculosis, and interpersonal violence. It is a brutal reality that a life is lost to suicide every 40 seconds across the globe (WHO, 2020a). Moreover, there's a significant prevalence of individuals experiencing persistent subthreshold symptoms that don't fully align with mental health diagnostic criteria, complicating early detection (Cuijpers & Smit, 2004). In Italy and Spain, the focus of this study, suicide rates are highest among the elderly, but there is a concerning increase among the youth as well. Specifically, in Spain suicide is now the leading cause of death for those between 15 and 29 years old (Observatorio del Suicidio en España, 2023). In Italy, it is the third leading cause of death for the same age group, following car accidents and cancer (Istituto Superiore di Sanità, 2022).

Approximately 38.2% of the European population is affected by a mental disorder annually, including conditions such as depression, anxiety, and sleep disorders (Wittchen *et al.*, 2011). In a 2019 analysis of 31 European countries, around 13.6 million youths were identified with mental disorders, alongside 3.2 million handling with substance use disorders, and 75,770 instances of self-harm. The incidence rates per 100,000 people set at 16,98 for mental disorders, 3,89 for substance use disorders, and 89,1 for self-harm. Notably, the most significant increases in prevalence since 1990 have been in eating disorders, rising by approximately 14.9%, and idiopathic developmental intellectual disabilities, highlighting evolving mental health challenges across Europe (Castelpietra *et al.*, 2022). Furthermore, the coming years are likely to witness an increase in the incidence of cognitive disorders due to the general aging of modern societies (Pais *et al.*, 2020). In particular, Italy has the highest median age of any country in Europe (EUROSTAT, 2024c).

Thus, the COVID-19 pandemic has worsened an already compromised situation. Public mental health has suffered due to measures like lockdowns and social distancing (Serafini *et al.*, 2020), indicating a decline in mental well-being on European and global scales. Similarly, the mental health of primary care physicians has been notably impacted by the pandemic, exacerbated by increased consults, the stress of implementing anti-contagion measures, and the inherent risks of infection. These challenges have amplified

the already precarious work conditions, affecting both the psychological well-being of physicians and the quality of care they provide (Di Monte *et al.*, 2020; Fiorino *et al.*, 2020). Further, the pandemic has led to a worldwide rise in anxiety and major depressive disorders among the young, both of which are linked to a higher risk of self-harm (Castelpietra *et al.*, 2022).

Primary care and Access to mental health services

The concept that health is not only a personal matter but also inherently "social", encompasses much more than the significance of an active and meaningful social life. It further involves the structural and functional dimensions of health service, which are critical in defining how health services are organised, accessed, and delivered. This broader understanding of health as a social construct indicates the complex interplay between individuals and the institutional frameworks designed to support their health needs.

Within bureaucratic organisations, such as the National Health Service (NHS), which strive to ensure universal and equitable health distribution, primary care serves as a crucial element in enhancing accessibility to, appropriateness of, navigation within, and patient candidacy for healthcare services (Dixon-Woods *et al*., 2006; Petmesidou *et al*., 2020). Operating as the frontline contact within the healthcare service, GPs play a pivotal role in the early detection of psychological symptoms (Becchi, 2015; Louma *et al.*, 2002), as well as in the treatment of common mental disorders and the overall consultation of patients with serious conditions (Grandes *et al.*, 2011; Lora, 2009).

However, understanding the strategic job of primary care for people health requires a look back at a defining moment in its evolution: the international WHO conference held in Alma-Ata, Kazakhstan, from the 6th to the 12th of September, 1978. The objective of this meeting was to initiate "urgent action by all governments, all health and development workers, and the world community to protect and promote the health of all the people of the world" (WHO, 1978, p. 1). Reflecting the WHO's initial 1948 definition of "health," the cornerstone document of the conference explains that:

> Primary health care is essential health care based on practical, scientifically sound and socially acceptable methods and technology made universally accessible to individuals and families in the community through their full

> participation and at a cost that the community and country can afford to maintain at every stage of their development in the spirit of self-reliance and self-determination. It forms an integral part both of the country's health service, of which it is the central function and main focus, and of the overall social and economic development of the community. It is the first level of contact of individuals, the family and community with the national health service bringing health care as close as possible to where people live and work, and constitutes the first element of a continuing health care process. (*ivi*, p. 2)

Effective management of mental disorders by primary care professionals is crucial, impacting both individual well-being and economic stability. Indeed, the significant costs associated with mental disorders stem largely from indirect expenses, such as the loss of productivity due to sick days, disability, and early retirement, rather than the direct costs of treatment (Wittchen *et al.*, 2011). The global economic impact of mental health conditions, encompassing both treatment and pharmaceutical expenses, is increasing, with depression accounting for a substantial portion of the global disease burden (Bloom *et al.*, 2012). The implementation of preventative strategies holds critical importance, offering the potential to decrease the economic burden of diseases by as much as 70% (Van Lerberghe, 2008).

1.3 Research design

Improving access to mental health services is essential for the well-being of individuals and communities, ensuring the provision of cost-effective healthcare, and advancing health equity. Given the importance and current relevance of the research topic, driven by the need to examine the phenomena more thoroughly, particularly considering both contextual and individual factors that influence the outcomes of GPs' management strategies, I have formulated the following research questions:

- How do the institutional environment and organisational context affect the GPs' management of patients with mental disorders?

- In what ways GPs' management of patients with mental disorders lead to the development of new behavioural patterns at a micro-level, which could potentially change the institutional and organisational framework?

Theoretical framework

This study is driven by the requirement to consider factors at macro, meso, and micro levels, providing a generalizable practical perspective on the work of GPs. Furthermore, it aims to understand how doctors manage the increasing demand for mental health care and to which extent management could be improved.

To develop a coherent research approach focusing on the role of primary care as the initial point of contact for users, this thesis employs the Street Level Bureaucracy (SLB) theory as its theoretical framework. Michael Lipsky's (2010) seminal study of service delivery within a bureaucratic organisation serves as a critical lens for studying the accessibility of mental health services through the examination of GPs work.

Lipsky's theory, fundamentally, explores the nuanced role that frontline public service workers, those operating "on the street", play in shaping public policy. This exploration is particularly relevant to understanding the institutional and organisational dynamics that could significantly influence individuals' mental health and their access to necessary services. The theory further delves into the operational dilemmas faced by Street-Level Bureaucrats (SLBs), caught between the imperative to provide personalised care and the practical constraints of limited resources and institutional pressures. This tension underscores a fundamental paradox within public service delivery: the expectation of individualised attention within a framework that inherently prioritises efficiency and uniformity (Lipsky, 2010).

Therefore, by applying Lipsky's SLB theory, this thesis aims to dissect the intricate dynamics between mental health service provision and policy implementation. It intends to illuminate how GPs, as SLBs, navigate their roles as both caregivers and policy implementers within the mental health domain. This theoretical perspective offers a nuanced understanding of the challenges and opportunities inherent in ensuring equitable access to mental health services, contributing to a more comprehensive discourse on mental health policy and practice.

The theoretical framework also incorporates Deborah Rice's micro-institutionalist approach to policy implementation (2013), which represents an innovative combination

of Michael Lipsky's SLB theory and Anthony Giddens' Structuration theory. This integration provides a nuanced understanding of the dynamic interplay between institutional structures and individual agency within the context of policy implementation. Giddens' core argument is that the relationship between societal structures, such as institutions and political organisations, and individuals is bidirectional: structures constrain individual actions, but individuals also have the power to alter these structures through their actions. This dialectic relationship highlights that while societal structures offer a framework that limits individual actions, individuals, through their actions, possess the potential to modify these very structures (Giddens, 2014).

Rice adopts Giddens's conceptualisation of institutions as "the long-lasting patterns of social practices that are recognised and adhered to by a majority within a society" (Giddens, 2014, p. 164). This definition underscores the notion that institutions are not merely physical entities but are constituted through shared ideas and social practices that become normalised over time through interaction (Rice, 2013). Through the lens of Rice's theory, the opportunity of GPs to generate micro-institutional transformations becomes evident. These transformations are operationalised through the mechanisms described by Lipsky, illustrating the significant role that individuals, within the healthcare service, can play in shaping policy outcomes at the micro-level.

Research hypotheses

Based on the theoretical framework, I developed three research hypotheses. These regard the operational dynamics of SLBs and their engagements with users, with a particular focus on mental health services and the structuring of public healthcare services:

- Hypothesis 1 seeks to examine the impact that the institutional and organisational background has on the GPs' management of patients with mental disorders.
- Hypothesis 2 explores whether trends in management approaches can be identified through the GPs' daily work.
- Hypothesis 3 considers whether these emergent management trends contribute to alterations within the institutional and organisational model.

Methodological framework

The methodology of this thesis is qualitative, with a narrative cross-case comparison between Italy and Spain, using both primary and secondary data. The critique from a quantitative standpoint highlights the challenges in directly comparing qualitative studies due to the unique sensitivities and circumstances of each research setting, alongside the difficulty in obtaining a large, representative sample. However, these limitations are viewed as inherent rather than negative, as qualitative research prioritises in-depth understanding over statistical representativeness (Gobo, 2002; Griffiths *et al.*, 2011). Cross-national narrative comparison studies possess significant analytical capabilities in identifying potential underlying mechanisms at both macro and meso levels that affect access to mental health services (Hill & Hupe, 2019). The comparison between Spanish and Italian institutional and organisational contexts aims to shed light on the differences in how GPs manage their patients, thereby offering insights into the varied approaches of these Health services. Since the investigation into GPs' handling of patients with mental disorders is specific and not universally applicable, it facilitates the comparison of these welfare systems (*ivi*).

Primary data collection, following the hermeneutic-phenomenological approach, was accomplished through in-depth biographical interviews, a method distinguished by the interviewer's non-judgmental stance and the use of dialogue to achieve a deeper understanding of the investigated phenomenon (Lindseth & Norberg, 2004; Rosenthal, 1993). In-depth interviews also incorporated questions designed to stimulate storytelling. Unlike the typical approach in qualitative SLB research, where storytelling is not often employed, this method presents an opportunity to gather valuable information (Gofen, 2014; Maynard-Moody & Musheno, 2000). The interviewees included GPs, patients with mild or severe mental disorders, and First-line (FL) supervisors, *i.e.*, GPs' coordinators. The interviews took place from June to November 2022. A total of 22 patients were interviewed, with an equal number from Spain and Italy. Moreover, 20 doctors were interviewed, 10 each from Spain and Italy, alongside 4 coordinators in Spain and 2 in Italy. Further details are provided in the methodology chapter.

1.4 Summary of the chapters

To produce a coherent research narrative, from the object, literature review, theoretical framework and methodology to the results and their implications, this thesis is structured as follows.

Chapter 2 “Literature review”. This chapter establishes the foundation for understanding the multifaceted landscape of mental health service access. It begins by exploring macro-level factors, including what “institution”, “organisation”, “agency”, and “top-down and bottom-up influences” mean. The institutional barriers and facilitators are scrutinised, emphasising how policy, societal expectations, and healthcare infrastructure shape service delivery. The chapter further explores the changing roles of GPs, from traditional biomedicine practitioners to holistic health advisers, and patients, from passive recipients to active participants in their well-being journey. Subsequently, the study of contributions on meso and micro factors influencing GPs management is presented. The chapter concludes with the identification of suggested gaps in the literature.

In Chapter 3 “Theoretical framework and research hypotheses”, the characteristics of SLB and Rice’s theory are presented in detail. The chapter questions the extent to which GPs act as SLBs, navigating between policy directives and patient needs. The chapter concludes by synthesising these insights to outline the research’s theoretical foundation and hypotheses, setting the groundwork for empirical exploration.

In Chapter 4 “Methodological Framework”, an in-depth discussion of the methodological approach is presented. This underscores the epistemological considerations guiding the research, based on Martin Heidegger’s philosophy. The qualitative, hermeneutic-phenomenological framework was chosen to capture the experiences of GPs and patients within the mental health service landscape. The chapter contains an understanding of the significance and utility of the term “validation of hypothesis,” considering the qualitative methodology of the research. The process for validating hypotheses through primary data collection, contrasting institutional and organisational contexts, and examining general practitioner (GP)-patient interactions, is presented. A detailed procedure for data collection and analysis is outlined.

In Chapter 5 “National case presentation”, a comparative description of mental health institutional and organisational context between Italy and Spain is presented. The relevance of this comparison is explored and justified.

Chapter 6 “Institutional and organisational impacts” delves into the institutional and organisational factors influencing GPs’ management in the realm of mental health disorders. It examines how patient and physician roles have evolved. Moreover, the chapter explores the various models of primary care organisations, access to primary care,

and the resource limitations, setting the stage for a comparison that highlights similarities and differences between the two countries. The results of this chapter have already been partially presented in a recently published article (Giosa, 2024).

In Chapter 7 “GP-Patient dynamics and management strategy innovations”, the discretionary practices of GPs in Italy and Spain are explored, focusing on the creation of welcoming environments for patients with mental health problems. It examines how shifts in patient and GP roles towards a more collaborative and proactive approach in health production influence management strategies. The comparative analysis between the two countries underscores innovative practices and challenges, leading to a discussion on the broader implications for mental health care delivery.

Chapter 8 “Changing from practice: bottom-up insights”. Exploring the transition from governing frameworks to practical applications, this chapter provides a detailed presentation of how the GPs autonomy can either fulfil or frustrate governing and patients’ expectations, with suggestions on evolving perceptions of mental health issues, tolerance education, prescription practices, and the integration of social and medical care. The comparison and discussion sections highlight how these bottom-up insights offer valuable lessons for developing mental health management strategies.

Chapter 9 “Conclusion”. The final chapter synthesises the research findings, offering a comprehensive discussion of their implications for literature and mental health policy. Moreover, the theoretical contribution of the thesis is discussed. After, the chapter presents the study’s limitations and suggested chances for future research.

CHAPTER 2
LITERATURE REVIEW

This chapter aims to present key studies and research that have contributed to understanding GPs' management, particularly in cases involving patients with mental disorders. It explores how this management can create barriers to accessing mental health services, highlighting the factors that influence the effectiveness of care and the challenges faced by patients. Access to mental health represents a multifaceted subject for study. In terms of discipline, it can be studied from an economic, sociological, political, and psychological perspective. In this chapter, literature contributions on the role of GPs in the management of mental disorders and their influence on patient access to specialised services are presented. The variables affecting this process are organised into three levels: institutional and cultural factors at the macro level, organisational factors at the meso level, and personal and individual factors at the micro level.

Before exploring the literature, it is necessary to introduce the chapter with two analytical considerations. First, the complexity of the variables influencing access to mental health services necessitates a focused approach, inevitably leading to a selection process in which only certain variables can be considered. This selection, as highlighted

by Hupe (2019a), introduces a degree of reductionism that, while necessary, permits acknowledgment. The vast array of potential variables, from socio-economic status and cultural norms to healthcare policies and individual health behaviours, presents a challenge in fully capturing the multifaceted nature of mental health service access. The chosen variables are thus reflective of those that align most closely with the aim of this thesis, offering a structured yet nuanced exploration of the topic. However, this approach does not diminish the relevance or impact of unselected variables but rather underscores the practical limitations of research scope and the importance of focused inquiry to achieve clarity and depth in understanding the selected areas. Secondly, the distinction between correlation and causality occupies a central place in the interpretation of research findings, especially within the domain of social sciences where complex, multifactorial relationships abound. Brossard & Chandler (2022) caution against the simplistic attribution of causality to observed correlations.

The chapter is structured as follow. The section 2.1 “Conceptualisation of institution and organisation” introduces the conceptual foundations of “institution”, “organisation” and “agency”. In the section 2.2, descriptions of access to healthcare services are presented based on the model of Aday and Andersen (1974), the five-components model described by Petmesidou *et al.* (2020), and the concept of “candidacy” (Dixon-Woods *et al.*, 2006). The chapter follows, with literature-based insights on how institutional and cultural factors could influence access to mental health services and their operationalisation. Section 2.4 examines the influence of both meso and micro level variables on how GPs manage mental health disorders. The final section synthesises insights from the literature to highlight existing gaps, setting the stage for this dissertation. Moreover, it introduces the research questions.

2.1 Conceptualisation of “institution”, “organisation” and “agency”

In this study, the term “institution” is conceptualised based on the perspectives presented in Hodgson’s work (2006). He suggests that institutions inherently possess a dual character: they are objective structures existing externally in society, as well as subjective forces residing within human cognition. Thus, institutions’ influence on individual actions can be understood as twofold. Firstly, they provide a set of external guidelines or norms that shape expectations and acceptable behaviours in a social context. This might include legal frameworks, ethical standards, or cultural norms that individuals

are expected to follow. Secondly, as subjective forces, institutions also shape individual worldviews, values, and beliefs internally. This means that the decisions and actions of individuals are influenced not just by external pressures but also by internalised norms and values that are part of their social conditioning.

Institutions establish and embed a set of social rules and norms, forming complex networks of social regulations that extend beyond mere rules. Individuals internalise these norms, shaping their values, beliefs, and worldviews. This internalisation affects decision-making and actions, reflecting a deep interplay between external social pressures and internalised values. In healthcare, the Hippocratic Oath embodies a common understanding of what it means to be a competent physician, sharing ethical standards. However, these perceptions are profoundly influenced by the "state of affairs": advancements in technological tools for conducting consultations and communicating with patients, the rapid dissemination of health news, and governmental efforts to curtail public healthcare expenditure are some of the factors that could modify the general perception of what it means to be a "modern, exemplary physician" (Antoniou *et al.*, 2010).

Further, following the metaphor of Beckfield *et al.* (2015), if the universality of health is the stage where patients and physicians act, there is a social object that determines them staging. As the authors state, the welfare state acts as an institutional arrangement, setting the *rules of the game* that dictate health distribution, including inequalities, influencing, and altering the impact of social determinants of health. If the determination of the rules is realistic on a chessboard during a game, where although the combinations are several, the possibility of moving the pieces is limited and determined, in the everyday life of the welfare state, however, the issue is more complex. The agents are not pieces, but individuals who have the possibility of interpreting and questioning, to varying degrees of awareness, the *rules*. In this work, I consider not the *cause of the causes*, focusing on the *rule of the game*, *i.e.*, the characteristics of the health service that influence GPs' management of patients with mental disorders and the access to special services. By examining the impact of the institutional and organisational environment on GP-patient interactions and identifying the potential for these interactions to generate systemic change, this dissertation aims to offer insights into more effective management strategies for mental health services. Ultimately, the research seeks to contribute to the development of more accessible, equitable, and effective mental health care services, in

line with the overarching goals of enhancing individual and community well-being and advancing health equity. This extensive analysis delineates the multifaceted obstacles hindering access to mental health services, scrutinising both individual (micro) and systemic (meso) levels.

Thus, institutions should not be viewed as static entities but as dynamic structures that evolve through the interactions of those they influence. This perspective provides insight into the mechanisms of institutional change and underscores the importance of engaging with the varied interpretations and practices of individuals within the system. Recognising the fluid nature of institutional perceptions underscores the potential for transformative change, driven by shifts in societal values, technological progress, and policy innovation. Interpretations of institutions not only shape the immediate context but also serve as a driving force behind institutional evolution, generating bottom-up transformative challenges. As societal attitudes shift and new challenges emerge, institutions must adapt to remain relevant and effective in governing social interactions and outcomes. For example, daily practices within healthcare and other societal domains are sites of continuous negotiation and reinterpretation. In this regard, Doblytė writes "Both healthcare providers and users of services, however, do not necessarily accept medicalization and its consequences passively and uncritically (…) There is always some space for resistance or agency" (2020, p.24-25).

Regarding their definition, organisations are distinguished by specific criteria that delineate their scope and identify their members. They incorporate governance principles that shape leadership and hierarchical structures that define internal roles and responsibilities (Hodgson, 2006). Organisations serve as the nexus where descending and emerging generative mechanisms manifest. This positioning of organisations implies that they play a critical role in both translating overarching structures and norms into practical actions and in fostering the development of new practices and ideas from within. As such, they are pivotal in shaping the evolution of societal norms and practices.

According to Aday and Andersen (1974), an organisation is a key element that characterises the delivery system alongside resources. The organisation determines how these resources are managed (Gulzar, 1999). In this context, the components of an organisation can be defined by using the concepts of "entry" and "structure". "Entry" refers to the process by which one gains access to the system, including aspects such as travel time and waiting time. "Structure", on the other hand, concerns the characteristics

of the system that dictate what occurs after entry, such as who the individual interacts with and how they are treated (*ibidem*). The characteristics of the delivery system, therefore, reflect its aggregate, structural properties.

Granovetter (1973) adds another dimension to the concept of organisation by distinguishing between strong ties (close and frequent relationships) and weak ties (more distant and less frequent relationships). He argues that weak ties are crucial for the diffusion of information and social mobility, as they connect individuals across different groups and networks, thereby facilitating access to resources and opportunities that might otherwise remain isolated. Despite organisations appearing fragmented at a macro level, Granovetter notes that there can be strong cohesion at a local level. This implies that organisations can function effectively through networks of weak ties, which enable collaboration and communication between different groups. Moreover, Granovetter highlights the importance of trust in leaders and within organisations. Trust is built through personal connections and intermediary contacts, which provide individuals with the confidence to engage in organisational efforts. This suggests that the effectiveness of an organisation relies not only on its formal structure but also on the interpersonal relationships that underpin it. From a broader perspective, trust contributes to social cohesion. Weak ties, which may be less intense but more widespread, can bridge different groups and facilitate the flow of information and resources, ultimately strengthening cohesion within a community. Granovetter further proposes that analysing interactions at the micro level (individuals and small groups) can offer insights into macro-level phenomena, such as community organisation and political structures. This approach underscores the importance of considering interpersonal relationships when seeking to understand the dynamics of organisations.

The concept of “agency” in Sociology refers to the capacity of individuals to act independently and make their own choices, but it is more than just individual decision-making. As defined by Emirbayer and Mische (1998), agency is a complex and dynamic process that unfolds over time and is deeply embedded in social contexts. It involves three interconnected dimensions: the ability to draw upon past experiences (iterational), to imagine and pursue future possibilities (projective), and to critically assess and adjust actions in the present (practical-evaluative). This definition of agency emphasises that it is not simply a matter of rational choice or individual autonomy. Instead, it is influenced by historical, cultural, and structural factors that shape how individuals perceive their

potential for action and change. Agency is seen as variable across different contexts and moments, with people continuously navigating between past patterns, future aspirations, and present realities. Emirbayer and Mische critique Anthony Giddens' conceptualisation of agency, particularly his focus on routinised behaviour within his theory of structuration (Giddens, 2014). While Giddens acknowledges that agency plays a role in the reproduction of social structures, he tends to prioritise routine practices in explaining social continuity. In contrast, Emirbayer and Mische argue that agency also includes reflective and creative capacities that can challenge and transform existing structures. Agency involves not only the repetition of behaviours that sustain existing frameworks but also the potential to innovate and reformulate those structures. It is through this interplay of past, present, and future orientations that individuals can effect change within organisations and broader societal systems. In conclusion, agency encompasses the repetitive dynamics of behaviours that contribute to the ongoing reproduction of social structures, thereby sustaining existing institutional frameworks. However, when individuals' agency is focused on what is personally considered significant and worthy of improvement or change, it initiates new dynamics. These behaviours not only seek to alter present realities but also aspire to transform broader structures with a view towards the future. Organisations provide the structured environment where individual actions and decisions can collectively influence broader social systems. Within organisations, people have the opportunity to implement changes that can start small but gradually lead to significant transformations. Over time, these changes can extend beyond the organisation, influencing wider social frameworks. Therefore, organisations act as critical platforms where efforts to change or innovate can be effectively initiated and nurtured, making them key sites for the realisation of structural change.

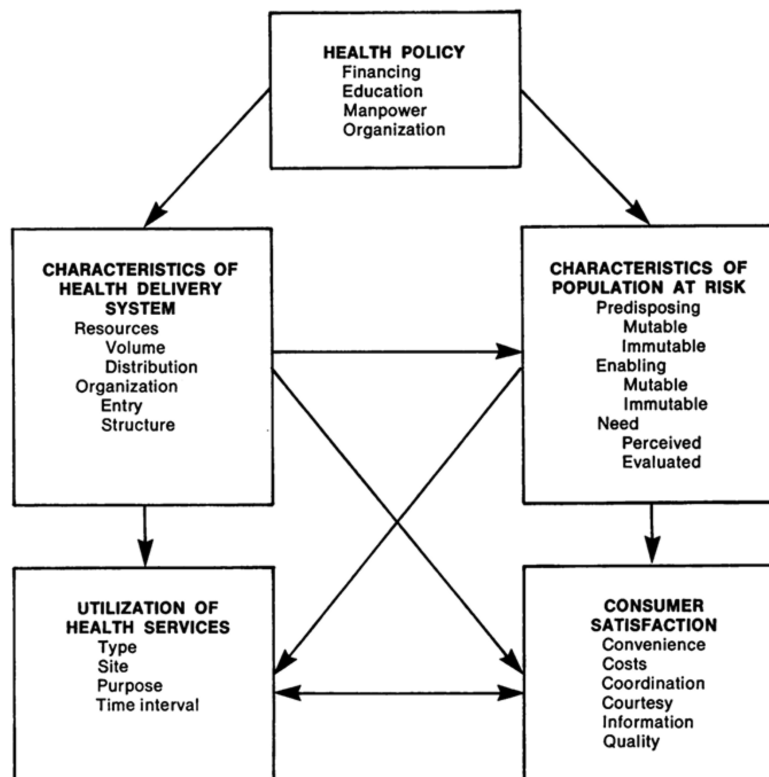
2.2 Conceptual aspects of access to healthcare services

Studying the barriers to access to a specialised health service, such as mental health, requires a clear definition of what is meant by "access". This is necessary to be able to put the subject of examination in focus. It is possible to measure access to health services by taking the equity of services and utilisation of services as indicators. However, given the multidimensionality of the access construct, neither of them is enough to yield comprehensive results (Gulliford *et al.*, 2002). Recognising the ontological complexity of the "access" construct allows for a multidimensional approach to studying barriers to

mental health services, with the understanding that findings are unlikely to yield complete knowledge.

Aday and Andersen (1974) proposed that access to healthcare can be indirectly defined by examining barriers to necessary services. They argued that defining access solely based on the characteristics of the healthcare system and users does not sufficiently explain whether individuals who seek services are actually able to utilise them. The most effective way to measure access is by observing people's behaviour, particularly their actual use of health services concerning their health needs (Gulzar, 1999). The framework they developed acknowledges that individual health practices and service utilisation are influenced by various factors, including the healthcare system itself and the broader external environment. These factors, in turn, shape population characteristics, which include predisposing factors, enabling resources, and need-related factors (*ibidem*). Figure 1 shows the framework for the study of access described by Aday and Andersen (1974).

Figure 1: Framework for the study of access



Source: Aday and Andersen (1974, p. 212).

According to the literature (Levesque *et al.*, 2013; Petmesidou *et al.*, 2020), access to healthcare services could also be defined using five components: affordability, availability, approachability, acceptability, and appropriateness. These components are complemented by specific user characteristics, such as the ability to receive care, the ability to seek help, the ability to attain therapeutic goals, the ability to pay, and the ability to participate in the therapeutic process (Levesque *et al.*, 2013). Briefly, affordability is defined as the ability of individuals to devote resources and time to visit the most appropriate health services. Availability relates to reaching health services easily, considering their geographical distribution, along with the logistics and infrastructure that citizens can use to contact health services. Approachability emphasises the information users have about their health situation and the presence of health services dedicated to their problems. It depends as much on recognising that a service exists and can be reached by an individual as on the transparency of the health care service. Acceptability relates to cultural and social factors determining the possibility for people to accept the aspects of the service (*e.g.*, the gender or social group of providers) and the judged suitability for the persons to seek care. Finally, appropriateness indicates the level of fit between what the client needs and what the health service offers (Petmesidou *et al.*, 2020).

Another model used in studying access is that developed by Gulliford *et al.* (2002). They identify four dimensions of access: availability of services, utilisation of services, effectiveness, and relevance, and equity of access. The last is defined as the possibility for people with the same needs and belonging to different groups to access health services without specific impediments. They also differentiate between "having access" and "gaining access": the former refers to the hypothetical possibility of accessing health services (related to availability), while the latter reflects accessing a health service (related to utilization). Availability, however, presents some critical issues if considered alone as a determinant of access to health services. In fact, some users may find it difficult to use the services both because of personal prejudices about the usefulness of the treatment, as well as obstacles related to a high degree of stigmatisation (Gulliford *et al.*, 2002). In addition, the quality of services offered must also be considered, as low quality may lead to high utilisation and, vice versa, high quality of services may correspond to low utilisation, as users quickly find effective support for their problems (Whittle *et al.*, 2019).

Another construct used for studying the barriers to access to mental health services is "candidacy". This expresses the "possibility for" and "ability of" the individual to choose the most appropriate health service through interaction with the welfare state and health professionals (Dixon-Woods *et al.*, 2006). This takes place through a continuous dynamic process between user, professional, and health service, of diagnosing what the disease is and what the most appropriate services for its treatment are. In the words of Dixon-Woods *et al.*: "Health services are continually constituting and seeking to define the appropriate objects of medical attention and intervention, while at the same time people are engaged in constituting and defining what they understand to be the appropriate objects of medical attention and intervention" (2006, p.1). With the concept of candidacy, the role of the physician, the user, and the relationship between them in mutually constructing their roles and defining illness and cure becomes more important. This concept underscores the role of social and healthcare policies, individual characteristics, and healthcare professionals in facilitating or obstructing access to care. It acknowledges that access is not merely about the availability of services but also about the recognition of need, the willingness to seek help, and the ongoing negotiation of care between individuals and healthcare providers.

In this study, the institutional framework's impact on access to mental health services is delineated using the dimensions of access as outlined by Petmesidou *et al.* (2020) and "candidacy" (Dixon-Woods *et al.*, 2006). This multifaceted approach is justified by the recognition that access to healthcare, and specifically mental health services, require to consider both the structural and individual factors that influence the ability of individuals to seek, obtain, and benefit from mental health services. The overview initiates with an examination of institutional and cultural variables, which are pivotal in shaping access to mental health services. Cultural factors are particularly analysed through the lens of the roles and experiences inherent in being a physician and being a patient with mental disorders. Subsequent sections delve into the analysis of factors at the organisational level, before moving on to examine individual factors.

2.3 Institutional and cultural factors influencing access to mental health service

The welfare state is a critical framework for understanding the distribution of health services, including access to mental health care. It could be defined as a system where the state is responsible for the health and well-being of its citizens, especially those

in need, through various benefits and services. Bergqvist *et al.* (2013) presented their literature review on comparative welfare state research. The authors aimed to present not the *rules of the game*, but the *cause of the causes*, indeed assuming a structuralist approach toward social objects. The results were aggregated into three categories: the regime approach, the institutional approach, and the expenditure approach. The definition reflected by these categories focuses on 1) the alignment of ideologies, policies, or political traditions, 2) the structure and implementation of welfare institutions, specific social policies, and programmes, and their impact on public health, 3) the extent of State commitment and generosity in allocating public funds for social protection and services.

Following the metaphor of Beckfield *et al.* (2015), if the universality of health is the stage where patients and physicians act, there is a social object that determines its staging. As the authors state, the welfare state acts as an institutional arrangement, setting the *rules of the game* that dictate health distribution, including inequalities, influencing and altering the impact of social determinants of health. The mechanisms at play involve redistributing goods, compressing health inequalities by setting lower and upper limits for social determinants of health, directly intervening in the factors that cause health inequalities, and balancing the indirect effects of other policies on health inequalities.

Welfare state impact on mental health care

The concept of the welfare state, underlining the state's responsibility for citizen health and well-being, is pivotal in shaping healthcare models, influencing policies toward balancing economic viability, accessibility, quality, and satisfaction in health services distribution, including mental health. It plays a crucial role in addressing the effects of social determinants and socio-economic factors on health through the redistribution of benefits and equity in rights, guiding the discussion on the efficiency and challenges of various healthcare approaches in achieving comprehensive mental health services.

Health policies are oriented towards four objectives: the economic viability of the service, equality of access to treatment, that treatment's quality, and guaranteeing the freedom of patients and professionals, including their satisfaction. It is not possible to achieve all four objectives and health policies are skewed towards one or more of these goals (Pavolini *et al.*, 2013). That is, efficiency with low costs is pursued, with different strategies from country to country.

According to Wendt (2009), three main “ideal” types of the healthcare service can be identified. The first is the “health service provision-oriented type”, characterised by a high number of health professionals, where users face small out-of-pocket (OOP) co-payments and doctors are mainly paid on a fee-for-service (FFS) basis. The second model, the “universal coverage - controlled access type”, is characterised by the universality of access to the NHS where healthcare is guaranteed to all citizens (Petmesidou *et al.*, 2020), strictly regulated patient access, and doctors are paid by capitation. The third model, “low budget-restricted access type”, is characterised by low per-capita spending and users face high and widespread direct costs, while doctors are paid through a fixed salary. However, according to Pavolini *et al.* (2013), healthcare models do not conform closely to these three categories, as they tend to have mixed characteristics.

Thus, an individual’s ability to access mental health services is influenced by the type of financing of the NHS. There are several types of financing: direct or indirect taxes by the state, social security contributions, voluntary private insurance, and OOP payments. These consist of direct payment for private or public health services. In the latter case, they are identified as co-payments, co-pays, or *ticket modérateurs* (moderating charges) (Pavolini *et al.*, 2013; WHO, 2005). This direct payment formula is also used by private bodies, where the insurance covers only part of the cost of the client’s health care services. The difference between the use of co-payments in the private or public sector is their voluntary nature: in the private sector, the user chooses to contract services; in the public sector, the state imposes the decision. OOP payments were introduced to reduce the cost of health services for the financing bodies, *i.e.*, the state or a private insurance company. In addition, they seek to moderate demand, hence the name *tickets modérateurs*, on the assumption that the presence of a charge for a service or a drug may deter those who do not need it. This claim is widely documented in the literature. However, it is not clear whether the moderating effect of co-payments is due to a real influence on users’ perceived need for a health service or because people with low incomes cannot afford the cost of the service.

Van der Lee *et al.* (2019) used secondary data to examine the variation in care received by people with a diagnosis of schizophrenia in the Netherlands from 2009 to 2014. This period was characterised by the implementation of state policies aimed at increasing OOP payments to controlling rising healthcare costs. The researchers found that, as the number of co-payments increased, the utilisation of psychiatric care decreased

markedly, with a corresponding increase in the consumption of antipsychotic drugs, though they were unable to establish a causal link. The cause would lie in the typology of psychiatric and psychological care needed to treat a mental disorder of the schizophrenic type, *i.e.*, over a long period and with a weekly frequency. For this reason, faced with an increase in the cost for users of mental health services, they noted an increase in the use of antipsychotics and emergency admissions for critical psychotic episodes.

Dixon *et al.* (2006) showed how OOP payments are one of the main methods of financial services in countries with low/medium Gross Domestic Product (GDP). Regarding mental health, the researchers state that when co-payments represent a high proportion of the financing of a health service, access to mental health services is strongly related to the ability to pay, leading to inequalities in access. Concerning high-GDP countries, organising funding by relying excessively on OOP payments would lead to problems with access to health services in the case of diseases and disorders that require prolonged treatment. Therefore, in this latter case, the user's income level and the type of disease jointly create access problems if the health service requires direct payment by the user.

In Austria, for example, the state guarantees free access to treatment for a maximum of thirty days, while in the case of prolonged illness, funding is heavily based on OOP payments. In their paper, Zechmeister *et al.* (2002) consider the effectiveness of the incentives in mental health financing that characterised Austrian policy in the early years of the new millennium. According to the researchers, the beneficiaries of such incentives are unlikely to be those with mental disorders. To support this claim, they use the economic model of the "principal-agent problem", applying it to the patient-finance-physician triangle. Using this model, the patient is the least powerful figure economically in the relationship with the physician and the financing entity. The doctor is in an advantageous position concerning patient for three reasons. First, the doctor has more information about the client's health status than the client does. Secondly, the doctor can obtain economic benefits by prolonging the therapeutic relationship, based on the type of payment received (fee-for-service). Third, the client is likely to pay for the services provided by the doctor, either through social insurance or OOP payments. In the case of patients with severe mental disorders, the disparity would be greater, considering clinical and cognitive status, as well as economic status, with mental disorders being more frequent in the lower-income population.

OOP payments, used as an instrument to generate economic savings and control demand, can lead to access problems in the case of chronic mental disorders. Their use has been accompanied by an increase in the prescription of drugs and the number of emergency admissions for severe psychotic episodes. However, greater financial investment in mental health is not guaranteed to lead to improved access or less utilisation of OOP payments by users. Therefore, OOP payments do not automatically lead to problems with access to health services, but, in the case of mental disorders, considering their chronic nature, they could represent a risk factor in the case of those at a low economic level (Zuvekas & Selden, 2010).

Institutional framework is also defined also by the steering model of Government (van der Tier *et al.,* 2021). This reflects the level of public or professional accountability and commitment that characterises the work of physicians within their national contexts (Bourgueil *et al.*, 2009). The authors discuss three primary frameworks of primary care. The "Non-hierarchical Professional" model, characterised by health practitioners leading without a cohesive primary care strategy, often results in gaps in outpatient care features. The "Public Hierarchical Normative" model, as seen in countries like Spain, places primary care under state control with local authorities managing facilities and employing GPs on a salary basis. This can impact the availability of services due to more centralised decision-making. The "Professional Hierarchical Gatekeeper" model, typical in the UK, features self-employed GPs who control access to healthcare services and resource allocation, potentially affecting both service availability and waiting times. These models form a continuum, with countries like Italy and France often adopting mixed or hybrid approaches (Bourgueil *et al*., 2009; Kringos *et al*., 2015). Each model influences the availability of primary care in different ways, affecting how patients can access and utilise primary care services.

Approaches to health and impact on mental health management

Another pivotal element shaping the values of the NHS is its approach to health. In the landscape of mental health care, the evolution of treatment models has been significantly influenced by both historical movements and the ongoing quest for equitable health care access. This evolution is notably embodied in the concept of "collaborative care", which emerges as a sophisticated response to two main influences: the deinstitutionalisation of mental health and the imperative to ensure equitable rights for

patients, including those with mental disorders (Aparicio Basauri, 1993; Basaglia, 1964; Basaglia & Basaglia Ongaro, 1966).

In a modern NHS, the main approaches are the "collaborative care" and the "population-based" models. These two models complement each other, the former being directed towards health issues and the latter towards all non-clinical activities that improve people's health. Following Basaglia's consideration (1964), the core of collaborative care is the democratisation of NHS, achieved by an equal distribution of rights, *i.e.*, health and freedom. This model is characterised by its emphasis on the seamless integration of primary care providers with specialists, such as mental health professionals, fostering a therapeutic alliance that transcends traditional boundaries of care. Such a model inherently advocates for a shift from hospital-centric treatments to more personalised, home-based care approaches (Reilly *et al.*, 2013). This shift not only reflects a more rights-based approach to treatment but also aligns with evidence suggesting that, particularly for severe mental disorders, home-based care significantly reduces treatment dropout rates and enhances the quality of life for patients (Marks *et al.*, 1994; Muijen *et al.*, 1992). A collaborative health care model relies on the participation of all the health professionals involved. Under this model, GPs have a high clinical responsibility considering their frontline position and the possibility of constructing a collaboration with mental health professionals (Reilly *et al.*, 2013).

If the collaborative care model focuses on linking the three areas of illness treatment, *i.e.,* biological, psychological, and social, the "population-based" model encompasses all individual and collective actions, along with public policies aimed at preventing mental disorders. It embraces all the non-clinical interventions, policies, and actions that aim to improve the well-being of individuals who share the same health needs and share socio-demographic characteristics (Purtle *et al.*, 2020). Population-based model not only fosters the development of public health initiatives but also significantly enhances mental health awareness across diverse communities. This approach actively works to dismantle the stigma associated with mental health issues, thereby facilitating a more open dialogue about mental wellness. Moreover, it strives to optimise the organisation of health services to better meet the needs of communities. Through such comprehensive efforts, the model ensures that health equity is deeply ingrained in every aspect of care delivery, promoting a more inclusive and effective health system that addresses both individual and collective needs.

These two approaches to health influence the model of collaboration between primary care and mental health services which could impacts on the appropriateness of care. By working together, primary care providers and mental health specialists can offer more comprehensive and personalised care. GPs have a broad understanding of their patients' overall health and can provide relevant information to mental health professionals, leading to more tailored mental health care. Moreover, mental health professionals can offer specialised expertise, ensuring that the mental health services provided are appropriate to the specific needs of the patient (Gemignani *et al.*, 2020).

(De)centralisation and its impact on access to health care

Another factor that defines the healthcare service is the degree of centralisation in the organisation of the health service. In a fully centralised service, responsibility for and management of patients who want to access the health service depends entirely on the central Government, whereas in a highly decentralised service, responsibility is shared by all front-line health professionals (European Committee of the Regions, 2012). Decentralisation was promoted to make the delivery of health services more attuned to different regional situations, and to improve citizens' health (Wyss & Lorenz, 2000). Further, a high level of decentralisation can lead to numerous differences in the treatment of the same health problem when considering different health agencies (*ibidem*). In decentralised healthcare services, the responsibility for managing resources, setting policies, and organising service delivery often rests with local or regional authorities. Decentralisation empowers these entities to tailor healthcare services to the specific needs and preferences of their populations. While this structure may not explicitly designate GPs as gatekeepers, it significantly influences the dynamics surrounding their role as the initial point of contact between citizens and healthcare services (European Committee of the Regions, 2012; Juliá-Sanchis *et al.*, 2020; Wyss & Lorenz, 2000).

Moreover, the decentralised nature of healthcare delivery looks for local adaptation and responsiveness to community needs. GPs operating within such services must navigate a complex landscape of resources, referral pathways, and specialist services, which may vary across different regions or localities. This may produce a lack of coordination among Health organisations, generating difficulties in the continuity and accessibility of health services (Juliá-Sanchis *et al.*, 2020).

Among studies that have examined whether the gatekeeper role of the doctor and the level of decentralisation in the organisation of services may be factors that hinder

access, Wammes *et al.* (2014), in their fieldwork with 157 German GPs, show that users access too many services. This is partly due to an excessive number of diagnoses, a direct effect of applying protocols to identifying health problems, and excessive collaboration with hospitals facilitates access to specialised care. Therefore, these GPs do not filter users, responding instead to an underlying dynamic of satisfying demand. This even happens in cases where the physician considers that the patient does not need specialised care.

On the other side, Forrest (2003) examines whether the primary care physicians play a useful role in quality access and limiting demand for specialist care. He argues that primary care physicians, in health services where they act as gatekeepers, limit user demand through their discretionary power. The physician can choose who is referred to specialist services. Thus, by limiting demand, primary care physicians reduce the public cost of the healthcare service. Their position in the front line makes them the main target of user complaints against the healthcare service.

From biomedicine to health counselling: mental health in primary care

Cultural factors are pivotal in shaping access to mental health services, including the help-seeking strategies in cases of mental disorders, stigma associated with mental health issues, cultural discourse within medicine, and the level of trust in NHS and their professionals. The influence of institutional context on access to mental health services is a complex and nuanced issue, which includes also understanding cultural perceptions of mental illness and assistance. Western notions of psychopathology, often rooted in specific emotional frameworks, may not resonate in other cultural settings (Hsiao *et al.*, 2006; Summerfield, 2004). This discrepancy underscores the necessity of culturally sensitive approaches in psychology and psychiatry (Pilgrim & Bentall, 1999). It is critical to recognise that certain emotions, deemed central in one culture, may be absent or differently expressed in another. In last years, “Stoic training” has been linked with reduced anxiety, rumination and the use of fewer negatively charged words in self-assessment and planning tasks (MacLellan & Derakshan, 2021). However, the concept of a stoic attitude has been employed as a personality trait to explain men’s inclination towards suicide. This highlights the diverse interpretations of mental disorders even within the same culture (Witte *et al.*, 2012).

Another central aspect in cultural attitude towards mental is medicalisation of psychological distress (Pilgrim & Bentall, 1999). The emphasis that physicians place on

the biological aspects of illness can significantly influence the type of care patients receive. As Pilgrim and Bentall noted: “While it is not surprising, then, that a biological and cognitive pincer approach seems to be effective, compared to no treatment, when helping miserable people, the danger of these reductionist approaches to treatment is that they may mystify the oppressive social conditions which generate the distress experienced by the patient” (*ibidem*, p.272). The increasing use of psychiatric drugs (Diaz-Camal *et al.*, 2022) may be contributing to the medicalisation and normalisation of mental health issues, leading to a broader “normalisation of medicalisation”. In this context, GPs often serve primarily as providers of biomedical treatments rather than evolving into holistic health counsellors who follow the biopsychosocial model. This model emphasises the importance of considering biological, psychological, and social factors in mental health (Fava, 2023).

After the closure of asylums, patients, once institutionalised in physical spaces, may develop a new form of dependency on physicians, including GPs, particularly due to the widespread use of medication. This dependency is not simply about seeking care but becomes a reliance on the medical authority for managing mental health issues, leading to what can be described as “soft institutionalism” (Basaglia, 1964; Basaglia & Basaglia Ongaro, 1966). Although this concept is traditionally associated with psychiatric care, given the high prevalence of mental disorders in primary care and GPs’ management of patients with mild symptoms, it also extends to primary care. In this context, although patients are no longer physically confined, they remain psychologically bound by a relationship with their doctors that subtly limits their autonomy. The freedom offered by medical care feels external, not an achievement of the patient’s agency, thus reinforcing their dependence on the very system meant to liberate them. However, medicalisation is not a unilateral imposition by healthcare providers; it is a dynamic, relational, and bidirectional interaction between providers and users. Service users, far from being passive consumers, actively challenge this paradigm (Doblytė, 2020; Meyer *et al.*, 2008). Patients with mental health issues have shifted from the paternalistic care of the asylum era to being treated more as consumers, primarily of medication. Although considered consumers, patients cannot often make informed decisions about their treatment, with those who comply best with the doctor’s approach being rewarded. This shift may limit patient autonomy, promoting conformity to prescribed treatments over exploring more personalised and potentially beneficial options (Fava, 2023; Stacey, 1974). These

phenomena reflect a shift from overt institutionalisation to a more insidious form of control, where the dependency on treatment providers can become just as confining as the walls of the old asylums (*ibidem*). Given these subtle paternalistic dynamics, GPs may prioritise medication and patient compliance over exploring alternative treatments or making referrals to specialised services. As a result, patients might remain within the confines of primary care, limiting their access to more tailored and potentially more beneficial mental health interventions, further deepening their dependency on the GPs' guidance and prescriptions.

Other cultural factors significantly affecting access to specialised services and influencing help-seeking behaviour include stigma and prejudice. Indeed, having a mental disorder, besides posing cognitive and behavioural challenges, often subjects individuals to stigma. Thornicroft (2008), in his review of stigma as a cause of limiting access to mental health services, states that stigma has three components related to lack of knowledge, prejudice, and discrimination against certain behaviours. Regarding stigma associated with gender, Burgess *et al.*, (2007) conducted a study on adult LGBT community groups in Hennepin, Minnesota, examining the impact of discriminatory episodes on the mental health of community members. Due to high levels of stress and anxiety, a predisposition toward depression, and a greater likelihood of using alcohol, cigarettes, and other addictive substances, members of the LGBT community more frequently report a perceived need for mental health care. Researchers have found that perceived discrimination within the LGBT community acts as a risk factor for developing mental disorders, which is closely linked to the underutilisation of specialised mental health services. Furthermore, Mackenzie *et al.* (2006) through statistical analysis of help-seeking attitudes and psychiatric symptoms in a representative sample of 206 adults, suggest that women's greater openness toward mental health care may explain their increased willingness to seek help for psychological issues. In contrast, the lower utilisation of psychological services among men could be attributed to their more negative attitudes toward mental health care. This phenomenon may also be influenced by stigma, as well as a cultural lack of education and information about mental disorders. Indeed, being a single woman leads to higher utilisation of healthcare services (Brand *et al.*, 2019; Goodwin & Andersen, 2002; Mackenzie *et al.*, 2006). Regarding hospitalised women with serious mental illness, they often experience low self-esteem, self-stigma, and social and sexual isolation. Their perceptions of men, often shaped by trauma, reinforce the link

between stigma and sexual victimisation, highlighting how hospitalisation can potentially retraumatise these individuals (Frieh, 2020).

Stigma associated with ethnicity also poses a significant barrier to access. Thornicroft (2008) highlights several studies showing that African Americans, despite having poorer overall mental health, receive only about half as much specialised healthcare as the white population. Similar results are shown by Kataoka *et al.* (2002) in a study on the need for psychological health care in children in the United States regarding ethnicity and the presence and type of health insurance. Through cross-analysis of data from the 1998 *National Health Interview Survey* (a sample of 39,209 persons, of whom 11,017 were children) and the *National Survey of American Families* (a sample of 44,000 nuclear families, with a total of 28,867 children), the researchers concluded that 80% of children and adolescents, aged 3 years to 17 years, did not receive health care for psychological problems, with a higher incidence among Latino children than among white children, and among uninsured children than among children with public insurance (*ibidem*).

Stigma arising from prejudices toward specific health disorders or conditions also generates barriers to accessing specialised mental health services. In the case of depression, a disorder with an aetiology, according to common sense, that is attributable to more everyday factors such as the loss of a job or the end of a romantic relationship, people seem less likely to seek specialist help, preferring the social support of family and friends (Thornicroft, 2008). According to a WHO (2005) review of 37 studies carried out in different countries, the least-treated psychological disorder is alcohol abuse dependence, with 78.1% of sufferers not receiving treatment; this is followed by untreated anxiety disorders at 57.5%, obsessive-compulsive disorder at 57.3%, depression at 56.3%, dysthymia at 56.0%, panic disorder at 55.9%, and bipolar disorder at 50.2%, while 32.2% of schizophrenia sufferers do not receive any treatment. In the Lombardy region of Italy, there has been a reported decrease in the incidence of schizophrenia and personality disorders, while the incidence of emotional disorders has risen (Lora *et al.*, 2012). This could potentially be attributed to the under-treatment of the disorder, as suggested by the WHO review indicating that a significant percentage of schizophrenia sufferers do not receive adequate care. Moreover, individual factors, possibly influenced by cultural norms and stigma surrounding mental health disorders, shape access to mental health services. These factors include difficulty recognising symptoms, underestimating

the severity of one’s condition, limited access to healthcare, reluctance to seek help due to prejudice and stigma, low treatment compliance, and economic constraints (Thornicroft, 2008).

In times of psychological distress, patients seek answers. Some turn to personal or collective philosophical interpretations of pain, while others look to insights from the news. Moreover, as the role of media comes into focus, the constant stream of conflicting and contradictory health messages has plunged the general public into a state of uncertainty (Meyer *et al.*, 2008). The media, with a particular focus on the suffering of individuals, can exaggerate the issues surrounding mental health disorders, contributing to the dramatisation and pharmaceuticalisation of psychological symptoms (Doblytė, 2020; Summerfield, 2004). In this quest for answers, doctors play a crucial role in guiding patients, thereby reinforcing their dependency on medical services (Meyer *et al*., 2008). It could be stated that people trust caregivers because, by definition, their role is to help. This trust in doctors, as healthcare providers, is not optional; we cannot choose not to access their services. For this reason, trust could be considered the foundation of the therapeutic alliance as it is inevitable when patients lack the specialised knowledge to navigate their health needs and enables open communication and collaboration in care (Ackerman & Hilsenroth, 2003). Along with many authors who have used “trust” as a theoretical instrument, Giddens’s delineation of institutional and interpersonal trust is critical here (Giddens, 1995). Giddens discusses the interaction between societal systems and their representatives, identifying these intersections as “access points”. Trust in the physician, and by extension in the medical service, hinges on these interactions. Hence, the complexity of trust extends beyond the physician-patient dyad to include broader social systems influencing healthcare. But trust in the health service is not automatic; it is cultivated through negotiation, making time, and knowledge key elements in building a therapeutic alliance (Giddens, 1991; Meyer *et al.*, 2008). This negotiation is particularly challenging in mental healthcare, where dialogue and mutual understanding are often constrained. Giddens’s assertion that trust arises from a lack of complete knowledge regarding health condition, the provider’s expertise, and a patient’s own experience. Physicians, knowing of this balance, should adapt their language and approach to encourage patients’ trust. Ward (2017) underscores the critical role of public health practitioners in building and maintaining trust with patients and clients. This trust is essential for enhancing public health and the efficacy of public health programmes.

Failure to establish and sustain trust can lead to reduced use of public health services, poor adherence to medical advice, and worse health outcomes. Public health practitioners must continually renegotiate their knowledge system with lay audiences, acknowledging the pivotal role of trust in their interactions.

In the current healthcare landscape, GPs often find themselves positioned as health sellers, focusing on prescribing medications and addressing immediate symptoms. However, to better serve patients and address the complexities of mental health, there is a pressing need for GPs to shift toward the role of health counsellors. This transformation involves moving beyond a purely biomedical focus to embrace a more holistic, biopsychosocial approach. By fostering a deeper understanding of the patient's cultural, psychological, and social contexts, GPs can guide patients toward more personalised and sustainable health strategies. This shift also encourages patients to move from being passive health consumers, who rely on prescribed treatments, to becoming active health producers. In this new role, patients are empowered to take control of their mental health by engaging in informed decision-making, self-care practices, and lifestyle changes that support their well-being. By cultivating this partnership, GPs can help reduce the dependency that often characterises the doctor-patient relationship, promoting a more autonomous and proactive approach to health management.

In the next section, organisational variables that may influence GPs' management of patients with mental disorders will be examined first, followed by an analysis of individual-level variables.

2.4 GP-centred studies

Understanding this role in more detail requires examining how various meso and micro-level factors influence GPs' management of patients with mental disorders, which directly impacts patients' access to specialised services. This section explores these influences and the barriers to mental health services created by organisational factors, including remuneration models for GPs, and the balance between guidelines and professional autonomy. Moreover, the discussion addresses factors such as waiting list, consultation times, and the level of mental health training GPs receive. Individual factors, like GPs' attitudes toward mental disorders and their emotional competencies, are also considered for their impact on service delivery.

2.4.1 Meso-level variables

Studies that have examined the payment method for primary care physicians about the type of work performed and their motivations are few and with little external validity, *i.e.*, they are strongly conditioned by the organisational and institutional environment in which they were carried out. Studies analysing how these variables directly affect patients' health are even rarer. Nevertheless, it seems that the type of payment influences the doctor's work and the creation of possible barriers to accessing mental health services. Regarding the types of GPs' remuneration, there are three main payment services. The first method is FFS where the physician is paid by the state for each health service provided. The second method is capitation, where the physician receives payment for each patient under their care. The third is a salary, where the physician is paid a salary based on the number of hours provided for in their contract (Gosden *et al.*, 2000). The presentation of the following studies will consider whether the payment method can influence the work of the primary care physician and how, and whether this can lead to barriers to access to mental health services.

Gosden *et al.* (2000) analysed the results of several studies which, in total, interviewed 640 primary care physicians and more than 6,400 patients. The purpose of the review was to analyse whether the doctors' method of payment affected their work. The researchers concluded that the services financed by FFS was mainly used by primary care physicians and contributed to more consultations and better continuity of care. However, patients were less satisfied with access to doctors paid through FFS models compared to those with access to primary care doctors on fixed salaries. In addition, the number of visits made by primary care physicians under a reimbursement (FFS) service was higher than in the other two services. Therefore, the researchers state that there is evidence that the payment service may affect physician behaviour. Vu *et al.* (2021) conducted a cohort study using secondary data on a district health administration in Ontario, Canada. The data covered the period from 2007 to 2016. In particular, the researchers analysed the blended payment service introduced into Canada in 2006. In this payment service, GPs are paid based on the number of patients they see (capitation) and on the type of services they provide (FFS). During working hours (until 5 p.m.), doctors receive 15% of the total cost of the services administered as reimbursement (FFS) and a fixed part based on the number of their patients (capitation). After 5 p.m., at weekends,

and on public holidays, doctors receive, for certain specialist services, 100% of the total cost of the services administered. The researchers noted an increase in some types of services offered during off-hours. That is, doctors in this remuneration scheme preferred to treat some patients during overtime.

Bjørndal *et al.* (1994) present the results of an analysis of 263 GPs in Oslo, Norway, divided between those who received FFS compensation and those who received a fixed salary. The results of the research indicate that the FFS doctors made more face-to-face consultations, while the others attended a higher number of calls. In addition, salaried doctors had longer consultations with a longer gap between consultations. In the case of mental health, salaried doctors may well provide more appropriate care, as a patient with mental disorders needs more time for attention. This is necessary for the doctor to gain a more comprehensive picture of the person's overall functioning. Thus, a consultation with a psychologist or psychiatrist in the private sector usually consists of a one-hour meeting.

Regarding GPs' training, the literature focuses on research that examines their academic preparation and on personal attitudes towards specific patient groups or disorders. Tarrant *et al.* (2003) conducted a study to identify the characteristics of GPs that help to create a trust-based relationship with patients. GPs from UK services who agreed to collaborate in the study administered the *General Practice Assessment Survey* to several patients, obtaining 1,369 completed questionnaires. Through statistical analysis of the results, the authors found that communication style, interpersonal care, mutual knowledge between doctors and patients, as well as the patients' age and ethnicity, accounted for 46% of the variance in trust scores. Notably, communication style is a skill that can be enhanced through training and is crucial in managing patients with mental disorders. In his literature review, Thornicroft (2008) presents several papers that have associated the poor training on mental health received by health professionals, especially on depression, with the continual prescription of antidepressant drugs, the creation of barriers to access to specialised health services, and difficulty in receiving appropriate treatment. Walker *et al.* (2016) analysed the curriculums of the 48 United States Schools of Public Health (SPHs) to investigate the training of future physicians in mental health. They interviewed 41 members of the different schools and analysed the material collected using MAXQDA software. They found that only 15% of schools provided doctors with in-depth training in mental health and that this situation had not improved in 50 years.

Literally, “Mental health continues to be underrepresented at SPHs, particularly relative to its burden to society” (p. 214). Moreover, the need for stronger mental health training for primary care physicians, especially on the symptomatology associated with the side effects of social-distancing measures and uncertainty due to the socio-economic crisis, was stressed during the COVID-19 pandemic (Turabian, 2020).

More specifically, the complexity of the issue makes it challenging to directly link the inadequate mental health training of primary care physicians with the increased difficulty users face in accessing specialised services. Magliano *et al.* (2017) studied GPs’ beliefs about schizophrenia, its perceived dangerousness, and possible discrimination against patients with this disorder. The researchers found that doctors who viewed schizophrenia as a difficult-to-treat illness and believed that individuals with the disorder had limited autonomy, best treated in specialised facilities, perceived these patients as more dangerous compared to their colleagues with different beliefs. This perception of greater dangerousness was notably higher among those who held these views. They also emphasise the need to provide GPs with more specialised training on schizophrenia and its treatments. This would help reduce the risk of discriminatory behaviour towards patients and ensure that users have proper access to mental health services.

Regarding protocols, on the website of the National Institute for Health and Care Excellence (NICE), an independent organisation that monitors the effectiveness of the UK health service, it is stated that guidelines can benefit users, staff, and health care organisations. In particular, “NICE guidelines can help patients (...) to receive care that is based on the best available clinical evidence” and help “health and social care professionals to ensure the care they provide is based on the best available evidence” (NICE, 2024). In addition, guidelines seem to offer the possibility of standardising clinical decisions by ensuring the most consistent administration of care possible. However, it is clear from the available literature that implementing guidelines is a discretional decision for doctors (Lugtenberg *et al.*, 2009, 2011; Woolf, 1998). Doctors do not implement the protocols in all cases because of the difficulty of fitting each case into the guidelines, because of the influence of organisational factors, or because the information contained is unclear or ambiguous. Given that doctors, particularly those in primary care, must address not only the medical aspects but also the human dimensions of their relationships with patients, it is understandable that they may not strictly adhere to protocols. Universal guidelines often fail to account for the unique circumstances of

each individual, making some flexibility necessary in their application. If, however, as the NICE sets out, the guidance guarantees the best possible care, not applying it leads to barriers to access to both primary care and specialised services.

Concerning the relationship between primary care physicians and users in rural areas, Pohontsch *et al.* (2018) analysed transcripts of several encounters with two groups of primary care physicians. The sample consisted of doctors practicing in urban and rural areas. Considering the area of work, the researchers found that doctors in rural areas claimed to have closer relationships with patients, regarding this as a facilitating factor in clinical practice. Moreover, they were aware of their responsibility in representing the first point of contact between citizens and the NHS. The doctor-user relationship is strong in rural areas, although services available could be fewer, and gaining access to specialised services is more complicated. This limited availability of services is not only related to the number of doctors but also to their geographical distribution and the infrastructure necessary to maintain effective contact with citizens. The shortage of healthcare services and professionals, coupled with inadequate transport networks, exacerbates the issue, leading to an increase in cases that are not treated as thoroughly as they should be (Wang *et al.*, 2005; Whittle *et al.*, 2019).

Another factor that influences the GPs' management, is the length of the consultation. Tai-Seale *et al.*(2007) analysed recordings of 385 consultations by 35 primary care physicians with new patients in the United States. They found that, during the consultation, the average length of discussion of topics involving mental health problems was 2 minutes, with the doctor speaking for 46 seconds and the patient for 1 minute and 10 seconds. Consultations involving mental health issues tended to last longer than those focused on physiological symptoms. This was because patients required more time to discuss their mental health concerns compared to presenting typical physical symptoms. Therefore, longer consultation times are linked to higher patient satisfaction and positively impact the acceptance of the physician's clinical advice, as well as the patient's willingness to participate in therapy (Deveugele *et al.*, 2002; Wilson & Childs, 2002). During the pandemic, many consultations shifted to remote formats, such as video calls or telephone consultations (WHO, 2020a). While teleconsultations are valuable, especially during lockdowns, and both patients and GPs generally express satisfaction with them, they cannot fully replace in-person consultations due to their inherent limitations (Vodička & Zelko, 2022). Research by McKinstry *et al.* (2010) found that

remote consultations are often shorter and offer less detailed information compared to face-to-face interactions. This reduction in depth can make it harder for GPs to build trust with patients and provide holistic assessments, as consultations may become more transactional (McKinstry *et al.*, 2010; Rosen *et al.*, 2022). Moreover, remote consultations limit or eliminate non-verbal communication, which is crucial for diagnosing and treating mental health disorders (Foley & Gentile, 2010; Hammersley *et al.*, 2019).

The existence of long waiting lists for mental health services also hinders the ability of primary care physicians to refer their patients to specialised professionals, thus representing an obstacle to putting the collaborative-care treatment model into action (Goldner *et al.*, 2011). In addition, Reichert and Jacobs (2018) studied whether the length of time spent waiting to receive treatment for a psychotic episode can lead to a worsening of patients' clinical conditions. The sample they analysed consisted of 8,949 English national health patients who had manifested a psychotic episode between April 2012 and March 2014. The selected patients were followed for a full year to analyse their clinical outcomes. The researchers showed that, if the waiting time between diagnosis and start of treatment was longer than three months, the subjects' clinical outcome was worse than that of patients who had waited a shorter time. The researchers acknowledge that a shortcoming of their study is not having considered the time between the patient's first contact with a primary care physician and the first diagnosis by a mental health specialist. In other words, if the clinical condition of the patients had been considered from the first contact with a primary care professional, their clinical outcome would have been even more compromised. Redko *et al.* (2006) examined how substance-dependent people react to waiting lists. It is important to recognise the strong association between substance use and the presence of mental disorders (Brand *et al.*, 2019; Burgess *et al.*, 2007). The researchers conducted an ethnographic study with 52 people in the United States, using semi-structured interviews and focus groups. The interviewees stated that they perceive waiting lists to be a barrier to accessing the health services they seek and that the wait is long both for obtaining the first consultation and for starting the course of treatment. Indeed, long waiting times can delay access to specialised care, complicating the treatment process and potentially worsening patients' clinical outcomes. This creates additional pressure on GPs to manage complex cases for extended periods without timely

specialist support, highlighting the critical need for efficient referral pathways and shorter waiting lists to enhance collaborative care and improve patient outcomes.

The integration of mental health specialists into primary care settings plays a crucial role in shaping the management of patients with mental health disorders and their access to specialised services. In many healthcare systems, this integration has evolved to bridge the gap between general practice and specialised mental health care. One widely implemented approach, particularly in the UK, is the liaison-attachment model. This model involves mental health specialists supporting GPs through case discussions, structured group meetings, and training aimed at improving the recognition and management of common mental health disorders. The specialist typically only directly assesses a small subset of patients, often those who do not respond to initial treatments, sometimes alongside the GP in joint consultations. Another effective model of integration is Collaborative Care, based on the Chronic Care model, which involves structured cooperation between GPs, case managers (often specially trained nurses), and mental health specialists. This model aims to provide a more coordinated approach to patient care, ensuring that both medical and psychological aspects are addressed comprehensively (Gemignani *et al.*, 2020).

The presence of clinical psychologists in primary care has also been shown to enhance the quality of care for patients with emotional difficulties by facilitating a biopsychosocial approach and offering evidence-based interventions (Gutiérrez López *et al.*, 2020). Collaborative work between psychologists and primary care doctors in multidisciplinary health centres has received positive feedback from both patients and healthcare staff, indicating improved patient satisfaction and a more holistic approach to care (Alonso Gómez *et al.*, 2019; Dahlöf *et al.*, 2014; Kaitz & Ray, 2021). Research suggests that providers in integrated settings are generally more satisfied with their collaboration, reflecting a broader shift towards patient-centred care that emphasises the importance of addressing mental health within the primary care context. This integration not only supports GPs in managing mental health disorders more effectively but also streamlines patient access to the specialised services they may require (Kaitz & Ray, 2021).

2.4.2 Micro-level variables

GPs' attitudes towards mental health issues and their emotional skills significantly affect the quality of care they provide. A crucial personal aspect that can shape GPs' professional performance is their ability to regulate their emotional reactions when dealing with patients. Doctors' communication abilities and their capacity to establish appropriate relationships with patients are strongly influenced by the type of education and training they have undergone. This is particularly true in the context of mental health issues. If emotional factors are not taken into account, both access to care and its management can suffer. Often, challenges to their self-esteem, which relate to their sense of self-worth (Smith & Zimny, 1988), can lead to negative emotional responses that hinder patient care. These challenges may arise directly from interactions with the patient or indirectly due to the doctor's perceived inability to manage both the clinical and relational aspects of the situation, leading to an increased sense of helplessness. Smith and Zimny (1988) recommend three strategies for enhancing doctors' emotional resilience and training: firstly, recognising that traditional medical training alone does not adequately prepare doctors to handle their emotional feedback; secondly, addressing issues related to self-esteem to help doctors more accurately assess their performance; and thirdly, incorporating this understanding into medical education.

Signs that a physician's feelings might be influencing patient care negatively include avoiding the patient, failing to communicate effectively with other healthcare professionals, making dismissive remarks about the patient to colleagues, neglecting details of care, and experiencing physical stress when interacting with the patient or their family. Moreover, more frequent than necessary contact with the patient can indicate underlying emotional difficulties (Meier, 2001). The inability to manage emotions can stem from frustrations, such as the inability to resolve a patient's health issues or when faced with demanding patients (Levinson *et al.*, 1993). The most evident outcome of unchecked emotional responses in physicians is the deterioration of patient care. Patients with serious disorders are particularly vulnerable during the often long course of their illness. Physicians, in turn, may respond emotionally, which can manifest as a desire to save the patient, feelings of failure or frustration when the patient's condition worsens, a sense of powerlessness, grief, fear of becoming ill themselves, or a tendency to distance themselves from patients to avoid confronting these emotions (Meier, 2001). Emotional responses in doctors, such as anger, feelings of being imposed upon, contempt for the

patient or their family, intrusive thoughts about the patient, self-blame, guilt, or a personal sense of obligation to save the patient, can severely impact the quality of care. Such feelings can lead to viewing patient complaints as manipulative or feeling victimised by the demands of medical practice (*ibidem*).

When exploring the barriers to accessing mental health services within the primary care context, it is essential to recognise that the value of the GP-patient relationship extends beyond treating biological dysfunctions. As highlighted, GPs serve as the first point of contact not only for physical symptoms but also for emotional issues, such as loneliness, which is often linked with depression and cognitive decline. GPs are frequently the first professionals approached in cases of psychological distress (Solmi *et al.*, 2020; Wang *et al.*, 2005). However, GPs' approach to mild psychological symptoms and loneliness has been criticised for focusing too heavily on managing its medical symptoms, treating them as an individual issue rather than a social one. Researchers suggest that this approach stems from doctors' difficulty in acknowledging the emotional dimensions of health problems. This tendency can perpetuate stigma and create barriers to discussing such topics. GPs often feel powerless to resolve these difficulties and believe the solution lies within the community, the individual, or social services, rather than in primary care (Jovicic & McPherson, 2020; Van der Zwet *et al.*, 2009).

Research on the impact of GPs age, gender, and experience on patient management has revealed nuanced differences in clinical practice. Britt *et al.* (1996) found that female GPs handle more psychosocial and female-specific issues compared to their male colleagues. They also tend to engage in fewer home visits, while managing a broader range of problems during patient consultations. However, the differences between male and female GPs in managing patients are not entirely clear, and the disparities in the quality and frequency of preventive care are not consistent across all practices. Studies like Delpech *et al.* (2020) indicate that while female GPs generally provide more preventive care, both male and female GPs show a tendency to favour male patients in their preventive practices. Moreover, the systematic review by Hedden *et al.* (2014) found that female GPs spend more time with patients and address more issues per consultation, but their overall number of patient encounters and services provided tends to be lower than those of male GPs. Regarding age, research is relatively limited. Charles *et al.* (2006) demonstrated that younger GPs are more likely to employ non-pharmacological treatments, such as counselling, and show higher rates of pathology

ordering. In contrast, older GPs tend to manage chronic conditions more frequently, prescribe more medications, and offer more home visits. Smeets *et al.* (2019) further supported these findings by showing that younger doctors reported a lack of confidence and experience, often consulting with senior colleagues, while older GPs exhibited greater confidence in managing complex cases, such as heart failure. Despite these insights, there is still insufficient research exploring the effects of age on GPs' clinical practices. Furthermore, in both cases, gender and age, studies specifically focusing on mental health disorders and their management within primary care are relatively scarce.

2.5 Conclusion and research gaps

The study of literature on barriers to accessing mental health services and the role of GPs in managing patients with mental disorders highlights several key insights. Table 1 provides a visual summary of the variables discussed in this chapter.

Table 1: Variables that influence access to mental health services and GPs' management

Level of analysis		
Macro	Meso	Micro
• Universal health coverage • Decentralisation of health service • Deinstitutionalisation of mental health • Model of care • Degree of government funding • The steering model of Government (public or professional accountability) • The role of GPs • Stigmatisation and prejudices • Normalisation of mental health	• Type of GP System Payment • Training on mental health • Protocols or guidelines • Working in urban/rural areas and distribution of resources (physicians, health centres) • Time resources (length of consultations) • Waiting lists • Primary care-Mental Health services collaboration	• Attitude towards patients with special needs • Emotional skills • Gender • Age

Source: author's own

The welfare state emerges as a pivotal framework, influencing healthcare distribution through its commitment to funding, policy implementation, and structural organisation. The chapter highlights how different healthcare models, from FFS to

capitation and salaried approaches, significantly impact the accessibility, quality, and satisfaction of mental health care. Moreover, the role of GPs as gatekeepers and the degree of decentralisation within health services further complicate access, with disparities in resource allocation and service delivery creating barriers for patients. OOP payments, intended to control costs, often exacerbate inequalities in access, particularly for individuals with chronic mental health conditions. The literature reviewed reveals that these financial mechanisms can lead to decreased utilisation of psychiatric services and a shift towards emergency care, highlighting the need for more equitable funding structures. The chapter also emphasises the importance of collaborative care models, which integrate mental health services with primary care to provide comprehensive and patient-centred treatment. However, the effectiveness of these models is hindered by organisational challenges, including insufficient GP training, long waiting lists, and limited consultation times. Moreover, GPs' attitudes and emotional competencies play a crucial role in the management of mental health conditions, influencing both the quality of care and patients' access to specialised services. In conclusion, ensuring equitable access to mental health services requires a multifaceted approach that addresses both macro-level institutional frameworks and micro-level individual factors. Policymakers and healthcare providers must consider the complex dynamics between funding models, decentralisation, and professional practices to create a more inclusive and responsive mental healthcare system. By addressing these barriers, the goal of achieving comprehensive and equitable mental health services can be more effectively realised.

Through the review of the literature, three significant gaps have emerged. First, there is an insufficient exploration of how the broader institutional environment and specific organisational contexts in which GPs operate influence their interactions with patients who have mental disorders. While some studies touch on aspects of this dynamic, a comprehensive examination of how institutional elements, cultural norms, and organisational practices shape the provision of care remains lacking. This gap highlights the need for research that delves deeper into how these larger structural factors affect the quality and accessibility of mental health services within primary care settings. Second, there is a lack of investigation into how micro-level interactions between GPs and patients might give rise to new behavioural patterns that could, in turn, influence broader institutional and organisational frameworks. The potential for these day-to-day interactions to act as catalysts for systemic change is an area ripe for exploration. Current

research often overlooks the capacity of adaptive and emergent behaviours within the GP-patient relationship to feedback into and reshape the institutional context. This suggests a need for studies that can trace these dynamics from the micro (individual) level to the macro (systemic) level. Third, the role of GPs' age, specifically in mental health management, is not thoroughly explored. Literature is lacking on how and why younger GPs might differ from their older counterparts in managing mental health disorders. While some studies highlight age-related differences in treatment styles and confidence, the unique challenges younger GPs may face in handling mental health cases, and the potential evolution of their practices over time, remain underexplored. Understanding these age-related dynamics could provide valuable insights into how GPs' approaches to mental health care might evolve with experience.

In the next chapter, the presentation of the SLB theory and the Micro-institutional theory of Policy Implementation is detailed to evaluate their significance and applicability to this study (Lipsky, 2010; Rice, 2013).

CHAPTER 3
THEORETICAL FRAMEWORK

This chapter aims to present the theoretical framework used in this study, aiming to provide a robust argument for its applicability and validity in the GPs management of patients with mental disorders. By employing SLB theory (Lipsky, 2010), this study seeks to explore the nuances of access to specialised services for individuals experiencing mental health problems.

As shown in the precedent chapter, the significance of political, economic, and social determinants in shaping access to mental health services is complex and involve macro, meso and micro factors. This encompasses not only individual capabilities such as managing one's thoughts, emotions, behaviours, and interactions with others but also broader societal factors including national policies, social protection, standards of living, working conditions, and community support networks. Lipsky's theory posits a framework through which the role of GPs in treating psychological symptoms can be examined as either barriers or enablers for accessing mental health services within the healthcare service.

SLB theory assigns a pivotal role in public policy implementation to professionals who interact directly with citizens, making crucial decisions based on their public

mandate, although with a degree of discretion. These bureaucrats are the government's frontline representatives to the public, handling everyday needs that impact citizens' lives in areas such as health, education, and justice. Lipsky argues that these workers possess considerable discretionary power, leading to potential discrepancies between the intended governmental policy and its practical application.

The chapter is structured as follows. Section 3.1 begins with a theoretical exploration of SLB theory, focusing on the development of coping mechanisms among SLBs. Lipsky identifies these mechanisms as strategies employed by FL bureaucrats to manage occupational stress and demands, enabling them to navigate the challenges of their roles effectively. This section delves into how these mechanisms influence the provision and access to public services. Following this, the concept of discretion is introduced, defined by Lipsky as the autonomy exercised by SLBs in determining the nature and quality of public services. According to Lipsky, this discretion arises from the need to address the complex and human aspects of public service delivery, which often require personalised responses. Next, Rice's Micro-Institutionalist theory of Policy Implementation is introduced. By synthesising Lipsky's SLB theory and Anthony Giddens' Structuration theory, Rice provides a nuanced understanding of the interaction between institutional structures and individual actions, particularly within the context of welfare services. The section then continues with an examination of the concepts of "top-down" and "bottom-up" influences, setting the stage for a deeper understanding of their roles within the healthcare context. By precisely defining these terms, the text aims to illuminate the intricate ways in which overarching policy frameworks and individual healthcare practices interact to influence patient treatment outcomes. Section 3.2 explores the role of GPs as SLBs, highlighting the unique challenges they face in managing patients with mental health disorders. It examines how GPs' discretion and coping mechanisms could influence patient outcomes and access to mental health services, underscoring the importance of understanding these dynamics to improve healthcare delivery. Concluding with the research hypotheses, section 3.3 outlines the key areas of inquiry for the study, which focuses on the interaction between GPs and patients with mental health disorders, and the broader institutional and organisational context within which these interactions occur.

3.1 Street-level bureaucracy and Micro-institutionalist theory: top-down and bottom-up policy influences

The Street-level approach assigns a pivotal role in public policy implementation to professionals who engage directly with citizens, making critical decisions on their requests under their public mandate, albeit with a certain degree of discretion. SLBs are the visible face of government for citizens, serving as the initial point of contact for those seeking assistance with everyday needs that impact their lives, health, education, justice, and other fundamental rights (Lipsky, 2010; Weatherley & Lipsky, 1977). Lipsky argues that such workers wield considerable ''case-by-case'' discretionary authority and may create a discrepancy between the original government policy design and actual policy practice (Lipsky, 2010). Such is the case with police officers, teachers, social workers, judges, healthcare workers, and other public employees (Lipsky, 2010; Weatherley & Lipsky, 1977). In his 2010 edition, Lipsky clarifies that not all "frontline" public employees qualify as SLBs. Thus, the work must involve direct, face-to-face interaction with users, a substantial workload that is often subject to considerable pressure, and duties that require a high degree of discretion. This discretion is deemed necessary by the legislator to ensure the effective functioning of public services, given the scale of the tasks involved (Lipsky, 2010).

The main issue that Lipsky wishes to investigate is the behaviour of SLBs and the structural and individual variables that determine it. He also wants to draw attention to the dilemma that these workers must face in their daily activities: offering their services to a public that requires personalised yet objective attention. We each want our needs to be met and resolved by means suitable to our case, but equal to those of other people. We expect a bureaucratic response with a certain degree of personalisation: a paradoxical and complicated, if not impossible, request to be carried out by employees with an almost infinite workload, targets to meet, and scarce time and material resources. This is the dilemma that SLBs find themselves in.

In short, Lipsky's theory underlines three issues. First, that SLBs are subject to a method dilemma because there is "conflict and ambiguity in the tension between client-centred goals and organizational goals (...). The ability of SLBs to treat people as individuals is significantly compromised by the needs of the organization to process work quickly using the resources at its disposal" (Lipsky, 2010, p.44). In these terms SLBs navigate a dual mandate in their roles, embodying the functions of both "state agent" and

"citizen agent" (Maynard-Moody & Musheno, 2000). As state agents, they are tasked with enforcing the policies and regulations laid down by government bodies, ensuring that laws are applied, and governmental objectives are achieved on the ground. This role demands a strict adherence to the procedural norms and guidelines established by the state, aiming to maintain order, fairness, and consistency in public service delivery. Concurrently, as citizen agents, SLBs serve the public directly, addressing the individual needs, concerns, and circumstances of the people they encounter daily. This aspect of their role requires a more personalised approach, often necessitating flexibility, discretion, and empathy to cater to citizens' diverse and sometimes unique situations. Balancing these dual roles involves a constant negotiation between bureaucratic procedures' rigidity and human needs' fluidity, making SLBs pivotal in bridging the gap between government intentions and citizen realities.

Second, SLBs provide discretionary services to citizen. This discretion stems from the unpredictable and complex nature of their work, which often involves addressing unique human situations that cannot be fully captured by rigid rules or procedures. These professionals are assigned with making judgments based on their expertise and understanding of the specific contexts they encounter. Given their professional status, SLBs are expected to apply their specialised knowledge and skills in ways that go beyond standardised responses. For example, a social worker assessing a vulnerable family's needs must consider various factors that a predefined checklist could never fully account for. Similarly, a police officer responding to an incident must weigh numerous situational details before deciding on the appropriate course of action. This reliance on professional judgment is a key reason why SLBs are often afforded a degree of autonomy in their roles. The autonomy granted to these bureaucrats is further reinforced by the recognition of their expertise by both their supervisors and Organisation. In many cases, they operate with relative independence, making decisions that are respected due to their specialised knowledge. This professional discretion allows them to tailor their actions to the needs of individuals and situations, enhancing the responsiveness and effectiveness of the services they provide. This level of discretion is unlikely to be significantly reduced as long as the nature of their work requires flexible and adaptable decision-making. Efforts to standardise or regulate their roles may occur, but the inherent variability of human interactions ensures that discretion remains a critical aspect of their service delivery. The

ability to exercise judgment in complex, real-world situations is what enables SLBs to meet diverse and often unpredictable needs.

Third, SLBs are policymakers, since sometimes welfare policies that are written often differ from those that are implemented. Thus, "... the necessary coping mechanisms that individual school personnel use to manage the demands of their Jobs may, in the aggregate, constrain and distort the implementation of special-education reform." (Weatherley & Lipsky, 1977, p.171). The influence of SLBs as de facto policymakers is not just a matter of individual actions but also a systemic phenomenon. When many SLBs in a particular sector make similar adjustments to cope with their work demands, these adaptations can collectively reshape the policy landscape. Their decisions and actions, often taken in response to the immediate challenges of their work, effectively create the policies that citizens experience. Engaging these frontline workers in the policy design process, understanding their perspectives, and addressing the constraints they face can help bridge the gap between policy and practice.

After this introduction to the theory, its two core concepts, the development of coping mechanisms and the exercise of discretion, will now be discussed in more detail.

Development of coping mechanisms

Given the resource constraints that define the daily work of SLBs, they are compelled to develop coping strategies to maintain the consistent delivery of policy services. According to Lipsky, these coping mechanisms are the ways in which SLBs manage their occupational challenges, allowing them to find practical solutions to meet the demands for services despite the limitations they face. These strategies help SLBs navigate their roles more effectively, balancing the expectations of their job with the realities of limited resources.

SLBs are public service workers who exercise their role under high levels of stress and pressure, mainly due to the enormous workload and the chronic shortage of resources, including time (Lipsky, 2010). Lipsky analysed the urban reforms introduced by the U.S. government in the 1960s identifying three primary sources of stress: "Analytically, three types of stress may be readily observed in urban bureaucracies today: inadequate resources, threat and challenge to authority, and contradictory or ambiguous job expectations" (Lipsky, 1971,p.393). The main coping mechanisms that SLBs use to

address resource shortages include creating routines, developing shortcuts, and employing other unsanctioned strategies. That is:

> …they develop conceptions of their work and their clients that narrow the gap between their personal and work limitations and the service ideal. These work practices and orientations are maintained even as they contribute to the distortion of the service ideal or put the worker in the position of manipulating citizens on behalf of the agencies from which citizens seek help or expect fair treatment (Lipsky, 2010, p.XV).

The routines that SLBs develop result in changes in three key areas: how they organise their daily tasks, manage and conserve scarce resources (such as allocating limited time to each citizen or referring more complex cases to expert colleagues), how they perceive and understand their roles, and the formation of stereotyped views of their clients. It is important to point out that the lack of sanctioning of such mechanisms by SLBs' managers is a bureaucratic strategy for dealing with the demand for the services. While on the one hand, this is another aspect of the dilemma to which, according to Lipsky, SLBs are subjected, on the other hand, the lack of sanctions imposed by the organisation for wrong behaviour leads to its reinforcement.

Therefore, the lack of sanctions can create cognitive dissonance amongst SLBs. Granting benefits or sanctions to some citizens for lack of resources and time may generate a discrepancy between the SLBs' idea of their work and what they are obliged to put into practice. Such a discrepancy could generate psychological suffering, which is resolved by modifying the idea of how best to do one's job. According to the "theory of Cognitive Dissonance" (Festinger, 1957), this internal dilemma is overcome by making an environmental change, modifying one's behaviour or cognitive world, *i.e.*, the cognitive representations of the objects or relationships that cause the dissonance. The strategies needed to resolve cognitive dissonance involve the SLBs' coping mechanisms that are effective in navigating complicated situations. In the volume, Lipsky writes that the main purposes of developing routines are rationing of services by limiting access and demand, control of clients through simplifications and cognitive shortcuts, husbanding worker resources, and facilitate management of the consequences of routine practice

(Lipsky, 2010). Developing such shortcuts not only provides moral relief to the bureaucrat on the street but also enables faster decision-making. These decisions become so rapid and automatic that they solidify into habitual practices, leading the worker to categorise and segment the population with whom they interact daily (Lipsky, 1971). Lipsky provides a clear example: statistically, US police officers stop more African Americans than white people (Lipsky, 2010). Another example is that of teachers who reduce their feelings of stress by labelling some students as unteachable or marginally teachable (Weatherley & Lipsky, 1977). Nevertheless, beyond their psychological origins, coping mechanisms and the exercise of discretion by SLBs are also influenced by the macro, meso, and micro-level organisation, as well as the resource constraints. Thus, the coping mechanisms that SLBs use to manage the demands of their jobs can constrain and distort the implementation of the policy that guides their work (Weatherley & Lipsky, 1977).

Under this perspective, top-down implementation is modified through a bottom-up change by SLBs, who, daily, must deal with a lack of resources and implement coping mechanisms to manage these constraints. As they navigate the challenges of limited resources and high workloads, SLBs modify policy execution through their discretionary actions and coping strategies. These dynamic highlights the critical role SLBs play in the actualisation of policy, demonstrating that the gap between policy design and implementation is often filled by the adaptive behaviours of frontline workers.

Discretion

According to Michael Lipsky's theory, "discretion" is the ability of SLBs to exercise their work with a certain degree of autonomy and freedom. Discretion is manifested as the possibility of "determining the nature, amount, and quality of benefits and sanctions provided by their agencies." (Lipsky, 2010, p.13). In Lipsky's words: "certain characteristics of the jobs of Street-level bureaucrats make it difficult, if not impossible, to severely reduce the programmatic formats, (...), Street-level bureaucrats work in situations that often require responses to the human dimensions of situations" (Lipsky, 2010, p.16).

A well-known example during the pandemic involves the use of discretion by police officers who were frequently the subject of numerous news reports. The complexity and sometimes contradictory nature of security measures implemented to control the spread of the virus granted law enforcement considerable discretion in

managing sanctions against citizens. As reported by the Spanish newspaper El Confidencial: *"...las medidas, difusas y mal definidas, dan pie a una interpretación enorme que recae en el criterio de los miembros de las Fuerzas de Seguridad encargados de sancionar.*" [... the measures, which are diffuse and vague, give rise to a wide interpretation that is left to the discretion of the members of the Security Forces in charge of sanctioning] (Parera, 2020). The Italian newspaper "La Repubblica" stated: "…*c'è anche chi ha avuto la sfortuna di incappare in qualche esponente delle forze dell'ordine che ha dato sfogo al suo eccesso di zelo talvolta semplicemente male interpretando, o addirittura ignorando, le disposizioni in vigore* […there are also those who have had the bad luck to encounter some members of the police who have displayed excessive diligence by sometimes simply misinterpreting, or even ignoring, the regulations in force] (Ziniti, 2020). These news items highlight several key aspects of the discretion exercised by SLBs. Firstly, discretion often arises from the organisation's tendency to issue guidelines that fail to account for the wide range of situations SLBs encounter in their daily work. Bureaucratic systems are structured in this way to avoid directly addressing and regulating the complexities of real-life circumstances. Secondly, there is the element of chance involved in encountering one public officer at a specific moment, which can result in varying outcomes, such as whether or not a citizen is sanctioned. This randomness underscores how discretion can lead to inconsistent enforcement, depending on the timing and the SLB's individual judgment.

The genesis of discretion as a mechanism for SLBs is twofold. First, it serves as a coping strategy that SLBs use to navigate the organisational challenges inherent in their work. Second, discretion acts as a tool that allows SLBs to manage the delivery of complex and personalised services, adapting their actions to the specific needs and circumstances of individual cases. This dual function of discretion enables SLBs to balance the demands of bureaucratic systems with the realities of frontline service provision. Thus, SLBs function as policymakers exercising significant freedom in the daily decisions they make within their roles. However, their actions are always constrained by the organisational structure of their workplace and the institutional dynamics of the public service to which they belong. While they have considerable discretion in interpreting and implementing policies, their decisions must align with the broader frameworks and guidelines established by their institutions, ensuring that their autonomy operates within defined boundaries. In his book, Lipsky writes: "Reformers

attempt to limit worker discretion at one time, and increase it at another, (...) to the extent that tasks remain complex and human intervention is considered necessary for effective service, discretion will remain characteristic of many public jobs" (Lipsky, 2010, p.16).

Hupe (2013) presents a nuanced distinction within the concept of discretion, identifying two distinct types. The first type, "discretion as granted," is rooted in the framework established by laws and protocols. This form of discretion is officially sanctioned, delineated by the boundaries of legal and procedural guidelines that aim to standardise the exercise of discretion. It represents the theoretical space within which public officials are permitted to make choices, constrained by the legal and normative structures designed to guide their actions in a controlled and predictable manner. One organisational figure that could limit the autonomy of SLBs is the Firs-line Supervisor (FLS). In Street-level organisations, FL supervisors are defined as "public managers with the task of supervising the work of SLBs while directly interacting with them regularly. This direct interaction is shown by the fact that is the FL supervisors who periodically give a task performance assessment of the individual SLBs concerned" (Hupe & Keiser, 2019, p.179). The behaviour of FL supervisors is a meso-level factor that could influence GPs' work. FL supervisors, through their sanctions or "permissiveness" contribute, alongside protocols and laws, to restricting the space for autonomy and the "discretion as granted" (Hupe, 2013) to SLBs. Within this dynamic, guidelines are negotiated, with FL supervisors applying discretionary decisions (Hupe & Keiser, 2019). The second type, "discretion as used" refers to the practical application of autonomy by public officials in their day-to-day operations. Unlike the formal permissions outlined in "discretion as granted" this form of discretion emerges from the realities of implementing policies and interacting with citizens. It encompasses the on-the-ground decisions made in response to specific situations, reflecting the adaptability and judgment calls that SLBs must make when faced with the complexities of real-life scenarios. "Discretion as used" is thus a dynamic and situational exercise of autonomy, often going beyond what is strictly defined by laws and protocols to accommodate the nuances and unpredictability inherent in public service.

Micro-institutionalist theory of policy implementation

Rice's theory is a synthesis of Michael Lipsky's theory of SLB and Anthony Giddens' "Structuration theory" (Giddens, 1994, 2014). This integration aims to provide a more nuanced understanding of how SLBs navigate their roles within both the

organisational structures and broader social systems they operate in. By combining Lipsky's focus on the discretionary power of SLBs with Giddens' insights into how social structures both shape and are shaped by human actions, Rice's theory offers a more comprehensive framework for understanding the dynamic interplay between individual agency and institutional constraints in public service delivery. Rice argues that it is possible to "understand how societal systems and institutions affect the interaction between citizens and welfare caseworkers, as well as how that interaction shapes societal structures in return" (Rice, 2013, p.20).

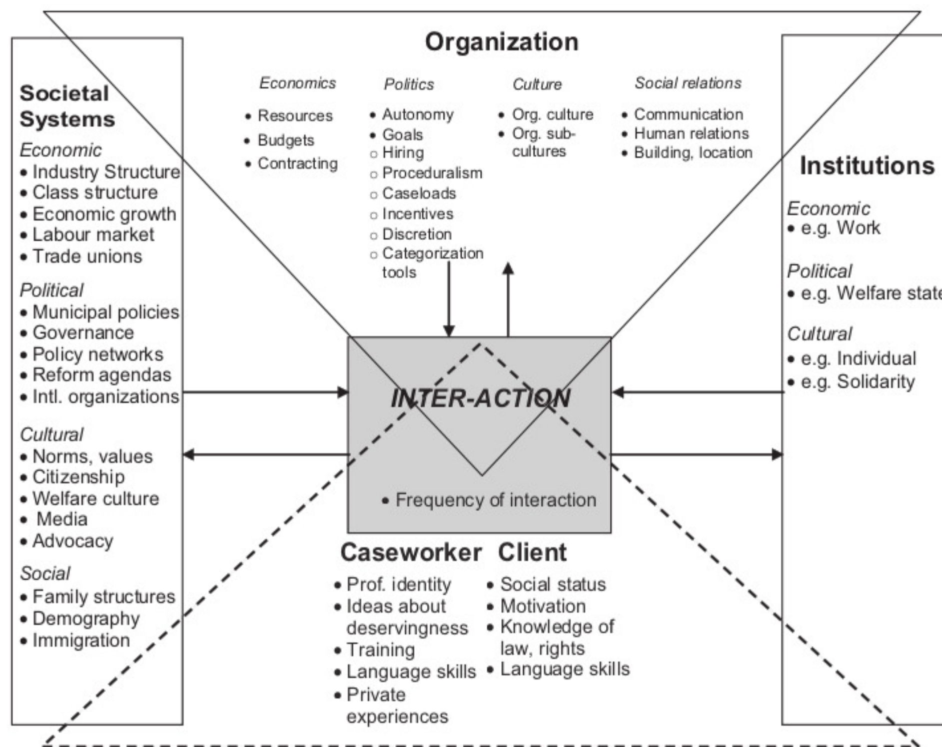
Regarding Structuration theory, Giddens affirms that there is a continuous interaction between societal structures, such as institutions and political systems, and individual actions (Giddens, 1994). Structures do not completely dictate people's behaviour, nor are individuals entirely free to act as they delight. Instead, structures provide a framework that both enables and constrains what people can do. However, these structures are not fixed; they can be reshaped by the actions of individuals or groups. While people operate within the limits set by societal structures, their actions can also modify or transform these structures over time. This ongoing interplay highlights that those structures and actions are mutually influential, constantly shaping and reshaping one another. While social structures influence human behaviour, they are also the products of that behaviour (*ibidem*).

The micro-institutionalist approach to policy implementation considers the interrelation between the interactions of SLBs and users and the broader institutional and systemic context in which these take place. According to this perspective, the welfare state is enacted through these personal interactions, giving significant importance to the local circumstances and organisation of services where these relationships occur. From this perspective, the contact between public welfare state workers and citizens represents the crucial intersection between top-down directives and bottom-up responses (Rice, 2013). This interaction can lead to either the renewal or reinforcement of social policies, depending on the dynamics at play. Thus, welfare states are not uniform across different contexts nor are they static, even when formal rules remain unchanged. Instead, welfare states display institutional diversity not only across national boundaries but also within them, continuously evolving due to the cumulative and partially independent actions that take place at the micro-level (*ibidem*). Within this framework, SLBs can drive micro-institutional change by applying the management strategies described by Lipsky. While

navigating and implementing policies in day-to-day interactions with clients, they influence and reshape institutional practices from the ground floor of the State organisation.

Rice organises the variables that influence the interaction between SLBs and citizens according to the three levels of sociological analysis of reality: macro (systemic context and institutions), meso (organisational context), and micro (interaction). This framework is visually represented in Figure 2.

Figure 2: Overview of systems and institutions influencing the caseworker–client interaction



Source: (Rice, 2013, p.18)

Understanding top-down and bottom-up influences

The goal of this study is to uncover potential top-down and bottom-up mechanisms in the GPs' management of patients with mental disorders and how these affect patients' navigation in the health services. After presenting the theoretical framework of the study, a brief overview of what constitutes top-down and bottom-up influences in this context is provided. Specifying what top-down and bottom-up

influences mean is useful to clarify the mechanisms through which healthcare policies and individual actions impact patient care.

Considering healthcare, top-down influences refer to the hierarchical imposition of norms, guidelines, and standards that dictate acceptable behaviour within a social or organisational context. These influences emanate from structured institutions which, through a combination of legal mandates, ethical considerations, and cultural expectations, guide the actions and decisions of individuals within the healthcare service. Not only do these entities establish external benchmarks for behaviour, but they also engender a set of internalised values and beliefs, subtly shaping the worldview and professional ethos of healthcare providers. The evolution of the healthcare landscape, marked by technological advancements, shifting public health policies, and the rapid dissemination of medical information, continually reshapes the paradigm of what constitutes effective and medical practice (Cowan *et al.*, 2019). The Hippocratic Oath historically symbolises the quintessential commitment to ethical medical practice. However, the contemporary interpretation of this oath is inevitably shaped by the current socio-political and technological context. Technological advancements, such as tools for conducting consultations and communicating with patients, along with the rapid dissemination of health-related information, have introduced new dynamics into the medical profession. These factors may alter the general perception of what it means to be a “modern, exemplary physician” as they influence both the expectations placed on healthcare professionals and the way they interact with patients and society at large (Antoniou *et al.*, 2010). This ongoing evolution highlights the dynamic nature of top-down influences, where external pressures, such as socio-political changes and technological advancements, intersect with internalised professional values to shape medical practice. As these influences continuously evolve, they redefine the standards and expectations of the medical profession, illustrating how both external forces and deeply rooted ethical commitments work together to guide the conduct of modern physicians.

Bottom-up influences, conversely, highlight the capacity of individual actions and interpersonal relationships to instigate structural changes within institutions. The agency of individuals and groups can significantly modify or redefine the operational paradigms of larger organisational entities. Historical examples, such as the movement towards deinstitutionalisation in psychiatry, underscore the profound impact that collective

professional advocacy can have on institutional practices and policies. The push for community mental health services over traditional asylum-based care show how joint initiatives can generate significant cultural and institutional transformations, leading to more inclusive and democratic psychiatric practices (Basaglia & Basaglia Ongaro, 1966; Caldas De Almeida & Horvitz-Lennon, 2010).

This dialectic between top-down and bottom-up mechanisms underscores a complex interplay where the macro-level influences of institutions and the micro-level actions of individuals and communities reciprocally shape each other. The organisational-meso level, encompassing more localised healthcare settings and services, acts as a critical nexus for this interaction. Organisational cultures, policies, and structures significantly influence the professional conduct and decision-making processes of healthcare providers. Understanding the interdependent relationship between top-down and bottom-up influences in healthcare requires a nuanced appreciation of how institutional directives, professional values, and individual actions collectively contribute to the evolution of healthcare practices and policies. This study aims to elucidate these dynamics within the context of GPs managing mental health conditions, offering insights into how these mechanisms affect patient care and navigation through health services. By examining these influences, it could be possible to better understand the factors that drive change within healthcare settings and the potential for implementing more effective and patient-centred care strategies.

3.2 Are general practitioners "Street-level bureaucrats"?

After the presentation of the theoretical framework of the research, some reflections on in which terms GPs could be considered SLBs are necessary. By definition, SLBs are characterised by their direct engagement with the public, substantial and pressure-laden workload, and the necessity to employ a significant degree of discretion in their roles. Discretion must be recognised as essential by the legislative body to facilitate the public service's operation amid the vast scope of work. The very nature of SLBs' work necessitates a flexibility to respond to the "human dimensions of situations," given the programmatic challenges and the unpredictable nature of their interactions with the public (Lipsky, 2010).

GPs are health personnel dependent on the NHS, generally funded by a taxation system extended to the population. It can be said, then, that they are assimilable as public officials. Second, considering their frontline position, working in primary care services, they face the public (Grandes *et al.*, 2011; Lora, 2009; Louma *et al.*, 2002). In this task, they exercise significant discretion in diagnosing conditions, deciding on the best course of treatment and whether to refer patients to specialists. These decisions directly influence patients' access to further healthcare services, embodying the essence of SLB through the exercise of discretionary power granted by the state's political and healthcare organisations. Further, GPs operate with few resources, especially in terms of time, materials, and space, and with a high level of autonomy, due to the limited control over the execution of their tasks (Sundquist & Johansson, 2000). While this may offer doctors a high degree of autonomy, it simultaneously forces them to take full responsibility for the management of patients.

The high demand, few resources, and the importance of their work lead primary care physicians to develop stressful reactions, which, in the most severe cases, can lead to Burnout Syndrome (Dreher *et al.*, 2019; Montero-Marin *et al.*, 2020), correlated with the appearance of various depressive disorders (Schonfeld *et al.*, 2019). This could manifest as a cynical, negative, and dehumanised attitude, along with a diminished sense of personal accomplishment in patient care (Maslach & Jackson, 1986). Burnout progressively deteriorates one' s commitment to work, drains one of enthusiasm, and fills one with anxiety and anger. It is common in the healthcare professions, especially in those that involve close and prolonged contact with patients. Among these are GPs, whose work is emotionally difficult and associated with absenteeism and low job satisfaction (McCray *et al.*, 2008).

The dilemma of having to offer generalised and tailored services, presented by Lipsky and common to all SLBs, in GPs it became evident in the impossibility, due to a lack of resources against high demand, to treat all patients to treat all patients in the best and most personalised way. Pandemic was a crystal-clear example of the FL exposition of GPs within the health service: "As the frontline first contact for patients with suspected infection with SARS-CoV-2, GPs are frequently exposed to the virus and can become the source of community spread if not adequately protected" (Fiorino *et al.*, 2020, p.1). It has been found that the category of healthcare professionals with the highest number of fatalities due to the virus is that of GPs and emergency physicians, being Italy the country

most affected (Ing *et al.*, 2020). In addition to this, all healthcare professionals' work has become more mechanical and bureaucratised due to the many anti-contagion, screening, and administrative data reporting protocols that must be implemented. However, doctors did not receive the required training regarding the new disease, thus underestimating its infectious potential, especially in the early months of 2020 (Fiorino *et al.*, 2020). In addition, due to their frontline role in the NHS, GPS faced an increased number of consultations, without additional time and material resources, such as personal protective equipment (Di Monte *et al.*, 2020). Together with stress-related symptoms, a high incidence of anxiety-related symptomatology has also been identified. Fear of contracting the virus, bringing it home, and worrying about returning to work the next day are some of the most frequent causes of anxiety identified among GPs (Monterrosa-Castro *et al.*, 2020). In its publication "Mental health and psychosocial considerations during the COVID-19 outbreak, 18 March 2020", the WHO warns of the psychosocial risks associated with dealing with the pandemic: "Some healthcare workers may, unfortunately, experience avoidance by their family or community owing to stigma or fear. This can make an already challenging situation far more difficult. If possible, staying connected with your loved ones, including through digital methods, is one way to maintain contact. Turn to your colleagues, your manager, or other trusted persons for social support – your colleagues may be having similar experiences to you." (WHO, 2020b, p.2).

In summary, GPs embody the characteristics of SLBs through their direct interaction with patients, discretionary decision-making authority, and pivotal role in implementing and interpreting healthcare policies at the individual level. Their work is essential in shaping the accessibility, quality, and efficiency of healthcare services, making their bureaucratic role both crucial and complex within the public service landscape.

Reflecting on General Practitioners as Street-level bureaucrats: Linking the literature of access to mental health services

Bridging the gap between the literature on access to mental health services and the modulatory role of GPs as SLBs demands some reflection. GPs often stand at the forefront, typically being the first to encounter patient complaints about the healthcare service (Forrest, 2003; Wammes *et al.*, 2014). As SLBs, GPs utilise their discretion,

leveraging their informal inter-organisational networks to tailor care (Loyens, 2019), while advocating for their patients' needs and concerns (Dunham *et al.*, 2008).

The intense workloads and a persistent lack of essential resources such as time, significantly impact the dynamic between primary care physicians and their clients. This situation is further complicated by the brief nature of consultations, as highlighted by Tai-Seale *et al.* (2007), which poses challenges in fostering a therapeutic bond critical for the patient's integration into community health services. Moreover, the resource constraints and the challenges in implementing existing protocols play a crucial role in influencing the effectiveness of consultations. Studies by Deveugele *et al.* (2002) and Wilson and Childs (2002) have shown that extended consultation durations correlate with increased patient satisfaction and can enhance the patient's adherence to medical advice and engagement in treatment plans.

The limited availability of resources, such as time and training, may also contribute to the use of drug prescriptions as a coping strategy (Thornicroft, 2008; Walker *et al.*, 2016). This limitation in resources may lead to inadequate prescribing habits, as GPs may not have sufficient opportunity to stay updated with the latest treatment guidelines or to engage in in-depth consultations with their patients. Moreover, a deficiency in training concerning communication and emotional intelligence appears to erode patient trust and foster an individualistic perception of mental health issues (Jovicic & McPherson, 2020; Tarrant *et al.*, 2003; Van der Zwet *et al.*, 2009). As Lipsky states, SLBs must also address the "human dimension of situations". A lack of knowledge in doing so can indeed create problems in their relationships with users. Specifically, in the case of GPs managing patients with mental disorders, this deficiency becomes an obstacle to accessing specialised services.

The lack of time and specific training in mental health could also contribute to misconceptions about certain disorders. For instance, Magliano *et al.*(2017) highlighted that GPs might create prejudices regarding conditions like schizophrenia, often viewing these disorders as more dangerous than they are, a view that contrasts with those held by practitioners who are better informed about these conditions. This gap in understanding and the consequent misperception not only affects the quality of care provided but also influences the management of these patients.

The payment mechanisms in place also critically influence GPs' decision-making processes (Bjørndal *et al.*, 1994; Gosden *et al.*, 2000; Vu *et al.*, 2021). These financial

structures can greatly impact various clinical and administrative decisions, from the allocation of consultation time to the selection of treatment options and referrals to specialists. It is possible that GPs who are self-employed or maintain a less bureaucratically involved relationship with the Health service may experience greater organisational autonomy (Bourgueil *et al.*, 2009). In the context of SLB theory, this suggests that the "discretion as used" by these GPs align more closely with the "discretion as stated" in official guidelines and policies, which may grant them greater flexibility and authority in their practice. This alignment allows them to tailor care more effectively to the unique needs and circumstances of each patient.

Coupled with the autonomy and discretion granted to healthcare professionals and organisations, decentralisation may affect their independence and coordination (Juliá-Sanchis *et al.*, 2020). This, in turn, possibly affects the continuity of services and access to care, suggesting that the broader policy environment in which GPs operate can either facilitate or hinder their ability to deliver consistent, coordinated care. Decentralisation can lead to variations in resources, policies, and governance across regions, which may create challenges in maintaining uniform standards and coordinating care effectively across different services and providers. The interplay between financial structures, professional autonomy, and policy frameworks underscores the complexity of ensuring effective healthcare delivery. These elements collectively shape the operational landscape of health services, emphasising the need for a balanced approach that supports professional discretion while ensuring service continuity and equitable access to healthcare.

In conclusion, GPs, as SLBs, operate within a complex role shaped by intrinsic discretion and the wider policy and resource landscape. Lipsky's theory offers a fundamental perspective on decision-making at the public service frontline, with various factors from consultation duration to decentralisation policies, and from training to perceptions, significantly steering GPs' decision-making.

3.3 Research Hypotheses

In this chapter, the explanatory and analytical value of Lipsky's (2010) and Rice's (2013) theories have been validated to understand how GPs manage patient with mental disorders. GPs, as SLBs, operate under stress with limited resources and high demand,

often developing specific coping mechanisms and exercising significant discretion. This approach allows for the study of policies in their everyday reality, specifically in the daily interactions between SLBs and citizens, essentially, where the State becomes visible. The notion that the delivery of public services often diverges from institutional and organisational designs due to SLBs' discretion offers valuable insights into the dynamics through which access to the national health service is realized. Considering the Lipsky and Rice's work, the following hypotheses will be explored in the next chapters:

- Hypothesis 1: the institutional and organisational context modulate the GPs' management of patients with mental disorders.
- Hypothesis 2: trends in management approaches can be identified through the GPs' daily work.
- Hypothesis 3: the emergent management trends contribute to alterations within the institutional and organisational model.

In conclusion, the theoretical framework presented underlines the potential for frontline public service workers, those "on the street" to actively shape policy. Moreover, it provides a foundation for discussing how institutions and organisations can directly impact people's lives.

The next chapter presents the qualitative methodology employed in this research, including the ontological and epistemological understanding, the research design, the data collection and analysis process, and the presentation of the participants.

CHAPTER 4
METHODOLOGICAL FRAMEWORK

This chapter outlines the methodological framework of the study, detailing the comprehensive approach taken to explore the management of patients with mental disorders. The chapter begins by elucidating the research's epistemological stance, clarifying the conceptualisation of knowledge in relation to the study's subject. This foundation is essential for understanding the qualitative perspective through which the study examines the phenomena, setting the stage for a deeper exploration of the dynamics involved. Following this, the chapter presents the qualitative research methodology, explaining the rationale behind its selection and describing the techniques employed for hypothesis validation. Rather than simply listing methods, the section critically examines what it means to validate hypotheses within a qualitative framework. The chapter then details the strategies for primary data collection and the comparative analysis used to investigate the institutional and organisational contexts. This approach is key to validating the first hypothesis, offering a detailed comparative analysis that highlights the factors influencing GPs' management practices. In addition, the criteria for participant selection and the framing of interview questions are carefully justified.

4.1 Epistemological stand

Before the presentation of the research methodology, it is essential to address certain considerations that may seem self-evident but are crucial for fully understanding the decisions presented in this chapter. The objective is to justify the choices made to validate the hypotheses. Explaining the rationale behind the selection of methods is necessary to enhance the validity of the research (Jones *et al.*, 2012; Kekez, 2019; Moravcsik, 2014). Kekez (2019) differentiates between "analytic transparency" and "production transparency". The first is treated during the presentation of the technique of research implemented for the validation of each hypothesis. The second "means that readers have insight into the procedures used to gather or choose evidence, arguments, and methods". The method encompasses all decisions regarding the most appropriate approaches, data collection techniques, units of analysis, sample selection, and data analysis techniques. The researcher must decide whether to follow established paths or create new ones. Consequently, justifying each methodological decision is crucial for ensuring the research's internal coherence. The choice of specific techniques and approaches must consistently align with the goal of achieving the research objective (Jones *et al.*, 2012; Kekez, 2019; Moravcsik, 2014).

In this context, it is also important to reflect on the nature of knowledge itself and what it means "to know". Scientific knowledge has long been characterised by a tension between realism and relativism, two perspectives that influence how research methods are perceived and applied. This consideration is fundamental to understanding the underlying assumptions that shape methodological choices and, ultimately, the validity of the research. (Aspers & Kohl, 2013; Dreyfus, 1990; Michel, 2012; Paley, 1998). The polarisation lies between the objective existence of reality and its objects (realism) and the belief that human judgement and perception are inseparable from it (relativism), which denies the possibility of objective knowledge (Danermark *et al.*, 2005). Objects of knowledge, or phenomena, could be considered "transitive" or "intransitive". Intransitive objects do not depend on human existence. Transitive objects' existence depends on human existence (Michel, 2012). Extreme realism assumes that objects, *e.g.*, institutional structures, culture, and policies, could exist independently nevertheless our ability to experience or control them. The independent existence of *intransitive* objects does not mean that they are irrelevant to the existence of humans. Thus, between the

epistemological stances of realism and relativism, there exists a continuum of positions. One such position is critical realism, which lies between the two extremes. Critical realism posits that certain objects and phenomena, referred to as intransitive objects, exist independently of human perception or experience. In other words, these objects are real and persist regardless of whether we observe or understand them. According to this perspective, it is possible to gain knowledge about these objects, even though our understanding of them may be shaped by social, cultural, and cognitive factors. However, critical realism distinguishes between the existence of these objects and our knowledge of them. It recognises that while our perceptions and interpretations are influenced by various processes, this does not undermine the existence of an objective reality. Through careful and systematic methods, such as scientific inquiry, we can overcome biases and limitations to gain valid knowledge of this reality (Danermark *et al.*, 2005; Wynn Jr & Williams, 2008).

Another stand that, as Critical Realism, assumes a critical position toward realism and relativism, is Heideggerian Realism. Heidegger writes on the *ontological difference*. This distinction involves two levels of "knowledge": the *ontological*, which refers to Being (Das Sein) and pertains to the fundamental nature of existence, specifically about humans, the only entities capable of questioning the meaning of their existence, and the *ontic*, which refers to specific beings or entities within the world (Heidegger, 2005). This distinction underscores the idea that before we can address questions of knowledge (epistemology), we must first consider questions of existence (ontology) (Hekman, 1983). In other words, the deep question should focus on "what human action is" rather than merely on how we come to know it. In analysing human phenomena, as institutions are, the prioritisation of epistemology, has often overshadowed the more fundamental question of ontology (what things are). This critique is not merely academic but goes to the heart of how we conceive of the existence and essence of social objects. Unlike Critical Realism, which often treats external reality as separate from human nature, Heideggerian Realism insists that the nature of reality is deeply intertwined with human existence.

However, this approach encounters limitations when we conceive social objects as human phenomena. Within the theoretical framework of this research, the ontological foundation of human agency is similarly reflected in the works of Lipsky and Giddens. Both emphasise the significance of human action in shaping social and institutional

worlds, highlighting the active role of agency in the creation and perpetuation of generative mechanisms. In this context, Heidegger's existential analysis offers valuable insights by suggesting that the everyday practices of individuals, such as GPS, are not merely the implementation of institutional policies but are instead dynamic sites of ontological engagement, where continuous change and transformation take place. In other words, while objects of reality may have an independent existence, their essence as objects of knowledge depends on human inquiry. Humans are unique in their ability to question the nature of entities, and thus the nature of Being itself (Michel, 2012).

Applying these considerations to the object of this research, *i.e.*, the GPs' management of patients with mental disorders and the access to specialised services, and in agreement with the theoretical framework, the institution and organisation are considered social objects. Consequently, GPs can modulate these social objects in a bottom-up direction because their meaning and function are inherently tied to our ability to understand and engage with them. Thus, Heideggerian Realism views institutions and organisations as both formed by human action and forming human action (Paley, 1998). Social objects differ from physical objects because their existence is fundamentally tied to human interactions. Unlike tangible objects, social objects, such as norms, roles, or institutions, come into being and are sustained through the ways people engage with and understand them. Therefore, in the field of social sciences, these objects are analysed based on the meanings and purposes that individuals and communities attribute to them. (Zanotti *et al.*, 2021). These reflections, along with the need to ensure transparent justification of methodological decisions (Jones *et al.*, 2012; Kekez, 2019; Moravcsik, 2014) are also relevant to the general sociological debate. Many scholars argue that in the social sciences, such reflections can facilitate a shift from an "individual ontology" to a "social ontology" (Aspers & Kohl, 2013; Knudsen, 2020; Koo, 2016; Schatzki, 2003). This concept highlights the understanding of a person not as an isolated, atomistic entity, but as someone deeply embedded in a network of relationships with others. In other words, human existence is inherently social. Consequently, it can be asserted that the existence of relationships with others, our collective existence, is what constitutes social objects, such as social practices, institutions, and organisations.

Building upon the discussion of social objects and their inherent connection to human interaction, Heidegger's concept of *Sorge* (care) provides a profound philosophical foundation for understanding the deeply social nature of human existence. *Sorge* is not

merely an expression of concern or attentiveness; rather, it is the fundamental mode of being that characterises human existence. According to Heidegger, “to exist” is to be in a state of care, an existential structure that precedes and underpins all specific behaviours and attitudes (Heidegger, 2005). Heidegger’s concept offers crucial insights into how individuals relate to their future, revealing that reflection on the future is deeply intertwined with emotional engagement, representing a preconscious affective connection with the world (Emirbayer & Mische, 1998). *Sorge* splits into two connected forms: concern (*BeSorgen*) and solicitude (*FürSorge*). “Concern” relates to our engagement with inanimate objects or tasks, such as the practical aspects of a GP’s duties, including diagnosing illnesses or prescribing treatments. It reflects our practical, technical, and theoretical interactions with the world, manifesting in the way we manage and use the things around us. In contrast, “solicitude” pertains to our relationships with other “beings”, particularly other people. It encompasses the ethical, emotional, and existential dimensions of our interactions, highlighting the interpersonal aspect of care that goes beyond mere interaction to include empathy and the nurturing of authentic relationships. Heidegger’s concept of *Sorge* highlights the complexity and depth of human engagement with both the material and interpersonal worlds, revealing that care for things and others fundamentally defines being-in-the-world. This understanding holds significant importance in the social sciences, particularly in the analysis of institutions and organisations, as it brings attention to the intricate web of relationships that constitute collective existence. In this context, the concept of *Sorge* enhances the understanding of social objects by emphasising that they are not only shaped by human actions but also profoundly influence those actions, grounding them in the fundamental structure of care that characterises human existence (Anosike *et al*., 2012; Dowling, 2007). In the context of GPs managing patients with mental disorders, *Sorge* should be particularly relevant. The care provided by GPs should extend beyond clinical interventions to include a deeper engagement with the social and existential realities of their patients. This care-oriented approach should challenge the impersonal narratives of bureaucratic detachment by advocating for a model that integrates empathy, relationality, and existential meaning into medical practice, thereby making sense of the emotional suffering of patients (Aho, 2008; Chodoff, 2002).

4.2 Qualitative approach of the research

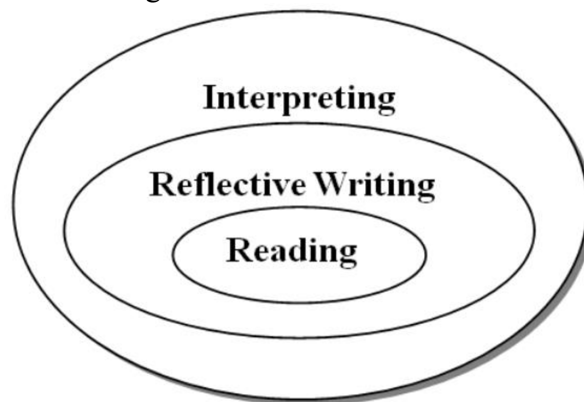
The primary aim of this research is to gain a deeper understanding of how GPs manage mental health. Qualitative methods are particularly well-suited for this purpose, as they allow for a more profound exploration of phenomena, going beyond merely the identification of correlations or cause-and-effect relationships between variables. From a quantitative perspective, one of the main limitations of the qualitative approach is the difficulty in directly comparing multiple studies of this kind. The sensitivity of the researcher, along with the variety of situations and circumstances during data collection, makes each study unique and isolated in its context, although they can still be compared based on the commonality of their research focus. Another drawback is the inability to sample a large number of participants, which prevents the study from being "representative" in the statistical sense, both in terms of the sample of subjects and the generalisability of the findings (Gobo, 2002; Griffiths *et al.*, 2011). These characteristics are not necessarily "negative" but rather "inevitable," as the primary goal of the qualitative approach is not to achieve "representativeness" but to deepen the understanding of specific phenomena. In qualitative research, the emphasis is on exploring the richness and complexity of the subject matter rather than generalising findings to a broader population. The time invested in data collection and analysis for each participant is therefore higher compared to quantitative approaches, where it is possible to administer a test or questionnaire to many people in a relatively short period. This intensive focus on individual cases or small groups is what allows qualitative research to provide detailed insights that might be overlooked in large-scale quantitative studies.

Hermeneutic-phenomenological approach

The research is grounded in an epistemological stance rooted in Heideggerian realism. The methodology guiding data collection and analysis is hermeneutic-phenomenological, drawing from the philosophical thought of Edmund Husserl, Martin Heidegger, and Hans-Georg Gadamer (Dowling, 2007). Father of occidental phenomenology, Husserl understands the knowledge of a phenomenon as its contemplation. Indeed, the term "phenomenon" derives from the ancient Greek *phaenesthai* which means "to show, to reveal, to appear" (*ibidem*). Heidegger shifts away from a contemplative view of knowledge, placing human interpretative action at the centre of the knowledge process. Hermeneutics, understood as the "art of interpretation" evolves into a research method, utilising Heidegger's concept of the "hermeneutic circle"

as a technique to deepen understanding and generate knowledge (Dowling, 2007; Kafle, 2013; Warnke, 2011). As Warnke writes: “For the hermeneutic tradition, the hermeneutic circle describes a means for testing our interpretation of a given text” (2011, p.94). In Gadamer’s phenomenology, the concept of the “hermeneutic circle” emphasises that understanding requires the personal involvement of the researcher. The researcher’s reflections during the research process and data analysis are considered additional data that contribute to a deeper knowledge of the phenomenon. Furthermore, the relationship with participants should be rooted in the exchange of reflections, fostering their deep understanding of the phenomenon. This approach is further enriched through collective discussions with participants about the research results (Dowling, 2007). Graphically, the hermeneutic circle can be depicted in Figure 3, where the process of knowledge moves from the centre to the periphery and then returns to the centre. This cyclical movement illustrates how understanding evolves through continuous interaction between the whole and its parts, reflecting the dynamic and iterative nature of the knowledge acquisition process.

Figure 3: Hermeneutic circle



Source: Kafle, 2013, p.195

In the hermeneutic-phenomenological approach, the researcher must engage in a continuous reflexive process, immersing deeply in the data and emerging with insights that can enrich the reader’s understanding of the subject matter. Despite its limited use in social sciences (Anosike *et al*., 2012; Barbera & Inciarte, 2012; Ehrich, 2005; Zanotti *et al*., 2021) this approach holds significant potential. As Zanotti *et al.* (2021) consider, social sciences focus on human actions, and these actions are interpreted by researchers

using various strategies. Applying these considerations to the study of GPs' management of patients with mental disorders, the hermeneutic-phenomenological approach can reveal the underlying mechanisms driving GPs' behaviours. As Ehrich states (2005), management is not merely a control technique but a process and practice imbued with a strong human dimension. This approach can also enhance GPs' understanding of their management practices regarding mental health, thereby improving the quality of healthcare services and access to mental health care (Anosike *et al*., 2012). Furthermore, within the theoretical framework of the research, it can be argued that applying the hermeneutic-phenomenological approach to the study of GPs' management practices can influence organisational policies and the broader institutional context. In the next section, following a discussion on the use of the term "hypothesis" in qualitative research, the methodological approach adopted to validate the hypotheses will be outlined, along with the specific techniques employed in the process.

4.3 Hypotheses' validation

In this thesis, the term "research hypothesis" is considered with the understanding that, in social sciences, a hypothesis is often viewed as a statement about relationships between variables. Consequently, within a qualitative approach, "validation of hypotheses" does not imply establishing statistical relationships between variables, such as cause-effect or correlation, nor does it involve numerical verification. The primary aim is to gain a deeper understanding of the research object by observing potential relationships between variables. In this work, the main objective is to develop an in-depth understanding of GPs' management of patients with mental disorder. Therefore, the validation of hypotheses is constructed narratively rather than statistically, focusing on enriching knowledge rather than proving cause-effect relationships. Certain elements of a phenomenon may influence other elements, but this influence is not measured, nor are the research hypotheses verified using statistical tools. Instead, these elements represent potential relationships within the research object, grounded in the theoretical framework previously validated in this study. This approach is consistent with the theoretical framework of SLB. As Hupe (2019a, p.272) writes: "Lipsky does not seem interested in causal explanations. Rather, aiming at understanding (Weber's *Verstehen*), he provides a *thick description* (Keerts 1973), while not speaking in terms of dependent and independent variables". This alignment between SLB theory and the epistemological

stance of this research supports a qualitative approach that seeks to deepen understanding rather than confirm predefined hypotheses. Moreover, the analysis of results may disprove existing relationships between variables, leading to the creation of new hypotheses. The hypotheses in this research are conceived as an open system, built on theoretical foundations (Lareau, 2012; LaRossa, 2012) combining a deductive strategy while allowing for new abductive insights into SLB theory. The goal is not merely to confirm or disconfirm the theoretical framework but to contribute to its development and enrichment (Dubois & Gadde, 2002). SLB theory guides this research not only to affirm its assumptions but also to potentially develop new ones, creating connections with other theories or highlighting the need for new theoretical developments. Anomalies are not dismissed but are seen as opportunities for generating new conceptualisations of existing theory (Timmermans & Tavory, 2012).

Continuing with the presentation of the methodological framework, this research validates hypotheses through the implementation of a cross-case comparison between Italy and Spain. This comparative approach seeks to identify similarities and differences that could reveal underlying generative mechanisms at both the institutional and organisational levels, which may contribute to obstacles in accessing mental health services (Babones, 2016; Doblytė & Guillén, 2020; Hill & Møller, 2019; Hupe, 2019b; Kuhlmann, 2019; van der Tier *et al.*, 2021). This require identifying a public task that enables meaningful comparison, ensuring that the task is defined in a way that avoids excessive generality while also being significant enough to align with the research objectives (Hill & Hupe, 2019). As Kulmann (2019) notes, comparisons are typically made between two systems using data from a specific period, or within one system using data from two periods, to identify information that could explain observed differences. In this research, a narrative comparison was carried out between Spanish and Italian primary and mental health care. Within SLB's framework, this type of research should delve into contextual aspects, providing a detailed exploration of *systems in action* through descriptions of institutional and organisational contexts (Hill & Hupe, 2019). The management of patients with mental health problems by GPs serves as a specific health task that enables comparative analysis between the two case studies, as this task is present in both contexts. Also, an analysis of three analytical levels, macro, meso, and micro, was developed to offer a rich and exhaustive description of the object of the research unveiling possible generative mechanisms of GPs' management. In this multi-level and cross-

national study, both primary data and institutional and organisational descriptions of the Italian and Spanish health services are utilised. Primary data was collected from three main groups of participants: GPs, patients with mental health problems, and FL supervisors. Interviews with GPs aimed to uncover their management of patients with potential mental health issues, focusing on key aspects of SLB theory, such as discretion, autonomy, resource constraints, and their relationship with FL supervisors. Patients with possible mental disorders were interviewed to explore their healthcare journeys, emphasising the obstacles encountered and the role of their GP. Finally, interviews with FL supervisors examined their oversight and sanctionative role concerning GPs' work.

For primary data collection, within the hermeneutic-phenomenological approach, semi-structured in-depth interviews, characterised by almost open-ended questions, were employed (Guion *et al.*, 2001). To achieve the complexity of identifying all the variables that influence the behaviour of GPs in managing mental disorders, spanning individual, organisational, and institutional factors at micro, meso, and macro levels (Klandermans & Staggenborg, 2002). During interviews, after a brief introduction to the study designed to make the interviewee feel comfortable, the researcher poses questions that encourage the subject to respond freely. If the subject does not respond, the researcher can repeat the question, expressing gratitude for any additional information provided. The researcher can paraphrase the subject's answers to ensure a clear understanding of the content, which also reassures the interviewees that their words are being attentively heard. If the researcher senses that the subject could offer more insight, in-depth interviews allow for the possibility of asking spontaneous, non-pre-established questions. In this method, interviewees should be encouraged to provide as many details as possible. The researcher must ensure that they do not feel "judged" and, if necessary, reiterate the anonymity of the interviews. In addition, given that the characteristics of the researcher can influence the responses, it is crucial to practise the "suspension of judgement" during interviews. This approach allows the interviewees' words to flow naturally, in a non-invasive and articulate manner, thus mitigating the risk of more concise responses where social desirability is more difficult to detect (Barriball & While, 1993). Indeed, the researcher have to build a relaxed rapport with the interviewee to minimising the risk of social desirability bias (Bergen & Labonté, 2020). In this research, the interview with patients and GPs also included some "storytelling" questions to recollect valuable information on their personal experiences (Gofen, 2014; Maynard-Moody & Musheno, 2000). For

example, storytelling can shed light on the daily work of SLBs by narrating concrete episodes that reveal routine practices, adherence to protocols, and organisational characteristics, such as resource constraints or relationships with colleagues. Storytelling, marked by open-ended questions, is particularly effective in gaining deeper insight into the interviewee's "lifeworld", a concept described by Husserl as *Lebenswelt*, which represents an individual's interpretation of reality, shaped by life circumstances and experiences (Kraus, 2015).

The techniques for the validation of the three research hypotheses are now presented. The constructs identified are defined based on the literature review and the theoretical framework. The drafts of the interviews and the socio-demographic questionnaire are included in the appendices of this thesis.

The institutional and organisational context modulates the GPs' management of patients with mental disorders

To validate the first hypothesis, a narrative comparison of the Spanish and Italian institutional and organisational settings was conducted, focusing on primary care and mental health services. Statistical data were used exclusively for descriptive purposes to construct a comparative narrative between the Spanish and Italian cases. The analysis covered macro-level elements such as universal health coverage, decentralisation of health services, deinstitutionalisation of mental health, model of care, resources of NHS, and the steering model of government. At the meso level, the study examined factors including the type of GP system payment, training on mental health, protocols or guidelines, time resources (length of consultations), waiting lists, and collaboration between primary care and mental health services.

The questions exploring the macro and meso influences on the relationship between GPs and patients were posed to GPs, FL supervisors, and patients with mental health disorders. For GPs, the questions addressed their attitudes towards patients with mental health problems, the scarcity of resources (with particular reference to the COVID-19 pandemic), the presence of protocols or regulations that might limit their autonomy (especially in managing patients with mental health problems), their relationship with FL supervisors and professional organisations, the number of consultations they conduct daily, the time allocated for each consultation, and the frequency with which they encounter symptoms attributable to psychological issues. Moreover, the role of GPs, stigmatisation and prejudice, the normalisation of mental health, levels of autonomy, and

management strategies for patients with mild and serious mental disorders were also explored. GPs were asked whether they considered themselves gatekeepers for access to mental health services and how they felt about the responsibility associated with this role. FL supervisors were asked about their relationship with GPs, the frequency and nature of meetings with them, the presence of internal regulations that might constrain GPs' autonomy, the sanctions imposed for non-compliance, and the actions taken in response to improper management by GPs, particularly concerning patients' mental health. They were also asked about strategies implemented during the pandemic to address resource shortages. Patients were asked whether they could choose their GP and, if so, the strategies they used to make this decision. They were also asked about the level of trust they had in their GP. A special focus on the pandemic was included, with questions about any difficulties they faced in contacting their GP and how their consultations were conducted during this period.

Trends in management approaches can be identified through the GPs' daily work

Regarding the second hypothesis, open-ended questions were posed to GPs about their management of patients with potential mental health issues. They were asked to discuss a specific case involving a patient with mental health concerns who sought their consultation. If a doctor had no personal experience to share, they were encouraged to recount an episode known to them, such as one involving a colleague. Guided by the theoretical framework of this research, the questions aimed to uncover potential management strategies that GPs might employ, particularly those based on routines and stereotypes. For example, the discussion sought to explore whether GPs would prescribe medication, refer the patient to a mental health specialist, or consult a colleague for advice on the best course of action. The aim was to deepen the understanding of how GPs exercise their discretion "as used" (Hupe, 2013), specifically regarding the autonomy they possess in managing patients with mental health problems and the strategies they employ in these situations. GPs were asked about their collaboration with colleagues and mental health professionals, exploring how these interactions might serve as a potential space for modulating their management strategies. Patients, on the other hand, were asked to describe their clinical journey, specifically whether their access to the NHS was initiated through primary care, mental health services, or emergency services. The storytelling approach was guided to delve into the factors, such as the management by GPs, that could either represent an obstacle or facilitate access to specialised services.

The emergent management trends contribute to alterations within the institutional and organisational model

Regarding the third hypothesis, questions posed to GPs and patients aimed to uncover "innovative" management strategies, recognising that these new approaches are often personal and specific to individual doctors. "Innovative" behaviour in this context is defined by efforts to effectively implement community care. This includes fostering patient responsibility for their own health, deinstitutionalising care, activating local services, and reducing the reliance on drug prescriptions. Such practices are considered innovative because they represent the practical application of community care principles, reflecting the directions most favoured by its adoption. This exploration acknowledges the role of patients with mental disorders not just as recipients of healthcare but as active contributors to their health. However, it is recognised that not all doctors may embrace these changes, with some potentially continuing to focus more on pharmacological treatments. In other words, while GPs' innovative practices may be impactful, they are not widespread by definition. Innovation involves creating something distinct that, if it were common from the outset, would not be considered innovative. Moreover, GPs were asked about differences in the management, protocols, and regulations for managing patients with mental health problems between the beginning of their careers and the present. If differences were noted, further questions were asked to explore possible explanations. These inquiries aimed to uncover the evolution of management strategies and attitudes towards mental health problems over time. GPs were also questioned about the difference in the prevalence of innovative behaviours between older and younger GPs. Moreover, FL supervisors were asked about possible mechanisms that might allow Health Organisations to accept management strategies implemented by GPs that are not explicitly forecasted by regulations, especially if these strategies prove to be functional and not harmful to patient health.

4.4 Sampling, participants, data collection and analysis

The research procedure was carried from June to November 2022. It started after the approval of the "Ethical Research Committee of the Principality of Asturias" (*Comité de Ética de la Investigación del Principado de Asturias*, *Hospital Central Asturias*, ceim.asturias@asturias.org). The three interview guides, the informed consent document for the processing of personal data, and the research plan were submitted to the Ethics

Committee (see the appendices of this thesis for the Consent Form and the Ethics Committee Approval). Following this, the researcher informed the Regional Health Department of Tuscany and the Principality of Asturias, and the local Public Health Organisations about the research. In Tuscany, the researcher received support from the Department of Political Science at the University of Pisa in contacting health officials. However these were the sites where the interviews were conducted, the focus of this thesis extends beyond local contexts, aiming to identify generalisable trends, *i.e.*, findings that are pertinent to the two national cases but also applicable to the broader practice of GPs. Then, the researcher contacted GPs via email, or in some cases, through prior contact with the health centre when necessary. In the email, the researcher introduced himself as a PhD student from the Department of Sociology at the University of Oviedo. He briefly outlined the research, its objectives, and the content of the interview, seeking their willingness to participate while assuring them of anonymity and the option to withdraw from the study at any time. GPs were also asked if they could facilitate interviews with some of their patients. Concurrently, the researcher reached out via email to local mental health centres. After presenting the research, he requested permission to interview some patients to understand their clinical pathways. Although interviews with patients could be conducted in the presence of a health professional, if necessary and with the patient's consent, this was ultimately not required.

The inclusion criteria for patients with mental disorders required them to be at least 18 years old. Exclusion criteria for all subjects included being underage or suffering from mental disorders with symptoms that could be aggravated by the interview process. If a GP agreed to participate, they would then, in the absence of the researcher, ask some of their patients if they were willing to take part in the study. GPs and professionals at the mental health centre were also asked to advise the researcher on which patients should not be interviewed. Once a patient agreed, the researcher would contact them directly. During the interview, GPs were also asked to identify their direct supervisor, with the usefulness of interviewing this individual explained to the physicians. Once the FLS was identified, the researcher contacted him to explain the purpose of the research and to request his participation in an interview. Anonymity and the option to withdraw from participation were assured at all stages. If a GP was also a FLS, he was asked to consent to both interviews. The anonymity of the participants was ensured, along with their right to withdraw from the study at any time. In all instances, care was taken to maintain the

confidentiality of the interviewees and to uphold their right to discontinue the interview at any point. The interviews, conducted by the researcher in both Italian and Spanish, were preceded by a brief questionnaire to collect the socio-demographic data of the participants. All subjects recruited for the study were required to sign a consent form prior to the interview. This form confirmed that they had been informed of the voluntary nature of the research, their right to withdraw at any time, and the fact that the interview would be recorded using a voice recorder. Moreover, the document provided information regarding the processing of personal data, in compliance with Articles 13-14 of the European Union's General Data Protection Regulation (GDPR). Refusal to sign any of these documents was sufficient to invalidate the interview. Interviews lasted at least one and a half hours. Interviews with GPs and FL supervisors were conducted in their consultation rooms, at an arranged location, or by telephone. Based on the preferences of the interviewees, most interviews took place in health centres or mental health facilities, with a few conducted in private homes or via video call. Interviews with patients were primarily held in mental health centres, in the GP's consultation room, in some cases at the patient's home, or in shared living facilities. To facilitate patient expression, nearly all interviews with patients were conducted in person, except for three out of twenty-two, which were conducted via video call. This option was chosen only when the patient had no difficulty expressing themselves and their health condition allowed it. The interviews with patients were more challenging, as many were dealing with severe mental health issues, which affected their ability to communicate. Consequently, the depth of the interview content was sometimes limited by these factors. Some of the patients interviewed had long-standing psychiatric disorders, with the initial diagnosis made at a young age. Particularly in the cases of patients in shared living facilities, they were heavily medicated. In less severe cases, patients followed a pharmaceutical treatment plan combined with psychotherapy. More details on the patients are provided when the quotes from the interviews are introduced.

Given the uncertainty in determining participants' willingness to join the study, the time needed for conducting interviews and their hermeneutic analysis, and the fact that the study was not intended to produce statistically representative results for the Italian and Spanish cases, participant sampling was carried out on a "convenience" basis (Etikan *et al.*, 2016) contacting the identified subjects directly and then implemented a "snowball" strategy to further expand the participant pool (Biernacki & Waldorf, 1981). However,

the researcher made an effort to ensure a balance in the number of subjects according to their gender and age. The sampling process was concluded once data saturation was achieved, meaning that the content of the interviews began to repeat. Saturation was reached after conducting 9 interviews with both GPs and patients within a single national case study (Francis *et al.*, 2010; Guest *et al.*, 2006). The saturation point with FL supervisors was not considered a critical issue, as the questions focused specifically on organisational issue, *i.e.*, their supervisory roles and how these roles might limit the GPs' autonomy in their specialised functions. In total, twenty GPs, ten from Spain and ten from Italy, were interviewed, along with twenty-two patients, equally divided between the two countries. Moreover, six frontline supervisors were interviewed: four coordinators from Spain and two from Italy. This resulted in a total of 48 participants for the two case studies. The median age of the Spanish GPs was 55 years, with a median of 1502 patients and 40 medical consultations per day. In comparison, the Italian GPs have a median age of 40 years, with a median of 1500 patients and 28 medical consultations per day. The participants' ages in this patient group range from 28 to 75 years. Among the Spanish patients, the median age is 52 years, while the Italian patients have a slightly older median age of 56 years. The ages of the supervisors range from 44 to 66 years. Regarding gender, male and female participants were almost equally distributed. Tables 2, 3, and 4 present a summary of the demographic and relevant characteristics of the participants.

Table 2 Summary of the participants: GPs

PART.	GENDER	AGE	Nº P	MC/DAY	HC
GP1S	F	55	1600	40	Yes
GP2S	M	48	1503	43	Yes
GP3S	F	59	1250	38	Yes
GP4S	F	31	1000	40	Yes
GP5S	F	59	1600	40	Yes
GP6S	M	64	1300	30	Yes
GP7S	M	60	1690	40	Yes
GP8S	M	64	1500	44	Yes
GP9S	M	28	—	—	Yes
GP10S	F	43	1400	50	Yes
GP1I	M	40	1500	27	Yes
GP2I	M	36	1500	20	No
GP3I	M	35	1550	31	Yes
GP4I	F	43	1300	28	No
GP5I	F	35	1200	15	Yes
GP6I	F	44	2020	21	Yes
GP7I	F	36	1700	38	No
GP8I	M	67	1200	28	No
GP9I	F	44	1750	40	No
GP10I	F	33	200	6	Yes

Note: The first ten GPs (above the black line) are Spanish (S), the second ten are Italian (I). GP9S is a residential doctor. Nº P=Number of patients. MC/DAY=Medical Consultations per Day (including face-to-face, telephone, and house visit consultations.) HC=working in a health centre.
Source: Author's own work

Table 3 Summary of the participants: patients

PART.	GENDER	AGE	MH in PC	DS	FtF/T interview
P1S	F	46	Yes	Mild	T
P2S	F	52	Yes	Mild	FtF
P3S	F	44	Yes	Mild	FtF
P4S	F	44	No	Moderate	FtF
P5S	F	67	No	Moderate/Severe	FtF
P6S	F	56	No	Moderate	FtF
P7S	F	60	No	Moderate.	FtF
P8S	M	50	No	Moderate.	FtF
P9S	M	28	No	Moderate.	FtF
P10S	M	51	No	Moderate/Severe	FtF
P11S	M	66	No	Mild	FtF
P1I	F	63	Yes	Moderate/Severe	FtF
P2I	M	37	No	Severe	FtF
P3I	M	59	No	Severe	FtF
P4I	F	57	No	Moderate	FtF
P5I	F	75	No	Mild	FtF
P6I	M	50	No	Moderate/Severe	FtF
P7I	M	61	No	Moderate/Severe	FtF
P8I	M	56	No	Moderate/Severe	FtF
P9I	M	52	No	Moderate/Severe	FtF
P10I	M	34	No	Mild	T
P11I	F	48	No	Moderate	T

Note: The first eleven Patients (above the black line) are Spanish (S), the second ten are Italian (I). MH in PC=Mental Health (MH) in Primary care (PC). DS=Disorder Severity. FtF/T=Face-to-face (FtF) or Telematic (T) interview.
Source: Author's own work

Table 4 Summary of the participants: FL supervisors

PART.	GENDER	AGE	HC
FLS1S	F	55	Yes
FLS2S	F	59	Yes
FLS3S	M	64	Yes
FLS4S	M	60	Yes
FLS1I	M	44	Yes
FLS2I	F	66	No

Note: The first four FL supervisors (above the black line) are Spanish (S), the second two are Italian (I). HC=working in a health centre.
Source: Author's own work

Regarding data analysis, to fully preserve the meaning and the experiences of the interviewee (Lindseth & Norberg, 2004) audio records were transcribed and analysed in

Italian and Spanish. The categorisation and analysis processes were conducted using the MAXQDA software. To prevent research biases and reduce the influence of the researcher's culture and sensibility during the early stages of data analysis, the report was shared with supervisors for their feedback. This step was taken to ensure inter-referee reliability (Cohen, 2018). Data analysis allowed for comparisons within each group of subjects and between the cases of Italy and Spain. Formulating an initial set of codes through both inductive and theoretical approaches, the process of identifying and categorising data relevant to the research was undertaken. Furthermore, a deductive categorisation process was employed alongside an abductive approach to account for the possibility of data not fitting into pre-established categories (Dubois & Gadde, 2002). A narrative representing the data was constructed, guided by broad themes and trends identified during a secondary phase of coding (Miles & Huberman, 1994). Within the hermeneutic circle, after the initial coding of the interviews, the analysis was continually revised by returning to the primary data to ensure that the results accurately represented the meaning and phenomena described in the interviews. Moreover, the researcher documented reflections on the analysis process, adhering to the reflexivity required by hermeneutic phenomenology. These notes became part of the data and were incorporated into the elaboration of the results, capturing the complexity of the research object. The complexity of the research object (Goggin, 2021; Hill & Hupe, 2019) and the impossibility of the researcher excluding his influence in the choice of the techniques and the data analysis (Roulston & Shelton, 2015) were objects of reflection and noted. These notes were treated as data and included in the elaboration of the results, addressing the complexity of the research object.

The following chapter presents an in-depth comparative analysis of the mental health systems in Italy and Spain. By examining the institutional and organizational structures within each country, it highlights how diverse healthcare models could shape the accessibility and efficacy of mental health services.

CHAPTER 5

NATIONAL CASES PRESENTATION

This chapter delves into the comparative analysis of Italy and Spain's mental health institutional and organisational contexts. Examining healthcare systems provides a framework to understand how different models possibly influence the delivery and effectiveness of mental health services. This chapter has been partially discussed in a recent publication (Giosa, 2024).

The Spanish Economic and Social Council (2024), citing the WHO, states that healthcare systems that are robustly supported in terms of primary healthcare tend to be more inclusive, equitable, cost-efficient, and effective in enhancing both the physical and mental health of individuals, along with their overall social well-being. The development of more efficient primary care was already present both in the WHO Mental Health Action Plan (WHO, 2013a) and in the Mental Health Declaration for Europe) where the priority was to "build up the capacity and ability of GPs and primary care services, networking with specialised medical and non-medical care, to offer effective access, identification and treatments to people with mental health problems" (WHO, 2005, p.3). Thus, the problem of guaranteeing equitable and equal access to all citizens, to their

different needs, while also building a framework of social institutions spread across the territory, continues to be at the core of the matter. For this reason, this chapter explores the evolution of the Italian and Spanish NHS and mental health services. Studying these systems allows to understand better the evolution, values, and organisation of primary care and mental health services, which is essential for analysing how these factors influence the day-to-day work of GPs in the face of contextual forces both past and present.

Key aspects discussed in this chapter include the organisation of GPs in primary care, the training in mental health received by primary care physicians, and the structural issues related to medical professional turnover within the NHS of each country. Moreover, the consumption of pharmaceuticals, the challenges of aging societies, the high levels of loneliness experienced within these populations, and the shift towards deinstitutionalisation are analysed. Furthermore, the chapter considers how both countries strive for efficiency while managing the rising healthcare cost, the increasing reliance on private health spending, and the ongoing issue of long waiting lists. By examining these elements, the chapter provides insights into the organisational and institutional factors that possibly influence the management of mental health patients by GPs.

5.1 Italian context

Law 833 of 1978, the foundational law of the Italian NHS, marked a significant transformation in healthcare in Italy. This legislation established a universal health system dedicated to ensuring comprehensive and equal access to medical services for all citizens, irrespective of their income or social status. By enacting this law, the right to health, as articulated in Article 32 of the Italian Constitution, was legislatively enforced. The Constitution states: “The Republic protects health as a fundamental right of the individual and an interest of the community, and guarantees free care to the indigent”.

The law established healthcare as a universal right, guaranteeing access to all, free at the point of delivery, and fundamentally departing from the previous system where healthcare accessibility was contingent upon an individual’s insurance coverage and socio-economic status. Under this new framework, the health system is collectively funded by the citizens, but managed by the state, which collects contributions to form a national health fund. This fund is then distributed among the regions, ensuring that

everyone enjoys the same health rights irrespective of their financial contribution, including those who are unable to pay.

The principles of the law focus on enhancing public health awareness and education, aiming to develop a modern health consciousness among individuals and communities. It emphasises the importance of preventive care, particularly in the realm of mental health, by integrating psychiatric services into the general health system. A key principle of health law underscores the commitment to mental health as a universal right: "The Republic defends health as a fundamental right of the individual and an interest of the community through the NHS. The protection of physical and mental health must take place with respect for the dignity and freedom of the human person". The objective was to eliminate discrimination and segregation, promoting therapeutic measures alongside initiatives that support the recovery and social reintegration of those with mental health challenges, thus fostering a more inclusive and supportive environment for all.

The historical evolution of Italy's healthcare system reflects a series of reforms aimed at enhancing equity and adequacy, with a focus on ensuring minimal levels of healthcare for all citizens. Following the establishment of the NHS with Law 833 of 1978, there was a significant shift towards decentralising management to prevent economic inefficiencies and the uneven distribution of healthcare services. This decentralization granted regional authorities greater autonomy over resource allocation and health service management, intending to meet local healthcare needs more effectively. However, it also resulted in variability in healthcare quality across different regions, influenced by the diverse capabilities and priorities of regional administrations (Kringos *et al.*, 2015).

The process of healthcare regionalization reached its peak in the 90s, and despite the decentralisation, policies continued to support universal coverage and free service delivery. However, the introduction of co-payment strategies added new dynamics to the system (*ibidem*). The first major reform after the establishment of the NHS was Law 502 of 1992. The reform introduced primarily pursued three principles: corporatisation, market orientation, and the distribution of responsibilities to the regions. It introduced the concept of evidence-based medicine to ensure appropriateness in healthcare services. Moreover, the reform established a national health plan that defines the "essential and uniform levels of care" that the state guarantees to its citizens either for free or with a co-payment.

The universality of the healthcare system was accompanied by significant changes in psychiatric care, closely aligned with a broader cultural movement towards expanding health rights and shifting towards community-based health approaches. This shift occurred during the same period as the enactment of Law 180, also known as the Basaglia Law, from the name of the psychiatrist who symbolised the Italian deinstitutionalising movement. Approved in 1978, this law marked a pivotal moment in Italian healthcare history by initiating the closure of psychiatric hospitals and promoting the integration of mental healthcare within community settings and a patient-centred approach (Barbui *et al.*, 2018). Another significant advancement for mental healthcare in Italy was the closure of the psychiatric hospital prisons in 2015, as determined by Law 81/2014. A significant milestone for mental healthcare in Italy was achieved with the closure of psychiatric hospital prisons in 2015, following Law 81/2014. A report from the Parliamentary Commission of Inquiry on the Effectiveness and Efficiency of the NHS characterised these institutions as: "All the psychiatric hospital prisons had a structural setup similar to a prison or asylum, markedly distinct from that of standard Italian psychiatric services" (Saccomanno & Bosone, 2011, p.3).

The Law 180 ensured that individuals with mental disorders receive the same care as those with physical illnesses. Key stipulations include the management of severe mental health conditions within specialised wards of general hospitals, capped at 15 beds to foster a more personalised treatment environment. The law prioritises voluntary treatment, limiting compulsory admissions to specific cases such as emergencies, refusal of treatment by the patient, or when no viable community treatment options are available. Such compulsory treatments must be officially authorized by the Mayor and are restricted to psychiatric department in general hospitals (Barbui *et al.*, 2018). Furthermore, Law 180 mandates the creation of community-based services tailored to provide mental health care locally, aiming to reduce reliance on institutional care. This approach is complemented by a policy of gradually ending all new admissions to public mental hospitals, thus supporting a transition towards community-integrated mental healthcare that upholds the dignity and integration of patients within society (*ibidem*).

Implementing deinstitutionalisation, Italy has developed community residential facilities to provide community care that offer overnight accommodations for individuals with mental health disorders. Despite having fewer beds compared to other European countries, in some Italian regions, it is observed that the average duration of stay at these

facilities often exceeds two years and can extend up to six years. This extended length of stay indicates a trend towards long-term inpatient and residential care, suggesting a lesser emphasis on proactive rehabilitation (*ibidem*).

Over time, the need for efficiency and cost control has encouraged the integration of the private sector into Italian NHS. This shift towards enterprise transformation within healthcare organisations has been particularly evident in mental health services. Both public and private, including non-profit and for-profit facilities, play critical roles in the system. The NHS and Regional HS often rely on these private providers to alleviate bottlenecks and address other service gaps. Indeed, financial pressures during the period from 2009 to 2011 exacerbated waiting list issues (Pavolini *et al.*, 2015), leading to a greater reliance on private occupational health services to meet demand coverage (Petmesidou *et al.*, 2020). The NHS and Regional HS are primary clients for accredited private healthcare, purchasing 60% of their services (Mapelli, 2012). Moreover, a significant portion of clinics and laboratories, with rates as high as 70% in Lazio and 80% in Campania and Sicily, are operated by privately accredited entities (Bobini *et al.*, 2022). Regarding mental health facilities, nationally private centres supply 54% of all acute and short-term psychiatric beds (de Girolamo *et al.*, 2007).

Referring to primary care, Italian GPs are self-employed workers and engage directly with the NHS through agreements outlined in the National Collective Agreement (SISAC, 2024). This agreement, negotiated by trade union representatives with the Interregional Structure of Affiliated Practitioners (SISAC), is renewed approximately every five years, with the latest iteration effective from April 2024.

To reach universality and community-oriented objectives, the NHS was structured to integrate hospital care, primary care, and preventive services, promoting a more comprehensive approach to health that includes prevention, diagnosis, treatment, and rehabilitation. This was implemented by enhancing the role of GPs as the central link among social services, the health service, and the patient. This redefined role of the GP reflects an emphasis on holistic health care, where the right to comprehensive health is rooted in the local community as the territory where health care takes place. GPs are trusted healthcare providers chosen by patients. Their role is pivotal in coordinating and integrating access to health services. By assessing the actual healthcare needs of individuals, GPs facilitate access to various services provided by the NHS. GPs have the flexibility to operate their practices from private consulting rooms, in an aggregated

consult or in one or more associated locations providing patients with free consultations and services, while also enjoying the autonomy to hire their administrative staff. According to the Collective Agreement, each primary care doctor is responsible for no more than 1,500 adult patients aged over 13.

In 1992 a significant agreement with the Regions and the NHS was established to ensure "basic levels of care", the range of benefits, services, and activities that citizens can receive from the NHS ensuring equal access to the Service. In 2015, "Territorial Functional Aggregations" (AFTs) were introduced, organizing GPs into units serving every 30,000 residents to ensure continuous 24/7 care (Kroneman, 2011). According to the collective contract, GPs must provide five days of in-person consultations each week and two hours of phone availability daily from 8:00 a.m. to 10:00 a.m. for urgent requests. Within the AFT, a Coordinator is elected by the member doctors. The coordinator ensures continuous communication between the health company's management level and each doctor in the AFT. GPs play a relevant role in the management of mental disorders. Data shows that 38% of people who suffered from some mental disorder in the preceding year turned to a family doctor (Ventriglia *et al.*, 2016).

Recently, Italy has advanced the development of multidisciplinary health centres aimed at providing both primary care and specialised services through a decentralised, community-focused approach. While there are nearly 500 health centres across the country (Pesaresi, 2022), obtaining official data on them can be challenging. Moreover, as part of the National Recovery and Resilience Plan, which is integrated into the broader Next Generation EU plan, Italy aims to construct 1,038 "Community Homes". These facilities have the aim of centralise primary care services, enabling the community to engage directly with the healthcare, social care, and social service systems. Moreover, the plan includes building 307 "Community Hospitals". These local healthcare facilities provide care for patients who need low-intensity medical treatments, *i.e.*, services that are generally manageable at home but necessitate continuous, and possibly overnight, nursing supervision that is unfeasible at home or when the home environment is unsuitable. However, it's important to note that while these centres aim to centralise primary care physicians, the doctors remain self-employed. The decision to relocate to these centres is voluntary and at the discretion of each physician.

One of the factors influencing access to specialised services and GPs management is training (Magliano *et al.*, 2017; Thornicroft, 2008). The academic training for GPs in

Italy heavily focuses on psychiatric topics and the learning of symptomatology based on diagnostic manuals. To pursue a career as a GP, a physician must complete a post-graduate three-year training programme. This training varies significantly across regions, although it aims to adhere to common standards aligned with guidelines set by the World Organization of Family Doctors (Michels *et al.*, 2018). Taking Emilia-Romagna as an example, the training programme dedicates three out of the total thirty-six months specifically to mental health. This segment of the training involves visits to specialized services and addiction treatment facilities (USL Bologna, 2018), providing practical exposure to managing these critical aspects of patient care.

Linked to specialised training, there are concerns about turnover and the decreasing availability of GPs in the future. This topic is extremely relevant cause a shortage of doctors means that GPs will have to see more patients, reducing the time available for each visit. At the moment, Italy has the oldest doctors in Europe, with 54% being over 55 years old. Between 2018 and 2025, about half of the specialist doctors currently employed in public health could retire posing challenges in maintaining sufficient staff in many specialties (ANAAO ASSOMED, 2024). One approach being implemented is the increase in medical school admissions, although a more effective solution might be to optimise the allocation of medical specialty training slots, as several specialties struggle to fill their available positions. Specialties experiencing low demand (each filling less than 50% of their slots) include emergency medicine, microbiology and virology, clinical pathology and biochemistry, anatomical pathology, radiotherapy, and community medicine and primary care. On the other hand, specialties that offer substantial career opportunities in the private sector and self-employment, such as dermatology, ophthalmology, cardiology, plastic surgery, gastroenterology, endocrinology, and radiodiagnosis, consistently fill over 95% of their positions, indicating strong interest and job prospects (*ibidem*).

5.2 Spanish context

A few years after Italy, Spain established its NHS in 1986 through the General Health Law. This period was marked by significant turbulence and reforms. Following the end of the dictatorship in the late 1970s, Spain transitioned toward democracy and

joined the European Union in 1986. The deinstitutionalisation of mental health did not directly drive the NHS reforms but occurred simultaneously.

The General Health Law extended health coverage towards universality, emphasising health promotion and disease prevention (Guillén & Cabiedes, 1997; Kringos *et al.*, 2015). The law addressed the organisational aspect by acknowledging the decentralisation of health responsibilities to Autonomous Communities (Guillén & Cabiedes, 1997). This decentralisation, which granted these communities broad health-related competencies, was aimed at achieving political stability after the dictatorship by transferring the management of public services from the central Government to regional Governments (Guillén & Cabiedes, 1997; Vázquez-Barquero *et al.*, 2001).

Similar to Italy, these health reforms were the actualization of constitutional rights, specifically Article 43 of the democratic Spanish Constitution, which guarantees the right to health for Spanish citizens, with special attention to prevention and healing strategies (Guillén & Cabiedes, 1997). However, health coverage was heavily influenced by the financing of public insurance entities, like INSALUD, until 1989, when the system began to be financed out of the public budget, almost completing the process of extending coverage (*ibidem*).

The law affirmed the right of all citizens and resident foreigners in Spain to access health services. However, due to economic constraints, it did not fully guarantee free services immediately but instead planned a gradual implementation. This approach allowed for a cautious observation of cost developments, which were not necessarily tied to the reform measures initially expected to reduce costs through better administrative efficiency. The recent amendment to Law 16/2003, dated 31/07/2018, extended health coverage significantly. Both Spanish nationals and all foreign residents in Spain are explicitly entitled to health protection and healthcare. This marked a substantial broadening from previous regulations, which primarily focused on legally resident individuals

Despite individuals' legal rights to healthcare being acknowledged, the Spanish Economic and Social Council (Consejo Económico y Social, 2024) highlighted in a recent report that practical administrative barriers frequently result in delays or outright denial of necessary healthcare services. This not only poses risks to public health but also deepens inequalities in healthcare access across various regions. Furthermore, the Spanish

Council noted that the full integration of prison healthcare into the NHS, as planned by the General Health Law, is still not realised. To date, only three autonomous communities have assumed responsibilities in this domain. This partial integration compromises both the quality of healthcare available to users and the working conditions for healthcare professionals within the prison system, where many positions remain unfilled (*ibidem*).

Regarding mental health, after the political subordination of psychiatry during Franco's regime, marked by an emphasis on punishment and the enforcement of established norms, albeit with some regional exceptions (Novella & Campos, 2017), Spain had the opportunity to develop a modern, community-based management of patients with mental health problems. This shift towards deinstitutionalisation was formally recognised in the Report for Psychiatric Reform in 1985 and further established by the General Health Law of 1986 (Aparicio Basauri, 1993; Guillén & Cabiedes, 1997).

The Report for Psychiatric Reform aimed to overhaul psychiatric care by integrating it with broader healthcare and social support systems, thus enhancing treatment and support for vulnerable populations. This holistic approach aimed to ensure equitable access to mental health services and uphold the civil and healthcare rights of all individuals, especially those affected by mental disorders or involved in the legal system.

Article 20 of the 1986 Law, based on the full integration of mental health services into the general healthcare system, emphasised treating mental health issues within the community. It aimed to enhance outpatient services, partial hospitalisation systems, and home care to minimise the need for full hospitalisation. Moreover, the National Health Strategy for Mental Health in 2007 further consolidated this roadmap (Juliá-Sanchis *et al.*, 2020), proposing forward directions for Spanish mental health, which aimed to promote public services, prevent mental illness, and eradicate the stigma associated with mental disorders. These strategies included improving mental health care, enhancing inter- and intra-institutional coordination, training healthcare personnel, advancing mental health research, and developing a mental health information system.

Despite these reforms, two public psychiatric hospital prisons and 10 psychiatric hospitals remain operational, with the latter housing a substantial number of long-stay beds, approximately 4,600 in total (Ministerio de Sanidad, 2023). A particularly emblematic and concerning case is that of the Conxo Psychiatric Hospital in Santiago de Compostela (A Coruña). The *Defensor del Pueblo*, an organ tasked with defending the

fundamental rights and public freedoms of citizens by supervising the activities of the Spanish public administrations, during a visit in June 2021, noted "*Se encuentra en un estado de deterioro significativo, se observaron gran cantidad de humedades por todo el centro, y ventanas muy deterioradas, ofreciendo unas condiciones insalubres para la estancia de personas. Existen múltiples espacios verdes que son escasamente utilizados con fines terapéuticos, y que también carecen de un mobiliario confortable. El espacio físico no es adecuado para el tratamiento, rehabilitación e integración social de las personas con problemas de salud mental*" [It is in a state of significant deterioration, with a large amount of humidity throughout the centre and severely deteriorated windows, offering unsanitary conditions for the stay of individuals. There are multiple green spaces that are scarcely used for therapeutic purposes and also lack comfortable furniture. The physical space is not adequate for the treatment, rehabilitation, and social integration of people with mental health issues] (Defensor del Pueblo, 2024, p.1). There is also a lack of information regarding the notification to the competent court of coercive measures and restraint used in this hospital (*ibidem*).

In Spain, the integration of private healthcare into NHS has been gradually increasing, driven by a need for improved efficiency and cost control. This trend is primarily facilitated through health insurance, which has seen significant growth over recent decades. The COVID-19 pandemic further accelerated this growth as more individuals sought additional coverage, reflecting heightened awareness of health-related risks (Consejo Económico y Social, 2024). Concurrently, public perception of extended waiting times within the NHS underscored challenges in availability and accessibility, pushing more people towards private healthcare options (Petmesidou *et al*., 2020). This shift highlights the continuous effort to balance public health services with private sector involvement, aiming to enhance healthcare delivery, efficiency, and patient satisfaction.

In Spain, GPs, who are salaried public servants, predominantly work full-time in multidisciplinary health centres. Most of these centres operate from 8 am to 8 pm, with reduced activity on weekends. Some of these centres operate 24/7, depending on local organisational arrangements (Kringos *et al.*, 2015). Each centre employs a coordinator responsible for organizing shifts and has minimal sanctioning powers. Moreover, these centres are supported by a public administrative staff that has passed region-specific public competitive exams. This staff handles initial patient interactions and significantly influences the doctors' schedules by managing calls and preliminary assessments.

According to the Spanish Economic and Social Council report (2024), primary care, which is fundamental to the Spanish NHS, receives only 14.2% of healthcare spending on average. This is notably lower in regions like Madrid and Galicia, where it doesn't even reach 12%. Despite primary care's high potential to meet healthcare demands efficiently, thereby saving costs for the system, it remains underfunded.

Regarding GPs' training, Spanish academic approach to family and community medicine receives limited attention in the curricula of many universities, where the training on mental health is narrowly focused on the study of psychiatric diagnostic manuals. Historically, the training of family doctors in psychiatry has primarily been theoretical, focusing on the psychopathology of patients typically seen in mental health settings. This training has often been delivered by psychiatrists who are not familiar with the primary care environment (García-Campayo *et al.*, 2001). For specialised training, medical graduates must pass the Resident Medical Intern access exam, after which they can choose from 50 specialties, including "family and community medicine" which is linked to primary care. In 2024, the exam included nine questions (numbers 82-91) on psychiatry out of a total of 210, with the majority of these questions concerning the use of pharmaceuticals (Ministerio de Sanidad, 2024).

In the Spanish primary care sector, there is growing concern over the turnover of medical specialists. Initial data from 2018 indicated a 2.9% shortage, which was anticipated to exceed 5% by 2020, surpassing the threshold considered for structural balance. This shortage is expected to worsen in the next few years due to an aging workforce, before potentially stabilising after 2025 with a projected ongoing deficit of around 12% until 2030. This scenario is reflected in the expected decline in the ratio of specialist doctors per 10,000 residents, which is projected to decrease by 5.4%, from 409.8 in 2018 to 387.5 by 2030 (Pérez & López-Valcárcel, 2019).

The response to this forthcoming crisis includes challenges in allocating training positions. For instance, in 2024, 8,772 places were offered for medical training, with family and community medicine accounting for the largest share at 2,492 places, an increase of 37 from the previous year (Consejo Económico y Social, 2024). Despite this, historically, about 39% of these positions have been filled, leading to additional recruitment efforts (Pérez & López-Valcárcel, 2019). Estimations predict that by 2026, about 2,500 doctors may complete their degrees without securing specialisation, potentially leading them to seek non-specialist roles or careers abroad. A corrective trend

is expected to slightly reduce these numbers by 2030 (*ibidem*). The risk in Spain, similar to that seen in Italy, is the potential creation of a surplus of doctors with specialisations that do not align with the NHS demand. By expanding access to medical schools and/or neglecting to regulate the number of specialisation positions according to actual demand, particularly in specialties like primary care that struggle to fill their offered positions, Spain risks inadvertently exacerbating this mismatch.

5.3 Relevance of the comparison

In examining healthcare systems across Europe, the aging demographics of Italy and Spain emerge as critical factors, particularly considering that the demographic shift is expected to heighten the prevalence of diseases, especially cognitive impairments and depressive states (Luanaigh & Lawlor, 2008; Pais *et al.*, 2020). In both countries, the bureaucratic workload has increased, particularly with the introduction of electronic prescriptions, the need for data recording and management, such as logging prescriptions and tracking healthcare spending, and other digital processes. This workload increased further during the pandemic, as additional protocols for infection control and safety measures were introduced. The focus on ensuring the traceability of patient care has intensified, with protocols primarily covering the administration or prescription of medications, referrals to mental health services, and specific cases, such as managing patients with suicidal behaviours. These protocols, however, are regulated at the regional level, resulting in variations in their implementation across different regions.

Regarding demography, Italy is the first nation in Europe in terms of elderly population size. With a median age of 48, Italy's demographic profile significantly impacts its healthcare demands. The old-age dependency ratio, in Italy is strikingly high at 37.8%, closely following Portugal and paralleling Finland. This ratio is indicative of the number of elderly individuals (aged 65 and over) per those of working age (15-64 years). Spain, while ranking eighth in the EU with a median age of 45, also faces similar challenges. The country's old-age dependency ratio stands at 30.4%, slightly below the EU average but even so significant. Such demographic trends are not merely statistical but have profound implications on public health strategies, especially in the early detection and treatment of cognitive mental health conditions (EUROSTAT, 2024c).

Cognitive impairment and depression, which are more common in older adults, are often linked to loneliness, which can intensify their effects(Erzen & Çikrikci, 2018; Luanaigh & Lawlor, 2008). Further, loneliness may underlie the increasing feelings of inadequacy and loss of social bonds that are typical in teenagers, which can sometimes lead to depressive moods. As Erzen and Çikrikci state “The need to feel a sense of belonging may be seen as the common characteristic between these two groups with very different age profiles and social environments” (2018, p.5). Yet, does this apply to Italian and Spanish Mediterranean societies, where social interaction and community are considered key characteristics?

A 2020 survey conducted by the Italian newspaper Il Sole 24 Ore (2020) revealed that 55% of the adult population experienced loneliness, with the issue being more pronounced among younger individuals; 32% of those aged 18-34 frequently felt lonely. These results may have been impacted by COVID-19 lockdown measures. However, data from Spain suggest that the issue may have deeper roots. In the most recent report on unwanted loneliness in Spain, a survey of 1,800 young adults aged 16-29 revealed that 25% of respondents currently feel lonely. Among these, 59.2% have felt this way for over two years (Ruiz Villafranca *et al.*, 2024).

In addition to depression and cognitive disorders, another phenomenon associated with loneliness is suicidal behaviour (McClelland *et al.*, 2020). In 2021, the suicide rate per 100,000 inhabitants among men was 9.73 in Italy and 12.53 in Spain, which are lower compared to the EU average of 16.75 and substantially less than Lithuania’s rate of 35.22 (EUROSTAT, 2024a). However, this issue remains highly relevant in the national cases studied in this thesis. In both countries older adults experience the highest rates of suicide, yet the trend is alarmingly rising among younger populations as well. In fact, in Spain, suicide is the leading cause of death among individuals aged 15-29 (Observatorio del Suicidio en España, 2023). In Italy, suicide ranks third, following car accidents and cancer, as the most common causes of death within the same age group (Istituto Superiore di Sanità, 2022).

There is a significant need for mental health care in both countries. This demand is also evident in the observed rates of medication use. In recent years, the use of psychotropic medications such as antidepressants, antipsychotics, and benzodiazepines in Italy has remained relatively stable, though there has been a minor uptick in benzodiazepine usage. From 2015 to 2017, the daily consumption of antidepressants

averaged 40 defined daily doses (DHD) *per* 1,000 inhabitants, while the use of antipsychotics was consistent at 9 DHD *per* 1,000 inhabitants during the same timeframe (AIFA, 2022). Spain leads the world in benzodiazepine usage, with a rate of 110 defined daily doses *per* 1,000 inhabitants in 2021 (INCB, 2022). The consumption of anxiolytics and hypnotics, which quickly increased during the pandemic, rose from 82.51 DHD *per* 1,000 inhabitants in 2010 to 93.05 in 2021 (Ministerio de Sanidad, 2022). Indeed, pharmacy expenses, including prescription costs, represent the second most significant expenditure in almost all Spanish regions (Consejo Económico y Social, 2024).

The use of medications for mental health issues remains significantly elevated, driven by both systemic issues and individual decisions. Insufficient training in managing conditions like depression among healthcare providers often results in the frequent and ongoing use of antidepressants (Thornicroft, 2008). The lack of time and proper training among medical professionals can lead to the excessive prescription of these drugs. In Italy, primary care physicians are permitted to prescribe psychotropic medications, with antidepressants such as SSRIs becoming more commonly prescribed to older adults who are often on multiple medications, leading to the chronic use of these drugs (Sultana *et al.*, 2014).

Moreover, there is a noticeable shift toward self-medication, attributed to its perceived benefits in terms of accessibility, affordability, and legality. Holborn *et al.* (2023) highlight the independent use of new benzodiazepines to treat anxiety disorders, with many individuals preferring self-treatment to seeking professional medical advice, often due to a belief in their ability to manage their condition more effectively than through established medical channels. In Spain, a significant portion of prescription-required drugs are often dispensed without an actual prescription, typically justified by the pharmacist's familiarity with the patient's medical history or based on a doctor's recommendation (Barbero-Gonzalez *et al.*, 2006; Carrera-Lasfuentes *et al.*, 2013).

Despite this prevalent self-medication, research suggests a positive attitude towards seeking professional help in these countries. According to Ten Have *et al.* (2010), a significant majority of respondents in Spain (88.20%) and Italy (80.50%) would probably seek professional help if faced with a serious emotional problem. The study also reveals that 90.3% of Spanish respondents would not be embarrassed if their friends knew they were receiving professional help for an emotional issue, a sentiment much less common in Italy (73.1%). Moreover, a majority in Spain (61.4%) and nearly half in Italy

(45.2%) believe that professional help is considerably or much better than no help at all, indicating a cultural inclination in these nations towards acknowledging the benefits of professional intervention over self-managed care. These findings suggest that despite the prevalence of self-medication, there is a substantial openness towards professional mental health services in Spain and Italy.

Regarding indicators of health, both Italy and Spain reveal distinct patterns when compared to the European Union averages. Health expenditure as a percentage of GDP stands at 7.3% for Spain and 7.60% for Italy, both below the EU average of 8.10%. Both countries allocate about 5% of their total government health expenditures to mental health, which is lower than the EU average of 6.21%. Regarding healthcare expenditure by financing scheme, the spending per inhabitant in Spain is 1,957.37 euros and in Italy 2,143.81 euros, compared to the EU-27 average of 2,893.37 euros from 2020. In terms of OOP expenses per capita, Spain and Italy exceed the EU average of 684.14 USD, reporting 858 USD and 885 USD respectively, which constitutes approximately 21% and 21.89% of their total health expenditures, suggesting that individuals in these countries face a higher financial burden for health services than the average European. Schematically, these data are presented in Table 7.

However, there are significant differences between the two nations. The role of primary care psychologists in both Italy and Spain is an emerging aspect of healthcare, reflecting a shift towards integrating mental health services into the broader framework of primary care. The Spanish NHS includes 3,042 health centres and 9,998 local clinics, with each health centre typically supporting around 3.30 local clinics. However, the distribution of these services is uneven, ranging from 27 centres per 100,000 inhabitants in some regions to only four in others, such as Ceuta and Melilla. Despite some progress, the presence of clinical psychologists in primary care settings remains limited. As of 2022, 419 psychologists were working in primary care across the country, reflecting an increase of 100 professionals since 2018 (Ministerio de Sanidad, 2023). In Italy, the integration of primary care psychologists is more inconsistent, with significant regional disparities. A legislative proposal (Ciocchetti *et al.*, 2023) is currently under discussion, which seeks to define the functions and organisational framework for primary care psychologists within local health authorities. If approved, this law aims to ensure psychological well-being within primary care services and Community hospitals. However, the implementation of primary care psychologists already varies significantly

between regions. Recently, regions like Campania and Tuscany have made considerable progress in this area, while others continue to lag. Actually, the presence of mental health services in health centres is regulated locally, depending on the collaboration agreement between the mental health and the primary care Organisations of the health centres. This collaboration is contingent on the willingness of local organisations to cooperate, further contributing to the regional disparities in the provision of mental health services. Thus, both Spain and Italy are gradually adopting therapeutic models that include psychologists in primary healthcare settings, although the extent and nature of their integration differ. Despite the uneven development among its regions, Spain has made more progress overall (Alonso Gómez *et al.*, 2019; Gutiérrez López *et al.*, 2020). In contrast, Italy's approach is still largely regional, with ongoing debates about whether these psychologists will work as independent professionals, akin to primary care physicians, or be integrated into Community hospitals. Regarding social services in primary care, in Italy, social services are a community-based service, but there is often no continuity with the primary care physician, meaning the patient is simply referred. Social workers are not present in health centres, although there is ongoing discussion about integrating them into Community Hospitals. In Spain, 1,928 social workers are employed in primary care, which, considering the number of health centres, results in a ratio of 0.634 social workers per health centre (Ministerio de Sanidad, 2023).

Regarding mental health services, Italy provides more local services, even though Spain still has a low level of usage of hospital services (Salvador-Carulla *et al.*, 2005). This disparity could be attributed to Italy's broader initiative toward the deinstitutionalisation of psychiatry, as evidenced by the relatively low number of psychiatric hospital beds, only 9 per 100,000 population compared to Spain's 36 and the EU average of 73 (see Table 7). Differences also exist in terms of "self-reported unmet needs for health care" (Table 5) and the ratio of GPs per 100,000 of population (Table 6). In both metrics, Italy displays worse figures than Spain and the European average. Waiting lists are cited as the primary reason for these unmet healthcare needs in both Spain and Italy. There are also fundamental differences in the systems for compensating GPs. Spanish GPs are salaried public servants, whereas Italian GPs are self-employed public officers who are compensated through a capitation fee. Moreover, Italian regional governments provide incentives to promote efficiency, such as bonuses for prescribing

generic drugs or reducing pharmaceutical prescriptions, aiming to contain the costs associated with prescription drugs (Kroneman, 2011).

Moreover, private healthcare spending is rising in both countries but is higher in Spain. In Italy, it increased from 1.49% of total current health expenditure in 2014 to 2.27% in 2023. In Spain, it rose from 6.24% in 2014 to 7.01% in 2021, the latest data available (EUROSTAT, 2024b). This could indicate growing public reliance on supplementary insurance, potentially due to perceived gaps in the public system. This trend raises critical questions about the equity and universality of a healthcare system where those with greater resources can afford access to private services, thereby avoiding the long wait times often associated with public healthcare. According to the Spanish Economic and Social Council report (2024), which analyses findings from the latest Health Barometer, the primary motivation for purchasing private health insurance is the promptness of care, as noted by 75.7% of respondents. Despite this, public healthcare continues to be highly regarded, with 61.8% of individuals expressing satisfaction with public health services in 2021. This scenario raises questions about the true universality of the healthcare system, indicating that despite high satisfaction levels, there may be disparities in service accessibility across different population segments.

Table 5. Reasons for self-reported unmet needs for health care*

	Financial reasons	Distance or transportation	Waiting lists
EU 27	13.0	4.0	19.4
Spain	10.3	1.1	13.0
Italy	13.6	8.3	25.2

Note: *measurement units represent % of responding people

Source: Author’s own work based on EUROSTAT (extracted on 20/02/2023)

Table 6. GPs per 100,000 inhabitants

	2018	2019	2020	2021
Spain	89.16	91.51	91.42	:
Italy	71.47	71.03	70.16	70.38

Source: Author’s own work based on EUROSTAT (extracted on 20/02/2023)

Table 7. Spain and Italy: a comparative analysis of key indicators

	Spain	Italy
Universal Health Coverage via Public-Private Partnerships	✔	✔
Decentralisation	✔	✔
Deinstitutionalisation	✔	✔
GPs as Gatekeepers of NHS	✔	✔
GP Remuneration	Salary	Capitation
GP Status	Public Servants	Self-employed Public Servants
Number of GPs in 2020 (per 100,000 inhabitants). EU average 78.33 (1)	91.42*	70.16
Psychiatric Hospital Beds (per 100,000 population). EU average: 73 (2)	36	9
Psychiatrists (per 100,000 population). EU average: 17 (3)	11	17
Health Expenditure (% of GDP). EU average: 8.1% (4)	7.3%	7.6%
Health expenditure (Euro per inhabitant): EU average: 2.893,37 (5)	1.957,37	2.143,81
OOP (USD per capita). EU average: 684.14 (6)	858 (21% of total health expenditure)	885 (21.89% of total health expenditure)
Mental Health Expenditure (as % of total government health expenditures). EU average: 6.21 (7)	5%	5%

Note: *data from Spain does not differentiate between General Practitioners and Generalist Medical Practitioners.
Source: Author's own work based on EUROSTAT (2023b) [1]; EUROSTAT (2021) [2]; EUROSTAT (2020) [3]; EUROSTAT (2023) [4]; EUROSTAT (2024b) [5]; OECD (2023) [6]; WHO (2013) [7]

5.4 Conclusion

Italy and Spain present many similarities with specific differences in their healthcare systems. Both countries aimed to provide universal health coverage, integrating public and private sectors to achieve optimal efficiency within cost constraints (Petmesidou *et al.*, 2014). However, there are distinct variations in their approaches to primary and mental healthcare.

Spain's primary care is characterised by protocolised health centres, decentralisation, limited funding, and a significant role for regional governments, aligning with the "Public Hierarchical Normative" model. In contrast, Italy's primary care integrates advanced strategies, capitation-based pay, and fiscal regulation, combining elements of the "Public Hierarchical Normative" and "Professional Hierarchical Gatekeeper" models. This hybrid approach highlights innovation within a traditional bureaucratic framework (Kringos *et al.*, 2015). Efforts to achieve cost efficiency have led to slightly below-average EU health expenditures in both countries, coupled with rising private health spending and long waiting lists for public services. These trends highlight the challenges in balancing public and private sector roles in healthcare delivery.

Both countries shared the challenge of integrating mental healthcare, primary healthcare, and social services, which is crucial for effective community-based treatment of mental disorders (Gemignani *et al.*, 2020). Italy has advanced further in deinstitutionalising mental healthcare, whereas Spain still maintains psychiatric hospitals. However, Italy records prolonged stays in community centres for individuals with mental health issues (Barbui *et al.*, 2018). Despite the advances, coordination remains a significant issue, impacting the quality and accessibility of services. GPs in both Italy and Spain play a pivotal role in the mental health landscape, extending beyond their traditional gatekeeper roles to intercept early mental health conditions and facilitate patient navigation through the NHS. Both nations face high medication consumption rates, aging populations, and significant levels of loneliness. GPs are strategically positioned to address these challenges effectively. The training of GPs in mental health is not so exhaustive in both countries, affecting their ability to manage patients with mental disorders effectively. Moreover, the turnover of medical specialists poses a structural problem for the NHS, with a risk of exacerbating this issue by increasing access to medical schools without adequately regulating specialisation positions based on NHS demand. The potential, contradictory consequence could be that some specialties might experience an oversupply of practitioners, while others, such as primary care, could face a shortage. This imbalance might lead to primary care doctors having to see more patients, which could reduce the time available for each consultation.

The comparison between Italian and Spanish healthcare systems is justified by their similarities and differences, providing insights into contextual, institutional, and organisational factors influencing primary care management of mental health patients.

Both countries, despite not having alarmingly high rates of mental disorders or suicides compared to the European context, face significant challenges. Demographic shift predicts an increase in suicides and cognitive disorders, emphasising the critical role of GPs in early detection and management. In addition, the high number of suicides among the younger population must be considered.

In conclusion, examining the evolution of healthcare services in Italy and Spain reveals shared values of universality, community care, person-centred approaches, and equal rights for mental health patients. However, the achievement of these values must interface with structural and organisational conditions that influence daily medical practices. This study aims to uncover how institutional and organisational mechanisms shape the management of mental health patients by GPs, reflecting on their strategies to navigate these forces.

In the following chapters, the findings of this thesis will be thoroughly examined and discussed in detail. These chapters will present the key results derived from the research, providing insights into their significance and how they relate to the research hypothesis.

CHAPTER 6

INSTITUTIONAL AND ORGANISATIONAL INFLUENCES

This chapter delves into the complex interplay between institutional and organisational factors and their influence on the management of patients with mental disorders by GPs in Italy and Spain. The chapter starts with a deeper exploration of how the traditional roles of patients and physicians shape GPs' management practices. Further, it examines the diverse models of primary care organisations, the access to primary care, and the challenges posed by resource limitations, exploring their combined impact on the dynamics between GPs and patients with mental disorders. A recent study partially presented the chapter's findings (Giosa, 2024).

Discussing the roles of patients and GPs in the mental health context, GPs are often positioned as "health sellers", primarily utilising prescription medication as their chief management tool. Concurrently, patients with mental disorders, often institutionalised and possessing a limited understanding of their conditions, act as "health consumers". This framing highlights the consumer-based model, where the dynamics of

service provision and consumption fundamentally shape the patient-doctor relationship. Understanding these traditional roles is necessary for evaluating their impact on the effectiveness of diagnosis, treatment, and ongoing management of mental disorders, and how they influence patient outcomes and satisfaction with the provided care. The model of primary care organisation delineates the structural and functional frameworks that govern the delivery of primary care. Within the context of this study, the models range from public employment systems with restricted organisational autonomy to self-employed systems that enjoy greater autonomy. Each model significantly affects the integration of primary care organisation and services delivery, particularly in terms of daily agenda organisation. Further, the closeness between GPs and patients possibly enhances communication and allows for more precise management of individual cases, particularly those involving mental disorders. Finally, the lack of resources, including the availability of services, training, and healthcare professionals, can impact GPs' ability to manage patients with mental disorders, affecting both the quality and accessibility of mental health care. This often leads to an overreliance on prescription medications.

The chapter is structured as follows. Section 6.1 focuses on the role of GPs in mental health, examining how cultural factors influence interactions with patients and treatment outcomes. Section 6.2 assesses the primary care organisation's steering model, highlighting the autonomy of GPs and the impact of insufficient supervisory mechanisms on care quality. Section 6.3 explores how different forms of access to primary care affect GPs' management and the availability of specialised mental health services. Finally, Section 6.4 delves into the resource shortages in primary care and how these challenges shape GPs' daily practices in managing patients with mental disorders.

6.1 GPs and mental health: the influence of cultural context

This section examines the influence of cultural context on the roles and attitudes of doctors and patients towards mental health, and its impact on medical management and interactions. It highlights how GPs, primarily functioning as health providers through drug prescriptions, become gatekeepers of medical care. Patients, especially those with mental health disorders, are often viewed as consumers within a soft-institutional model, where their full agency and accountability are limited by a structured dependence on medical authority. The discussion explores the growing normalisation of mental health, which often results in its medicalisation. This trend challenges traditional medical

judgments and requires doctors to adopt a balanced approach to meet evolving patient demands while upholding rigorous medical standards.

6.1.1 Italy

Primary care, particularly in mental health management, underscores the crucial importance of the doctor-patient relationship. This relationship is notably more holistic than other medical interactions, with the depth of dialogue and trust playing a therapeutic role essential to effective treatment. The following GP contends that this distinctive relationship is what sets her work, transforming it from mere medical practice into an essential element of the healing process.

> A key element to consider, even in a hospital setting, is the holistic aspect of care. However, the relationship between doctor and patient, which I believe is a crucial part of the therapy, takes on an even more holistic dimension outside the hospital. In hospitals, even with a trusted specialist, the level of trust and confidence in this relationship often falls short. Ultimately, the essence of this work lies in the doctor-patient relationship, which, in my opinion, should be the primary focus and defining feature of the therapeutic process (GP5I).

When a doctor takes an active role and customises patient management based on personal rapport, patients with mental health issues could develop a dependency to this approach. This dependency arises not only from a lack of information about their own health condition but also due to their psychophysical state. It is especially evident in patients with chronic conditions and severe disabilities, who tend to place considerable trust in their doctor's decisions. The case of a psychiatric patient living in shared accommodation exemplifies the profound trust and reliance that patients frequently place in their healthcare providers.

> I usually don't ask questions; I simply follow his instructions. I don't recall having any specific doubts... But I rarely see him in person. When I need

> medication or a prescription, he typically sends it to me via text message, which happens quite frequently (P6I).

The management of patient care by doctors, especially for those with psychiatric conditions, is meant to be highly personalised, addressing both psychiatric and non-psychiatric challenges. However, the doctor-patient relationship can sometimes become repetitive, dominated by pharmacological management and routine interactions. This procedural approach may overshadow the personalised care essential for effective mental health treatment. A patient with a long history of psychiatric conditions describes his relationship with his doctor as focused mainly on getting medication, with little personal interaction.

> In general, my relationship with the doctor is very informal. It's mostly about getting my medication. She sends the prescriptions to my email or mobile phone, and I haven't needed to see her in person for several months now (P8I).

The role of the doctor as primarily a prescriber is a recurrent theme, particularly evident in the experiences of older physicians who may adopt a distanced approach to patient care. A patient reflects on her interactions with an older doctor, highlighting a dynamic where the focus was heavily on medication dispensation without in-depth examinations. While convenient, such practices can compromise patient safety and the overall quality of care.

> Older doctors are a bit of a pushover, in my opinion. Mine, when he retired…I would ask him for medicine, he would give it to me. He never examined me. He never told me - Come here, I want to examine you. What do you need this for? - Then also medicine… being a psychiatric patient, I received heavy, tranquillisers. It suited me egoistically, but I didn't find it right. Then one "can leave the skin" (a metaphor for dying) (P4I).

Further, the next GP offers a critical view on some doctors' tendency to focus solely on prescribing medications, neglecting comprehensive patient care. In her opinion, this reductionist approach undermined the traditional role of family doctors as holistic caregivers. The critique calls for a return to a more engaged and thorough medical practice, where doctors fully embrace their responsibility for patients' health and well-being, rather than merely facilitating pharmaceutical solutions.

> Some doctors have diminished the role of the family doctor, reducing it to little more than that of a scribe or a mere attendant within the health service. It is because of these individuals that the profession has lost some of its respect and significance (GP5I).

The doctor-patient relationship is influenced by broader structural and historical health contexts, which shape the dynamics of medical interactions. Recently, it seems that the accessibility of information online, compounded by the urgent circumstances of the COVID-19 pandemic, amplified patients' expectations for immediate medical advice, complicating the traditional, more deliberative nature of medical consultations and potentially straining the doctor-patient relationship.

> What I find increasingly troubling is the growing expectation from patients for immediate responses. The Internet has worsened this issue, as many people now turn to it for answers, especially since COVID. This has led to a lot of confusion and has strained relationships between doctors and patients (GP4I).

The pandemic not only overwhelmed health institutions, placing greater demands on individual practitioners, but also altered patient behaviour, resulting in more frequent and often unnecessary contacts. This crisis underscored both the growing dependency of patients on their healthcare providers and the significant strain it placed on these providers, challenging their ability to manage the surge in patient interactions effectively.

> Everyone turned to us for help. We were the only ones responding. The institutions had completely disappeared, overwhelmed by the demands. With no clear direction, people called us for everything. This easy access spoiled them a bit, leading some to call 12 times an hour or more, even on Saturdays and Sundays. Now, it's difficult to reverse this habit, but patients need to understand that we can't manage this level of demand on a regular basis. COVID was just one illness, but we can't sustain this for all the others (GP5I).

Normalisation of mental health

Hence, the current healthcare context, shaped by both the pandemic and the normalisation of mental health issues, significantly influences the doctor-patient relationship, especially for those with mental health conditions. The pandemic led to a surge in health inquiries, decreased patience for waiting, and a demand for rapid responses. Separately, the normalisation of mental health awareness has evolved into a "normalisation of medicalisation" where pharmacological solutions are frequently sought to meet the increased demands. Patients are quick to seek drug-based solutions for immediate symptom relief, bypassing deeper psychological understanding and treatment. Next GP highlights the dangers of over-relying on medications like benzodiazepines, which are often used indiscriminately.

> The use of benzodiazepines on an as-needed basis is somewhat risky because it can lead to counter-addiction. I've noticed that, in some cases, even pharmacists are prescribing them, which is concerning. I sometimes receive requests for benzodiazepines from people I didn't prescribe them to, so they must have obtained them elsewhere. Using these drugs so indiscriminately is problematic because it fosters a reliance on medication rather than encouraging a mind-set focused on healing. This immediate availability of a "quick fix" for every symptom prevents people from exploring the underlying triggers and understanding the mechanisms behind their issues. It ultimately leads to the misuse of benzodiazepines, allowing people to avoid truly knowing themselves, which, in my view, is a harmful distortion of their well-being (GP7I).

The cultural perception of mental health care and therapy has shifted significantly, particularly among younger generations, reflecting broader societal changes. A GP discusses this transformation, noting the emerging risks trivialising the serious nature of mental health disorders, turning the use of psychiatric medications into casual, almost fashionable acts separated from medical need.

> Today, however, it has become cultural almost. It is often the young people or those suffering from disorders who ask you - Look, I've been thinking about going to see a psychotherapist, do you have anyone to recommend? - or whatever. But I notice, on the other hand, that it is becoming a fashion in the upper classes. For example, if you don't have a therapist, you are nobody. That's what I've noticed. It seems almost a fashion to have the therapist as a confessor… This issue is also partly rooted in cultural habits. Medications like these pass easily through families. For example, someone might say - So yesterday I couldn't sleep, I went to get Xanax from grandma's bedside table. I took ten drops…- (GP6I).

6.1.2 Spain

The relationship between patients and doctors is shaped not only by medical knowledge and clinical expertise but also by ethical considerations and cultural values. These human aspects, like trust, empathy, and understanding, play a crucial role in how the doctor and patient interact. It's not just about diagnosing and treating. It's also about connecting on a personal level, respecting cultural differences, and making ethical decisions that consider the patient's overall well-being. GPs must carefully navigate the complex emotional dynamics that can greatly impact the therapeutic process. This GP highlights the delicate balance needed in mental health care, where it's essential to create a trusting environment while ensuring that personal feelings do not overshadow professional judgment.

> This is the subjective part, the emotional part, which is very complex because it has to be worked on. You have to work on it a lot because it cannot, let's say, transcend the relationship. But we are human beings and human beings love and hate, and that's how it is. You can't fight against emotions. You have them, what you can't let them transcend. They cannot influence the clinical relationship. For me these relationships, these types of patients (psychiatric patients) are very difficult because I always have to be very careful not to make mistakes, and not to let myself be carried away by emotion. It is complicated, but these are the two things that make the relationship easier or more complicated for me: trust and emotions (GP6S).

Indeed, for patients with severe psychiatric conditions, the relationship with their doctor is often one of the few stable pillars in managing their condition. These patients have limited options for negotiation or participation in their treatment decisions, constrained by the nature of their conditions. Further, trust in medical professionals often emerges not just as a choice but as a necessity.

> Of course, it's inevitable. You have to trust someone, even if you don't know him at all. Maybe I only know him by sight. The more you see him, the more you know him. You have to trust him because there's nothing else you can do. What else can you do? You have to trust him all the time. Just because of that, because he is a doctor (P10S).

The evolving cultural context surrounding healthcare significantly influences the doctor-patient relationship, particularly in how patients perceive illness and the role of medical intervention. The next GP illustrates the disconnect between societal expectations and medical realities, highlighting the difficulties healthcare professionals face in managing patient expectations.

> But in general, the change in society and the change that medicine "sells", let's say - Everything has a solution, everything has to be treated - And also

> that everything has to be immediate. Suffering does not exist and pain does not have to be suffered because there are medicines for everything, when this is a lie. As a result, unrealistic expectations are created, which is evident in our consultations. The reality is that there isn't a solution for everything (GP3S).

In response to the growing demand for quick and effective solutions, the relationship between doctors and patients has often become routinised, with a heavy reliance on prescribing medications. The regular use of certain drugs has become the norm, especially among adult patients who have been on these medications for an extended period. This entrenched practice can hinder more holistic approaches to patient care and limit conversations about alternative, potentially more beneficial treatments. This reliance on medications not only reflects a preference for quick responses but also underscores a resistance to change among those accustomed to immediate pharmacological relief.

> Well, I have a lot of people who tell me - Why don't I sleep? - And they've been taking Orfidal (a tranquiliser-anxiolytic) for ten years and there's no way. They don't even think about it, and you don't even have a little space to say - Hey, maybe... - Out of a hundred people, you might have only two who say - Well, I'm cutting back, take it away, I'm not taking it anymore - For the rest, it's just not happening (GP1S).

> Patients come to me saying - I want a solution to my problem - expecting that the doctor will provide the answer. They feel like they shouldn't have to figure it out themselves. That always makes me quite nervous (GP5S).

> It's like WhatsApp medicine: people now expect instant responses. If you don't get an answer to a message in two minutes, you start feeling anxious. The same thing happens in healthcare today: everyone wants a quick solution to their problems. But if someone has a personality disorder or has made poor

> life decisions for fifteen years, you can't fix that in twenty-four hours. Re-evaluating one's life is incredibly complex, with many conditioning factors involved (GP7S).

Furthermore, the next GP highlights the generational differences in patient attitudes, noting a noticeable decrease in tolerance for waiting and a growing demand for immediate solutions to health issues. This shift presents challenges for healthcare providers, who must balance the need to manage realistic treatment timelines with the increasing expectations for quick and definitive healthcare responses.

> When I started here almost 30 years ago it was more rural and the population was more respectful, more submissive. There were a lot of older people. And now people are more demanding. They want more promptness in everything, more immediacy and people are less tolerant. But that happens everywhere. Less tolerant of waiting, of frustration. People want a solution to everything (GP6S).

Normalisation of mental health

The role of the patient within the healthcare service has evolved significantly, particularly in the context of mental health, where normalisation has led to changing expectations and demands. Patients are seen as consumers or users with rights, which can sometimes challenge traditional medical judgments. This changing landscape requires doctors to navigate complex interactions where they must balance patient demands with the best medical practices. Indeed, this GP, with 39 years of experience, observes that this shift can lead to over-medication as a way to quickly satisfy patient demands, potentially at the expense of more thorough and appropriate care.

> I believe that people are becoming more demanding, more exigent, and they have less tolerance. Life is becoming very medicalised, the normal suffering of life... I think we have a population that is hyper-medicated, numb, or drugged. It is also influenced by the fact that we professionals have been

> stripped of a little bit of our authority, and so the authorities or politics, in general, have sold patients the rights of users instead of patients (GP8S).

The increasing normalisation of mental health discussions has possibly led to a concerning "normalisation of medicalisation" where routinised drug prescriptions are seen as both a response to and a catalyst for this trend. Medications are now frequently used as the default solution to complex emotional and social issues such as loneliness. This approach not only poses significant risks of physical and psychological side effects but also diminishes the perceived gravity and seriousness of consuming such potent medications.

> But the most frequent thing is loneliness, people are very lonely… In the end, what is the easy way out? To hyper-medicalise people with drugs that you are not sure of their efficacy or their goodness. Everybody talks about these drugs as if they were soda pop. Well, it has become so normalised that people are even sharing their pills (GP7S).

Beyond the potential disadvantages, a positive consequence of the normalisation of mental health is that patients are becoming more informed about their conditions and are actively participating in decisions about their treatment. The capability to articulate personal needs and critically evaluate the appropriateness of prescribed medications is transforming patients from passive recipients to active participants in their healthcare journeys. The following patient's testimony, gathered during the storytelling part of the interview, provides a profound insight into these personal experiences.

> Since then, I've been dealing with a lot of anxiety, a tightness in my chest that made it hard to breathe, and poor sleep. I went to my GP, and he told me that he wouldn't prescribe any medication at first, explaining that what I was experiencing was normal grief that I needed to go through. He gave me some natural herbal pills. Later, when I returned to the GP, the original doctor wasn't available. Instead, I saw a different doctor, not the new one but

> someone in between. This doctor told me that my sadness, given that two years had passed, seemed to have become chronic. He prescribed two types of pills, one of which I'm still taking, and the other was a relaxant or painkiller. I told him that I didn't think those pills were right for me because what I needed was something to lift my spirits, not something to relax me further or make me more subdued. I started taking the prescribed pills, and he referred me to a psychologist. She understood exactly what I was going through, which is why I chose not to take the other pills. What I was feeling was simply sadness (P1S).

6.2 Model of primary care organisation

The model of primary care organisation sets the structural and functional frameworks pivotal to the delivery of primary care. This section explores how, within this model, services range from those where practitioners are public employees with a wide but limited clinical autonomy, to those that are self-employed, enjoying greater independence. Such variations markedly influence how primary care is integrated with overall service delivery, impacting aspects like the organisation of daily schedules and mental health management. Furthermore, this discussion highlights how both Italy and Spain share similar economic oversight mechanisms, characterised by infrequent sanctions, shaping the operational dynamics of primary care within each country. This exploration seeks to understand the implications of these models on efficiency, patient care, and administrative interactions within the healthcare system.

6.2.1 Italy

Autonomy

In examining the autonomy of self-employed Italian GPs, a significant aspect is their ability to manage their practices and staff. This autonomy allows GPs to tailor their administrative and clinical environments to better address the needs of their patients. The freedom to hire skilled staff who can manage non-medical tasks is crucial, freeing up more time to focus on patient care.

> We have a girl who has agreed to work with us… She is a person with many skills and competences…. She also quantifies the health needs a little. When she is not here, the phone calls double. So, this means that she can attend to all non-medical needs (GP10I).

The autonomy afforded to Italian GPs also extends to how they manage communication within their practices, a crucial factor in maintaining the focus and efficiency needed for patient care. Next GP's strategy reflects the significant autonomy that self-employment grants, allowing for a customised approach. By delineating specific times for different tasks, the GP ensures that patient consultations are conducted with the utmost care and attention, free from unnecessary distraction.

> I never allow myself to be disturbed during a patient visit, except in the case of a personal emergency, which has only happened twice in three years. The only other exception is if the hospital calls. Since it's very difficult to get in touch with the hospital, if I see a call from them, I always answer. Otherwise, I don't pick up the phone, and I don't let the secretary interrupt me either, as it can be very tiring. I need to concentrate. Everyone has their way of organising their work, and I am very methodical. I allocate specific times for phone calls, emails, and patient consultations, ensuring that during each hour, I focus solely on the task at hand (GP7I).

Among the benefits of autonomy in the Italian healthcare service, there is an ongoing debate between different generations of GPs regarding the focus of their professional commitments. The next quote, from a GP with 28 years in the field, reflects a concern among older GPs who value the liberal profession and advocate for a patient-centred approach. They perceive a shift towards a more corporate model within the healthcare service, which they fear might compromise the quality of patient care. The dialogue between the generations highlights differing views on the balance between professional autonomy and service configuration.

> There is a risk of no longer being at the service of the patient. I am the caregiver of the patient. Because then, as is happening now, the let's say corporatist component is taking over, in its pros and cons. Let me be clear, this is not a criticism. But I feel that my client is my patient, not the healthcare service. Among colleagues of my generation there is this opinion (GP8I).

Younger GPs, especially those working in health centres, express a preference for a model more akin to the Spanish service, where GPs are more integrated into the public health framework. This perspective stems from concerns about the potential for conflicts of interest and challenges in achieving shared objectives across the profession when operating as self-employed individuals. Next GP, with 3 years of experience, expresses her desire for a more cohesive and standardised approach to healthcare.

> In my opinion, a GP should be a civil servant like all other public professionals This is to avoid excesses of conflicts of interest and to be able to give common objectives to the professional category, to all GPs and, together, also to the State…Because I also find myself managing, distributing resources on behalf of the State. I distribute examinations, prescriptions appropriately, and because I try to engage more with those who are most in need (GP10I).

Supervision and lack of sanctions

The autonomy of Italian GPs, while offering substantial clinical freedom, also links with aspects of supervision and the (infrequent) imposition of sanctions, particularly regarding financial management. This system of economic sanctions, although rare, underscores the limited nature of supervisory actions, which predominantly focus on economic rather than clinical outcomes. For GPs managing patients with mental disorders, this can present challenges. The emphasis on staying below average drug expenditure might discourage the prescription of necessary but potentially expensive treatments, affecting the quality of care provided to patients with mental health needs.

> Health Authority sends us a report of all health expenditures. Mainly regarding drugs. Then compares us to the average of the Health Organisation doctors and we have to stay below the average without a standard goal…So this is the spending control that is carried out, but if I don't do it they deduct money from my salary or I am called to account in the Health Directorate (GPI1).

The tension between maintaining cost-effective management and exercising clinical autonomy can lead to significant ethical dilemmas for GPs, particularly in the realm of mental health care, where the risks are inherently high. This issue becomes vividly apparent in the experiences of the same GP who, under the pressure of financial supervision, made decisions that compromised patient safety. Possibly, this situation highlights the dangerous impact of a healthcare system that prioritises economic considerations over clinical outcomes (or supervision).

> …it was a case in which I put a patient's life at risk for economic reasons because otherwise, it would never have occurred to me doing this evaluation (GP1I).

The debate surrounding supervision in healthcare often centres on balancing economic control with the need for clinical oversight. However, clinical supervision could serve as a valuable training resource for GPs, helping to address any gaps in their expertise. Next GPs underline the gap in the healthcare system's supervisory practices, highlighting a strong focus on economic aspects rather than the effectiveness of clinical outcomes.

> Only pharmaceutical spending. Just money. Prescriptive appropriateness. So, whether a drug is used off-label, on-label, or inappropriately. But we don't have oversight for clinical outcomes. Nobody cares about that. They look more at the economic side (GP5I).

> Among other things, diagnostic supervision would be more appropriate. Why did you prescribe this examination? In the end it brings you nothing from a cultural point of view. Not even from a scientific point of view. If, on the other hand, you give me an oversight of - Look, why did you mark this drug to that patient with diabetes? Mark him this other one - Maybe it could have been better (GP6I).

In the context of healthcare supervision and the limited scope of sanctions, the process of patient reporting emerges as a complex mechanism that only occasionally leads to punitive measures. This framework often leaves those with mental health issues, already burdened by emotional and cognitive challenges, in a particularly vulnerable position. They may be less likely to navigate the bureaucratic processes necessary for making complaints, thus relying heavily on the discretion and management of their doctors. The autonomy and independence of GPs remain largely intact, with only severe cases potentially leading to sanctions. This scenario underscores the need for a more responsive and effective system of accountability in healthcare, especially to better support those with mental health needs. Two healthcare coordinators describe the pathway for patient reporting and their respective roles in this system.

> The patient usually goes to the department, and sometimes I'm aware that they might visit the public relations office to make a report (FLS2I).

> I am called by the public relations office if there is a report. We discuss it together, me and the manager (FLSI1).

6.2.2 Spain

Autonomy

In Spain, the dynamic between GPs and administrative staff differs significantly from the Italian model, primarily due to the GPs' status as public employees deeply embedded within organisational constraints. Unlike their Italian counterparts who hire their administrative teams, Spanish GPs work with administrative staff who are also

public employees, assigned based on public entrance exams rather than by the GPs' choice. In this context, the administrative strongly influences the GPs' work, scheduling patient visits. Possibly, the lack of control over their scheduling can lead to inefficiencies and frustration, impacting the GP's ability to effectively manage patient care.

> They are the ones who organise my schedule, my work. If they organise it badly, for me it is a disaster. That influences me in my relationship with a patient. … Imagine if everyone who comes wants to see me at the moment. The administrative staff says (to the patient) - What do you want? - A prescription for a blood analysis - Well, don't worry, is not urgent. Come tomorrow at 10 -. And there is no problem. Imagine if that they say - Go upstairs (to see the doctor) -. And everyone who comes, goes upstairs … I don't have time to see everyone, I get angry (GP6S).

> I have already seen tomorrow's agenda and I have 43 patients, plus 12. All because if a patient comes to you, they force it as urgent. The administration staff are the ones who determine whether a patient can be referred to me or not (GP10S).

Despite the structural constraints imposed by their roles as public employees, Spanish GPs still enjoy a significant degree of clinical autonomy. This freedom allows them to make independent medical decisions. This freedom within constraint reflects the dual nature of their professional environment: while their administrative duties and schedules may be tightly regulated, within the confines of their consulting rooms, Spanish GPs retain full authority over clinical decisions. This autonomy highlights the delicate balance they must navigate, meeting the structural demands of their roles while preserving the freedom essential for delivering effective, patient-centred care.

> During the visit, you have absolute freedom. I am not controlled. I own my consultation, and I own the decisions I make. It is a huge autonomy. I don't have the rigidity of public servants (GP6S).

In the Spanish healthcare system, the dual role of GPs as both state agents and patient advocates adds a nuanced dimension to their professional identity. This complexity is evident in the differing perspectives of two Spanish doctors, each reflecting on the challenges and responsibilities inherent in balancing these roles. These perspectives highlight the complex balance between bureaucratic responsibilities and the empathetic, human-centred approach essential in healthcare. GPs face the dilemma of balancing organisational constraints with the need for personal autonomy, which is essential for providing individualised care, particularly in managing patients with mental disorders.

> We are not civil servants at all. Because we talk about feelings, we see a person when they are very vulnerable, which is when they are sick or when they have a worry, an emotional pain, a pain in the soul. The biggest part of our job is to have human qualities. Because we are not just civil servants (GP1S).

> But it is clear to me that I work for a public company, for a public health service, paid for by taxes. The problem is that sometimes civil servant is also used as an insult. But it is also a cultural problem or a problem of bad reputation... but that's what I am and I have no problem with that (GP2S).

The role of coordinators in Spanish health centres is pivotal in shaping the autonomy of medical staff, particularly in managing patient feedback and operational logistics. These supervisors act as intermediaries between the medical staff and the broader health service administration, overseeing human resources and patient care dynamics while navigating the limitations of their authority.

> The role is not clearly defined. It functions as a mediator, a facilitator, and an organiser of various elements. In my health centre, where 24 or 25 people work, I manage open consultations, cover gaps, handle holidays, manage

> supplies, and arrange for substitutions. I'm also responsible for teaching. However, I do not have the executive authority to recruit staff, as that responsibility lies directly with the health service. While I cannot hire or dismiss anyone, I do have the authority to open or close points of care and consultations (FLS4S).

Supervision and lack of sanctions

In examining the model of primary care and its impact on the management of patients by GPs, particularly those with mental disorders, the role of supervision is critical. Strong supervision can significantly influence how GPs navigate their responsibilities and the quality of care they provide. Similar to the Italian context, Spanish GPs experience a form of oversight that is primarily economic, focusing on financial metrics rather than clinical outcomes. This can affect how medications are prescribed and managed, but the actual impact on changing GP behaviours remains minimal due to the leniency of the system. This quote from a health centre coordinator illustrates the flexible nature of the supervisory system, where objectives are set but the absence of tangible consequences for not meeting them leads to a varied approach among GPs.

> I don't know how it is in other countries, but here, let's say that the management gives you the premises, gives you the practice and then you work. They give you certain objectives, but if you don't meet them, nothing happens. Everyone looks for his way of resolving things. So, some are quicker, others are slower, others are more or less time-consuming, and others are more or less time-consuming. So, there is no sanction mechanism. I think there should be. For example, our salary should be tied to meeting specific targets. That's the aspect of compensation we truly notice (FLS2S).

The level of autonomy granted to doctors, particularly in prescribing practices and diagnostic testing, brings to light significant disparities in resource utilisation. The absence of stringent supervision and sanctions contributes to these variations, underscoring the need for a balance between clinical independence and responsible spending of public funds. This health centre coordinator introduces the need for a

supervisory system that actively fosters accountability, rather than merely imposing sanctions.

> Here, doctors have the freedom to prescribe any medication or order any diagnostic test, and not all prescriptions align with scientific recommendations. For instance, in my health centre, I spend €19 per patient per month, while some colleagues spend €35. So why this variability? When dealing with public funds, it's important to exercise caution (FLS4S).

Next GP highlights the desire among healthcare professionals for a supervisory framework that not only monitors but also constructively guides their clinical practices. This feedback would not only promote adherence to scientific guidelines and fiscal responsibility but also improve the quality of patient care, especially in the complex field of mental health.

> I always say that in my company the relationship is based on irresponsibility. Nobody is responsible for anything. It doesn't matter if you do it right or wrong, as long as you don't kill people, nothing happens. So that's not right. I think there has to be a supervision that is not too strict. There has to be feedback, telling me how I have patients or how I work so that I can work better. That's what I'm waiting for in my company, but I've been working for thirty years and this hasn't happened (GP7S).

Indeed, the current supervisory practices within the Healthcare System reveal significant gaps, particularly in how medical professionals' work is evaluated and improved. One GP highlights these challenges and the pressing need for a reformative approach to supervision that fosters both accountability and training growth.

> Then they have to evaluate the work of the workers - Hey look, what you are doing is failing you a lot, why are so many people dying to you and not to the other one? Why are you responsible for consuming 50% of the

> benzodiazepines prescribed at this health centre? What's happening here? - You would need to evaluate this situation and understand the reasons behind it - I just don't have much idea - OK, don't worry, I'll train you - I just don't have time - OK, we try to manage it - There is no evaluation, there is no supervision. Corrective measures aren't implemented because they hesitate to take action. This system is unsustainable and needs a complete overhaul. I would appreciate being told what I'm doing wrong. Sometimes you believe you're doing the right thing, but you might be mistaken. (GP6S).

A health centre coordinator elaborates on this issue, highlighting the challenges faced due to the absence of responsive feedback. Optimising spending to ensure that financial resources are effectively used to enhance patient outcomes is crucial, particularly in mental health management where prescription medication is often a primary treatment strategy.

> I work in a rural area. Here we have a budget of €7 million and we spend €4.5 million on pills. My question is whether we are doing it right or we are over-recipient. Maybe we should spend up to 6 million. You never get that feedback (FLS4S).

6.3 Primary care access and contact with GPs

This section explores how access to primary care and its overall accessibility, affects how GPs manage patients with mental disorders. The discussion analyses various perspectives, including those from patients and GPs, to understand how access to care is experienced at the ground level and its implications for the continuity of mental health services.

6.3.1 Italy

The decentralised nature of primary care in Italy, which allows patients direct contact with their GPs within a specific timeframe, ensures that individuals can reach out quickly and directly when in need. This direct line of communication is particularly

advantageous for patients with mental disorders, as it facilitates immediate access to care during acute episodes, potentially streamlining the pathway to ongoing specialised mental health services.

> If there is an emergency, for example, a fever of 38 and the patient can't go to work or even more serious things, they call me in the morning from 08 to 10 and I always see them during the day anyway. Either in the consult or I will see them at home if they call me by 10 a.m. If they call me after 10 a.m. they can contact me leaving a message to the administrative staff (GP1I).

The continuous accessibility and reliability of family doctors are crucial in strengthening the patient-doctor relationship. In the interview, focusing on the evolution of the GP profession in Italy, particularly the shift towards a salaried regime, a health centre coordinator, who is also a practicing physician, highlighted the enduring connection that primary care doctors maintain with their patients.

> But the relationship of trust must never be lacking, because otherwise a duplication of the specialist will be recreated, because the taking in charge that we have... we never disconnect. Because even if it arrives on Saturday, on Sunday, the patient showed me the examination on Friday, I remember it. On Monday I see it again, it's not that I see it again after six months. So the great strength of primary care is this (FLS1I).

The high level of accessibility to GPs plays a pivotal role in the treatment and management of mental disorders. Patients benefit significantly from the ability to have frequent and direct communication with their healthcare providers. This accessibility not only supports continuous care but also ensures that any changes in mental health conditions can be promptly addressed. The following quote from a patient exemplifies this dynamic, illustrating how his GP acts as a critical point of contact for regular monitoring and immediate intervention during periods of mood fluctuations.

> The doctor helps me so much weekly or when I have mood changes or problems directed towards that. She is the first one to interface (P10I).

GPs play a central role within the local healthcare ecosystem, particularly in terms of accessibility for patients. Describing themselves not just as a “gateway”, the next GP emphasises the personalised and pivotal function she serves for her patients. The proximity and the metaphor of a home rather than a mere entry point reflect a deep integration into the lives of her patients, fostering an environment of trust and immediate accessibility.

> I am the gateway to the NHS for 1750 people who, by the way, in my case, all live within a one-kilometre radius. So, I could say that I decide a little bit about the health of this area... I don’t like the term “gatekeeper of the health service” because I don’t see my role as guarding a gate. I prefer to think of it as “the home of the NHS”. From here, I guide my patients to seek further care, and they return to their primary home for continued support (GP9I).

The GP often serves as the first point of contact for patients seeking initial guidance due to their accessibility and proximity. However, as highlighted by P4I, finding a GP who can provide consistent and trustworthy support is not always straightforward. This patient, who has been under psychiatric care since adolescence, describes the difficulty in establishing a reliable connection with a GP, expressing feelings of abandonment and uncertainty during critical times of need.

> I would contact this doctor by phone because I didn’t even see him in person. But I truly felt abandoned, unsure of what path to take. When I emerged from my crisis, I would ask the doctors in different districts “Now that I’m leaving here, what should I do?” and they would gradually give me advice. You know, finding a doctor you trust takes time. You don’t immediately find a doctor with a magic wand (P4I).

The COVID-19 pandemic significantly changed healthcare accessibility, as noted by GP8I. Digital communication via email and WhatsApp became crucial, while home visits decreased significantly. This shift possibly had serious repercussions for patients needing continuous, in-depth attention, particularly those with severe depression or anxiety disorders, who rely on regular face-to-face interactions for reassurance and support. The reduction in these visits likely intensified feelings of isolation and abandonment for these individuals.

> The change which has ballooned greatly is that of the digital-IT component. So, email, WhatsApp, and more. This aspect became very important. Home visits have also decreased, which were sometimes just courtesy visits in a sense. Because (during the pandemic) you couldn't go, except in special cases (GP8I).

Speaking about accessibility, special mention needs the comparison between urban and rural settings highlighting significant differences in how patients interact with their GPs. In rural areas, as described by GP4I, patients rely more heavily on their GPs due to the greater distance and inconvenience of accessing hospitals and specialists. The GP becomes a crucial reference point for ongoing care and navigation through the healthcare service. In contrast, urban patients often bypass their GPs, directly consulting specialists and thereby missing out on the guidance and comprehensive care that GPs provide. This bypassing can result in missed opportunities for early detection and holistic treatment plans that GPs are well-positioned to provide.

> So, people rely more because the hospital is further away, because the specialist is more inconvenient. In the city it is completely different, one is very often bypassed (GP4I).

Despite the high accessibility of GPs, they are often bypassed, as highlighted by GP7I.

> You can't manage all the requests you have. So, in 20 to 30% of cases, you are bypassed, and the patient goes directly to the hospital. Therefore, you no longer work as an access door. You are overwhelmed or patients go to the private system (GP7I).

The accessibility of GPs, to be efficient and useful, requires continuity in the relationship between patient and doctor, which involves a stable contract and low rotation of GPs. This ongoing relationship is crucial for managing mental health, as highlighted by both P10I and GP5I. The patient appreciates frequent interactions and the GP's understanding, while the GP reflects on the evolving relationship with patients over the years, which fosters a deep sense of trust and familiarity. This continuity allows GPs to create a welcoming environment where patients feel comfortable expressing their inner struggles, facilitating better understanding and tailored care strategies essential for effective mental health management.

> We see each other practically very often. He's a nice person. And clearly mental health is a difficult subject for me too, for everyone. It's changeable, it's hard to predict (P10I).

> The relationship over the years evolves. Our work allows precisely this kind of overview, compared to the hospital. You grow with the patients, some die, some born, some start families, and slowly you become a confidant. Let's say you enter in their lives, as they let you enter. I know everything about them, even their relatives, because they told me about (GP5I).

6.3.2 Spain

Also in Spain, the role of the family doctor is seen as pivotal in the healthcare service, especially regarding accessibility to the health service. However, unlike in Italy, access to GPs in Spain involves a higher level of bureaucratisation. Patients do not have direct contact with their GP's. Indeed, their communication is mediated by administrative staff. This additional layer can impact the immediacy and directness of patient-GP

interactions, contrasting with the more direct access seen in Italy. However, as GP7S states, the family doctor serves as the fundamental pivot around which people's health rotates.

> I believe that the family doctor is the fundamental pivot where people's health should rotate. You have a complete version of the disease's social determinants. You follow people in their environment, you know their neighbourhood, how they live and with who. This gives you much more information than in hospital care specialties (GP7S).

The accessibility of GPs is crucial for effective healthcare delivery, especially in mental health management and access to specialised services. GPs are often the first to identify and address mental health issues, providing early intervention and monitoring. Their gatekeeping role ensures timely and appropriate referrals, preventing delays in care. The continuous and supportive relationships GPs maintain with patients foster trust, encouraging early and regular help-seeking, essential for effective mental health management.

> We are the ones who somehow establish the first contact with the population. We are the ones who decide who will go somewhere else, who will not go or who will stay (GP6S).

The high accessibility and availability of GPs are fundamental to making decentralised healthcare a reality for patients. As GP2S emphasises, GPs are not just gatekeepers but serve as the closest and most accessible healthcare professionals, acting as critical entry points into the system.

> I am not a guardian, nor am I a policeman and someone who limits a patient not to go to the hospital or not to go elsewhere. I am one of the professionals of reference for health care and to attend to health problems. So, I am the

> closest, the most accessible, and therefore a bit of a "door". But I am much more than a door (GP2S).

According to GP6S, this accessibility is not only extensive but also highly effective, as GPs can resolve almost all the patients' requests.

> Then it's important because we have a high resolution, so we are the first step, the first point, where the patient comes in and where we solve 80% of people's problems (GP6S).

Effective and accessible primary care services rely on continuity in the patient-doctor relationship, which is supported by stable contracts and low turnover of GPs. Organisationally, this continuity is achieved by ensuring consistent employment conditions and minimising staff changes. This stable and continuous relationship builds trust and open communication, which are crucial for both accessibility and effective resolution of mild mental health issues.

> I have been in the same health centre since 2013. I know them, they know me and I do my job better. I know the people. As patients get to know me, they feel more comfortable sharing what they see and feel, whether they agree with my approach or if something isn't working. I believe this trust is evident in our relationship. In the past, when I spent a month in one location and then moved to another, I had to earn the trust of people I had never met before, which made building those relationships more challenging (GP2S).

Thus, the next patient highlights the challenges posed by the instability of not having the same GP. Living in a rural area characterised by frequent rotation of health professionals, P6S describes the difficulty of building a consistent and continuous rapport, which is the foundation for a relationship based on trust.

> We don't always have the same doctor, so every time you go you have a different one... In the beginning, we had one consistent doctor, until that doctor left. Since then, it's been different every time, each visit, there's someone new. You might return and find another new doctor, or sometimes, the original one is back, almost as if they disappeared and then reappeared.... In the area where I'm from, we always have to change, I don't know why (P6S).

6.4 Lack of resources

Drawing on qualitative data, this section presents how a lack of resources might influence GPs' ability to manage patients with mental disorders. This discussion focuses on how limited training opportunities, reduced consultation time, staffing shortages, and increased reliance on pharmacological treatments could affect critical aspects of care. The insights aim to illustrate the broader implications of resource limitations on the accessibility and quality of mental health care in primary settings.

6.4.1 Italy

Lack of training in mental health

In the exploration of the degree of government funding and its impact on GPs' training and patient care, the testimonies from practitioners reveal significant gaps that possibly affect the quality of healthcare delivered. A lack of training in mental health not only hinders the effectiveness of patient management but also impacts the confidence and capability of GPs, underscoring the need for more comprehensive training initiatives to better equip them for these demanding scenarios.

> Especially for me, the patient with psychosis was very scary. I was so terrified because I didn't know how to treat them (GP7I).

The consequences of inadequate GP training significantly affect patient care dynamics and GP engagement, leading to coping strategies like limiting their involvement

to basic duties to manage workload and emotional strain. This approach, while understandable, can drastically reduce the quality of care, limiting patients' access to comprehensive and empathetic healthcare. It highlights where the service fails both patients and providers, underscoring the urgent need for enhanced training and support to help GPs manage complex cases more effectively and compassionately. Furthermore, patients with mental disorders often exhibit challenging behaviours and a high dependence on healthcare specialists, burdening GPs and exacerbating their withdrawal from engaged care. This underscores the necessity for training that enhances not only clinical skills but also equips GPs to manage relational aspects, fostering a more supportive healthcare environment.

> It may not be elegant to admit, but she is one of those cases where I tend to do the bare minimum out of fear. With her and two others, if I make myself even slightly more available beyond my work obligations, it becomes overwhelming. It's difficult to say, but this reflects the challenges of balancing professional duties with personal involvement and going beyond what's strictly required (GP1I).

Perceived inadequacies in handling challenging patients can lead to apprehension among GPs. Prejudices, stemming from a perceived lack of knowledge and capability, may deter GPs from engaging fully with these patients, potentially delaying or inhibiting their access to specialised services that could more effectively address their complex needs.

> He is a very difficult person to approach, very difficult to handle. I won't hide the fact that when I read his name among the patients I panicked a bit too, because I said - I don't know how to handle this, I don't know where to put my hands - (GP5I).

The need for ongoing professional development in general practice is emphasised by the next GP who advocates for continuous learning beyond initial

medical training. This GP also points out a significant challenge that impacts the feasibility of ongoing training: the overwhelming bureaucratic workload faced by practitioners. This highlights how the absence of an organisational structure that supports it, along with insufficient time allocation for post-academic training, can significantly hinder the continuous professional development of GPs.

> The family doctor should have one month a year spread out, to say - you go four days in otolaryngology, one week in psychiatry - because then he acquires specialist skills that he can then use. Without this training, time inevitably shifts towards bureaucratic tasks instead of acquiring and applying specialist skills that could be beneficial in practice (GP8I).

The consequences of inadequate mental health training for GPs are articulated through the experiences shared by two doctors. One GP describes the practical implications of this shortfall during clinical encounters, while the other highlights the logistical challenges of balancing professional development with personal commitments. These reflections emphasise how the scarcity of structured, accessible training opportunities can directly impact the quality of mental health management. Without adequate tools and knowledge, GPs may struggle to effectively diagnose and manage mental health conditions, thereby restricting patients' access to competent and timely mental health care.

> So going back to what I was talking about before, what techniques you can use to approach the patient...you look for answers and find nothing, as there's no solid ground with these pathologies. In the hustle and bustle of daily life, it can be challenging to take the time to revisit how certain symptoms manifest, and how others might develop (GP3I).

> There is little time for training outside working hours They organise courses. The problem is time, because we are not only doctors, we also have families (GP4I).

Another coping strategy in the absence of training, when available, is to consult a mental health professional at the health centre. It is important to note that, in Italy, the integration of primary care and mental health services in health centres is often the result of local initiatives where professionals establish collaborations to provide mental health services within these centres. However, unlike in Spain, where health centres are the main organisational structure for primary care, in Italy, GPs often operate in rented offices, making access to integrated services less common. As a result, the availability of mental health services in Italian health centres varies significantly, depending on local initiatives and infrastructure.

> If, however, the patients present significant challenges, I do attempt therapies, but it's not often that I refer them to a psychiatrist. If I find that I can't manage the situation on my own, either because I can't fully understand the issue or the patient is not compliant, I may decide to refer them. Since there is a mental health department at the health centre, I can refer them by arranging an appointment through the secretariat (GP1I).

When training is provided, it is often centred on an overemphasis on a specialist perspective. The next GP criticises the current approach to mental health guidelines and training, suggesting they are too heavily centred on specialist settings rather than addressing the realities faced in primary care. This statement underscores the need for training that is more aligned with the day-to-day experiences of GPs in primary care, ensuring they are equipped to manage the broader spectrum of mental health issues that are prevalent in the general population.

> This issue is significant and warrants further investigation. There is a risk that our understanding of depression and mental disorders is skewed by the cases seen by specialists, while the broader mental health struggles within the general population go unnoticed. Even the guidelines are problematic, in my view, as they are developed in contexts that differ greatly from the realities of everyday practice (GP8I).

Despite a general lack of training, the attitude towards mental health seems to be evolving among younger generations of GPs. This shift may be attributed to their more modern academic training, which makes them more receptive to psychiatric and psychotherapeutic approaches compared to their older counterparts.

> The older generation still held some prejudices. I recall a highly esteemed colleague, very knowledgeable in organic medicine, who regarded psychiatry as a form of witchcraft. Psychotherapy wasn't even considered. In contrast, the younger generation is more open and accepting of these fields (GP1I).

Lack of time

Time constraints faced by GPs can influence their approach to patient care, often resulting in a preference for pharmacological solutions over more time-consuming, holistic methods. Such practices can not only impact the quality of care but also restrict patients' access to specialised services that could provide alternative and potentially more effective treatments.

> Obviously, the drug is more comfortable, quicker... a drug is easier to give to the patient, instead of understanding why he may have a problem and trying to solve it in another way (GP6I).

> Surely it is easier to give the drug to the patient, than to stand there and figure out why he may have a disorder and still try to solve it in another way (GP6I).

The lack of time in primary care settings, which often results in an increased reliance on drug prescriptions, can be attributed to a variety of factors. The heavy burden of bureaucratisation in primary care significantly restricts the time GPs can allocate to their patients, which is especially detrimental in the management of mental health disorders. This intense administrative workload not only reduces the time available for

individual patient consultations but also impacts the quality and depth of care GPs can provide. Consequently, this may delay or prevent timely referrals to specialised mental health services, as GPs may not have sufficient time to conduct thorough assessments or follow up on complex cases.

> Then there is also the other thing, that excessive, let's say bureaucratisation, it also leads us to be less efficient medically. Because you can't spend as much time on that person anymore. Bureaucratic time exceeds 70% (GP8I).

> We are so accustomed to the bureaucracy that I can't even distinguish it from ordinary work. Regarding a working day, if it goes well, 40% is dedicated to patients. The rest is repeat prescriptions, putting together treatment plans, listing requests, correcting prescriptions made by specialists (GP1I).

This increasing focus on bureaucratic tasks, even among self-employed GPs, signifies a recent shift in the nature of their work. A senior doctor with 28 years of experience offers insights into how the doctor-patient relationship has evolved over time.

> In the sense, much less bureaucratic. The doctor-patient relationship was completely different. It was a more let's say traditional medicine, centred on the important interpersonal relationship (GP8I).

In addition to the bureaucratic workload, the shortage of time in healthcare settings is also due to an insufficient number of physicians, which greatly affects the quality of patient interactions. Personnel shortages disrupt the continuity and stability of care, eroding the essential empathetic connections and trust between patients and their healthcare providers. These disruptions can severely undermine the effectiveness of treatment, especially in fields like mental health, where a strong therapeutic relationship is crucial.

> In public healthcare, unfortunately, the empathy and trust that are essential in the therapist-patient relationship can sometimes be diminished. The continuity and stability of the therapist are not always maintained, which can weaken this crucial bond (GP6I).

Waiting lists

The presence of long waiting lists in mental health services significantly impacts the management practices of primary care physicians. Extended delays in accessing mental health services compel GPs to seek alternatives, such as referring patients to private specialists, to ensure timely care. Such practices reflect the strain on public mental health services and the challenges faced by primary care providers in managing their patients' needs effectively.

> I now have a 13-year-old girl… Paediatric neuropsychiatry does not work, because it has very long waiting times…and sometimes I turn to the private specialists (GP6I).

In response to systemic delays, GPs often leverage their inter-organisational informal networks to advocate for their patients and personalise the care they can offer. GPs sometimes need to exercise discretion and use their professional connections to accelerate necessary specialist care, effectively navigating the challenges posed by long waiting lists in the healthcare service.

> It can happen that you refer someone for a specialist visit, with a 30-day priority and they give the patient an appointment in four months… I must "force their hand" to make it a more urgent priority (GP3I).

In primary care settings where a psychologist is available, much of the mental health workload is transferred, yet this might overshadow the valuable role of the physician as a counsellor and their significant contribution to mental health. Moreover, having mental

health professionals on-site at health centre facilitates immediate specialist contact, thus shortening the initial waiting period for care.

> Lately with the advent of mental health here in the health centre I have also been using the health centre channel a lot, and therefore the public service, because I then have a direct relationship with the therapist (GP6I).

The same doctor presents considerations on the creation of the figure of the primary care psychologist. This figure, currently present in some Spanish health centres, is still missing in the Italian organisation. Possibly its implementation could lead to a reduction of demands on GPs.

> There was a time when in the region they talked about putting the primary care psychologist. It would not have been a bad thing. Because I believe that in our daily work, maybe there is a 20% of real pathology, the others are all somatic pathologies (GP6I).

6.4.2 Spain

Lack of training in mental health

Given the importance of a thorough understanding of symptom manifestation, including the presence of somatisation symptoms, the lack of training significantly impacts GPs' management of individuals with mental disorders. This deficit can hinder their ability to effectively diagnose and treat patients, potentially restricting access to specialised mental health services. Further, the absence of sufficient training in mental health care often leads GPs to default to routinised pharmacological solutions, rather than more comprehensive or appropriate interventions.

> What we usually do when we don't know what to do is to prescribe - Take this. Out. You ask me for help, I'm supposed to give it to you. I don't know how to give it to you - (GP6S).

Lack of training can also reinforce prejudices towards specific medical conditions, particularly those associated with depression. An example of this is evident in the treatment of fibromyalgia, particularly among women, where biases can significantly affect the quality of care provided.

> For example, in women diagnosed with fibromyalgia, there are prejudices. Some professionals do not feel at all comfortable. These are very difficult pathologies to treat, and there is rarely success (GP2S).

One strategy GPs employ to address the shortfall in mental health training within primary care is to seek advice from colleagues. This collaborative approach can significantly influence both the availability and quality of mental health care provided in a primary care setting.

> Sometimes you ask colleagues. But there is no expert colleague in mental health either. There used to be a psychiatrist who worked as a primary care doctor who used to work here, but he retired. He was a psychiatrist, so almost all psychiatric patients were taken by him (GP3S).

Another strategy for managing in the absence of training, when available, is to seek advice from a primary care psychologist at the health centre. According to the next doctor, the referral to the in-house psychologist at primary care allows for easier and more continuous follow-up than in the case of referral to specialist services.

> There was a lot of work to do, so you identified the situation and referred her to the psychologist, but you remained her doctor. Often, when I say - Go see the psychologist and then come back and tell me about it - it helps maintain my involvement in the relationship. Sometimes, it's easier for me to engage with psychology in this way, but with psychiatry, I feel less knowledgeable,

> especially regarding patients in mental health care. Having a psychologist nearby makes it easier to simply walk across the hall and ask - What did you think of this patient, or how do you see her? - (GP4S).

While physicians receive some training in mental health, there remains a notable knowledge gap that is specifically tailored for primary care settings. This deficiency is highlighted by the predominantly one-directional flow of knowledge from hospital to primary care, which fails to fully address the unique challenges encountered by primary care providers in managing mental health issues. The next quote from a Spanish GP emphasises the need for a more integrated approach, advocating for a reciprocal exchange of insights and practical strategies that would enhance the understanding and treatment of mental health across all levels of healthcare.

> This model, seems to me a bit questionable, that from the hospital care area training is given to primary care, but the other way round, it is an implantable question. The hospital never has anything to learn from primary care. It is primary care that has to learn from hospital care. I think psychiatry is in the same trend and I don't perceive that there is a close relationship between the two (GP9S).

Next GP acknowledges his lack of formal training in handling mental health situations. The GP discusses the challenges faced during a referral to psychiatry, illustrating how inexperience can impact the level of confidence in managing patient care.

> It was a referral to psychiatry, and these moments are somewhat unfamiliar. You're navigating them without certainty. I imagine there are situations where, if we were better trained, we would feel more confident. In a typical medical consultation, there's a level of assurance, but with mental health cases, there are times when I sense I can help, and other times when I'm unsure where to position myself or how to guide the process (GP4S).

Experience often involves learning from one's own mistakes in a process of knowledge construction. Beyond a lack of formal training, the reluctance to discuss errors can also hinder learning opportunities. In particular, in the area of prescribing medication, sharing mistakes could be highly educational. This is especially relevant in mental health care, where the stakes of prescribing errors can be particularly high. A physician shares a poignant experience that underscores the importance of this open dialogue.

> It was my mistake and the patient died. I said this and people said to me - Don't worry, it's Ok, these things usually happen - They were trying to sympathise with me, they were trying to relieve me. Then what I noticed was that they were not trying to relieve me, they were trying to relieve their fear, their panic. Who has never had a patient die? Let's be clear. Who hasn't screwed up and given a drug that was contraindicated? (GP6S).

Lack of time

Time constraints significantly impact the management of patients with mental disorders, who often require more time to fully express their conditions and for the GP to conduct thorough assessments. The pressure to adhere to tight schedules can compromise the quality of care provided to these patients. The inability to extend conversations as needed possibly forces GPs to prematurely conclude discussions, potentially overlooking critical aspects of a patient's mental health condition.

> You have eight minutes per consultation. Some consultations are five minutes too long, especially bureaucratic ones, and there are consultations where you deal with a stressful situation, a mood disorder… these eight minutes cannot be established…You are in a hurry to finish because you know you have a full agenda. So of course, at the end of the day, sometimes you are abrupt in cutting an interview short (GP7S).

Furthermore, due to their extensive agendas and workload pressures, GPs must balance direct patient care with other necessary administrative tasks. GPs often try to

alleviate work pressure, facing the challenge of managing a packed schedule that includes both patient consultations and other obligations integral to a GP's role. This constant juggling act can compromise the depth and attention given to each task, particularly those involving complex patient needs like mental health. In addition, the next GP reflects on how the COVID-19 pandemic has significantly increased the reliance on telephone consultations, adding another layer of complexity to GPs' schedules.

> I understand that many times what we want is to "get rid of burdens" so that we have more time to do other things, to see reports, to prepare other things, but it's difficult…Now it's a much colder job, more of a telephone consultation, more of a computer job than having the patient in front of you, you don't explore them (GP5S).

However, the next GP highlights the return to pre-pandemic modes of operation, with a renewed emphasis on in-person consultations.

> You looked like a call-centre. I think the doctor has to touch, you have to see, we can't be slaves to data. We can't be slaves to algorithms... now I've come back here again and I've found that most of the consultations are face-to-face, so the treatment has been almost the same again (GP6S).

The lack of time in primary care settings is also due to the significant strain on resources caused by persistent understaffing. With a substantial portion of the workforce unavailable, the remaining doctors are forced to handle an increased workload, exacerbating time constraints and potentially compromising the quality of care provided to patients. Testimonies from a health centre coordinator and a GP, supported by data on the primary care workforce, suggest a continuing, if not worsening, trend in the coming years. This indicates a pressing need for systemic solutions to address these challenges in primary care.

> There are no doctors in primary care either. We are now minus three all summer. We are always going to be short three out of ten. 30% are going to be absent. The other seven doctors have to make up for the three who are missing for the whole summer. We will be like this until October. So, of course, we have fewer resources than we should have. Right now, there is no forecast that it is going to get better. It is going to get worse in the next years (FLS2).

> The limitations of the public health system, particularly the shortage of professionals, may lead to an overreliance on medication in patient care (GP7S).

Waiting lists

Lack of resources also contributes to extensive waiting lists for specialised services, such as mental health care. This creates significant challenges for GPs managing patients who need timely intervention. GPs face the dilemma of providing optimal patient management in the presence of long waiting times for mental health services. Having no viable alternatives, they forced the service to ensure that patients receive the urgent care they need.

> Mental health is unfortunately terrible right now. The approach and communication are terrible. I recently referred a girl with self-harming ideas and she had an urgent referral. Mental health services told me - Well, send her for emergency care - but there was no risk of suicide. The girl didn't communicate it, she didn't have clear suicidal ideas and so on. There are many parameters to assess. But you know this person isn't well and needs to be seen by mental health services as soon as possible. When I was told, - Yes, it's marked as "urgent" but it's still on the waiting list - I asked how long that would be and was told -Two months - I was shocked. How can a young girl wait 2 or 3 months to be assessed as "urgent"? That's just not right. So, what do you do? You end up misusing the system by sending her to the emergency

> services. We know it's not the proper approach, but what's the alternative? It's very unfortunate and sad, but that's the reality we face (GP10S).

Due to the presence of large waiting lists GPs often find themselves compelled to navigate and negotiate within the healthcare service to advocate effectively for their patients often resorting to their inter-organisational networks.

> Yes, they often take a long time. Sometimes I have to follow up with a call. I also refer cases of substance abuse. I schedule an appointment, but if the wait is too long, I call to see if they can be seen sooner. In urgent cases, I send them directly to the hospital. If the person is very aggressive, experiencing a psychotic break, or has attempted self-harm, they go straight to the hospital. After that, an appointment is arranged for follow-up at the Mental health centre (GP3S).

Waiting lists for mental health services can have a profound impact on a patient's life, leaving psychological issues unresolved and disrupting daily social and work activities. In response to these gaps, doctors often advise patients to seek urgent care or use personal connections with specialists to expedite the necessary attention. This patient's experience underscores the challenges of not having timely access to specialised services, highlighting the practical consequences of extended waiting times.

> In the end, psychological problems are very long-term because if I stop to think that I've had a problem for twenty years... I've had better times and worse times. Maybe I was without the problem for four months, then I relapsed, then I got up again. Maybe the care right now is every month and a half. The previous time it was like every three months. A consultation every three months, when you're struggling, that gap feels almost meaningless. You go in, share what's happening, and then hear "I can't see you again for three months". What am I supposed to do during those three months? Just continue taking a pill and lie in bed feeling abandoned? (P3S).

In settings where a psychologist is integrated into primary care, the majority of mental health requests are shifted, potentially diminishing the physician's crucial counselling role and their impact on mental health. However, the availability of mental health professionals within health centres ensures quicker access to specialists, effectively reducing the initial waiting times for patients.

> On this occasion my doctor told me that I was going to be referred to the primary care psychologist, and she were going to call me. The next day she called me to give me an appointment (P3S).

> I went to the doctor and explained my problem. He referred me to a psychologist from the start, explaining that psychiatry was too overwhelmed to take on my case. (P2S).

6.5 Discussion and conclusion

In this chapter, quotes from interviews with GPs, patients with mental disorders, and FL supervisors illustrate how institutional and organisational dynamics create mechanisms that influence the daily practice of mental health management in primary care. The findings underscore that while both Italian and Spanish healthcare systems exhibit similarities in challenges related to resource limitations and training deficiencies, differences in GP autonomy and administrative structures lead to distinct approaches in managing mental health. In Italy, the self-employed model grants GPs greater autonomy whereas in Spain, the employment model, restricts flexibility, making the permeability of health services different in the two contexts (Dixon-Woods *et al*., 2006). Permeability refers to how easily or difficult it is for a patient to move from primary care to specialised services, influenced by organisational factors such as referral processes, bureaucratic requirements, and system coordination. The Italian system, with more GP autonomy, tends to allow for smoother transitions, while the Spanish model may impose more barriers. The "discretion as stated" of Spanish and Italian varies with different degrees leaving more opportunity to the implementation of "discretion as used" (Hupe, 2013).

Both models reflect a trade-off between autonomy and support in the context of a health guided profession within a bureaucratic context each with implications for the effectiveness and personalisation of mental health care. For example, while the organisation of health services in both countries facilitates GP autonomy, it is also constrained by supervision that limits their discretion, albeit without the imposition of widespread economic or other significant sanctions.

Moreover, In Spain, where GPs are typically public employees, they work within more rigidly structured systems where administrative tasks are handled by public staff. This system may reduce individual GPs' flexibility to adjust schedules or treatment approaches based on patient needs, potentially leading to a more standardised but less personalised care. This difference highlights a divergence in how healthcare professionals in each country view the balance between autonomy and accountability within their respective healthcare systems. Italian GPs, self-employed, autonomously manage their schedules. This autonomy allows them to potentially offer more tailored care experiences, adapt more quickly to patient needs, and innovate within their practice constraints. Thus, GPs' ability to respond flexibly to patients' needs is tied to the autonomy granted by their employment model.

Access to healthcare is another key difference. In Italy, the process is less bureaucratic, allowing patients to contact their GPs directly by phone during set hours, making it easier for them to present their care needs and navigate primary care services. This direct communication may also facilitate quicker access to specialised care, as patients can reach their GP immediately, potentially speeding up the referral process (Dixon-Woods *et al*., 2006). Despite this, Italian GPs conduct fewer daily visits than their Spanish counterparts.

The heavy reliance on prescriptions, driven by a lack of resources such as time, training, and personnel underscores the consumer-based model of healthcare interactions. This routinisation of care through quick fixes like prescriptions is an example of coping strategies SLBs develop to handle the high workload, as described by Lipsky (2010). This practice also connects to the concept of "candidacy" (Dixon-Woods *et al*., 2006), where GPs, constrained by limited resources, must quickly adjudicate which patients are eligible for certain services. In doing so, they influence patients' access to care, often relying on prescriptions as a simplified solution when more in-depth interventions may be needed. This model fundamentally shapes and routinises the patient-doctor relationship through

the dynamics of service provision and drug consumption. Thus, the universality of the health service in both countries is compromised, relying heavily on the availability of well-trained GPs and whether they have sufficient time to thoroughly engage with mental health cases. The structural scarcity of resources not only limits the treatment options available to GPs but also restricts their ability to engage in more time-intensive, personalised care. This pressure pushes GPs "away" (Gofen *et al*., 2019) from patients, not through a deliberate choice, but as a consequence of organisational constraints that force them to prioritise quick response over personalised care.

In both countries, the normalisation of mental health varies across age groups. Younger patients tend to be more familiar with mental health issues, largely due to increased access to information and a cultural shift towards more open conversations on the topic. This trend possibly has led patients to increasingly seek quick, drug-based solutions for immediate symptom relief, often at the expense of the deeper psychological understanding and treatment needed for holistic healing. This emphasis on immediate, medicalised responses highlights the tension between patients' expectations for rapid service delivery (Lipsky, 2010) and the ideal approach to patient management that GPs aspire to. While patients often expect quick, tangible solutions, such as prescriptions, GPs may prefer a more comprehensive and personalised approach but are constrained by time and resource limitations. The negotiation of best practice between GPs and patients is indeed influenced by this cultural shift, turning what could be a "candidacy to best practice" into more of a "candidacy to drug prescription". In other words, contextual factors shape and impact the agency of GPs (Rice, 2013). As medicalised, quick-fix solutions become the norm, patients are more likely to be assessed for their eligibility for medications rather than for more comprehensive or long-term treatment strategies. This shift prioritises immediate, tangible outcomes over holistic care, further reinforcing the prescription-driven approach. As a typical tool of SLBs, GPs, constrained by limited resources, time, and training, often rely more heavily on a more routinised approach to care, where prescriptions become a default response to high workloads and pressure. On the other hand, patients today are generally more informed and interested in mental health issues than in the past, thanks to the increasing accessibility of information. This greater awareness has the potential to foster more open dialogues between patients and healthcare providers. However, the quality of information patients' access is not always reliable, as online sources vary in accuracy and depth. This can lead to situations where patients come

into consultations with preconceived notions about treatments that may not align with the best medical practices or evidence-based care. While the desire to engage in discussions about mental health is encouraging, it also presents a challenge for GPs who must navigate these conversations while balancing the demands for quick solutions with the need for more comprehensive, long-term care strategies. Therefore, GPs now have to negotiate with a more informed and proactive patient base, which can influence how they adjudicate care and the patient's candidacy for certain treatments.

In both context, rural areas exhibit a strong dependency on GPs due to greater distances and the inconvenience of accessing hospitals and specialists, making GPs crucial reference points for ongoing care. Conversely, in urban settings, patients often bypass their GPs, directly seeking specialists, potentially resulting in missed opportunities for early detection. Both countries highlight the urgent need for a more structured supervisory approach that not only respects and guides clinical decisions but also ensures that care is both effective and economically prudent. Establishing a supervisory system that actively fosters responsibility, rather than simply imposing sanctions, could result in more consistent and higher-quality care across both nations. Furthermore, the "normalisation of medicalisation" plays a significant role in mental health care.

In conclusion, institutional and organisational factors profoundly influence GPs' management of mental disorders to the extent that GPs can offer universal, equitable, and effective mental health care. Addressing these systemic issues is crucial for enhancing mental health outcomes and ensuring that all patients receive the care they need. However, considering their autonomy and clinical independence, GPs, as public employees, have great agentic potential which could be utilised to change and reduce the influence of the macro and meso dynamics presented in this chapter.

CHAPTER 7

GP-PATIENT DYNAMICS AND MANAGEMENT STRATEGY INNOVATION

This chapter explores the discretionary practices and specific strategies employed by GPs in Italy and Spain for the management of patients with mental disorders. It focuses particularly on highlighting how human agency manifests in the daily work of GPs. The overarching aim is to use this analysis to better understand access to specialist services.

Discretionary behaviours are observed concerning how medications are prescribed, how a trustful environment is created, and how the doctor acts as a counsellor for the patient's well-being. This chapter emphasises the discretionary, personal, and potentially transformative management strategies that GPs adopt when dealing with patients suffering from mental disorders. Top-down influences are not entirely excluded, but their definitional force is considered less significant than the agentic power of autonomous decision-making.

The core concept is that these individualised management strategies are not isolated in their effect. They have the potential to generate changes at higher levels of the

health service, influencing both macro-level policies and meso-level organisational practices. The implication is that the personal and discretionary approaches taken by GPs in managing mental health patients could contribute to broader systemic evolution and improvements in healthcare delivery. In addition, it is important to recognise that the ongoing effort is to study the evolving nature of the medical profession at large, with a specific focus on mental health management. This approach not only sheds light on the broader trends within healthcare but also underscores the vital role that GPs play in shaping the future of medical practice and patient care. In summary, this chapter aims to answer the question of which (innovative) strategies GPs employ to manage patients with mental disorders. How do GPs daily address the "human dimensions of situations"? Could these strategies be considered trends that apply to the primary care profession as a whole and not just to mental health management? Are GPs gatekeepers or the health problem solvers of the health service, managing and resolving a vast array of (mental) health conditions?

The chapter is structured as follow. Section 7.1 delves into the discretionary practices in Italy and Spain, with a primary focus on prescription habits and how these are influenced by the age of the patients. Section 7.2 is dedicated to the initiatives taken by GPs in both countries to foster welcoming environments for mental health patients. 7.3 investigates the role of GPs as patient counsellors, emphasising the transition towards a model of collaborative health management. The chapter concludes with the discussion and conclusion. Here the findings and their broader implications are presented, drawing connections between these micro-level changes and potential shifts in the overall healthcare landscape.

7.1 Prescription in practice

This section explores the management strategies used by Italian and Spanish GPs, with particular emphasis on prescription practices and their influence by the patient's age. Specifically, aspects that demonstrate the agency and individual decision-making capabilities of the GPs are highlighted. These strategies reflect the ability to tailor approaches based on personal judgment and the specific needs of individual patients, rather than strictly adhering to overarching variables such as resource limitations, employment status (self-employed or salaried), or established guidelines.

7.1.1 Italy

One fundamental aspect of GPs' strategies in managing patients with mental health disorders is the use of pharmacological interventions. GP9I illustrates a restrained approach, favouring alternative solutions over benzodiazepines unless necessary. This approach is indicative of a broader trend towards sustainable, long-term management options, moving away from dependency-inducing medications.

> Private therapist is expensive, so I try to avoid it. I don't prescribe benzodiazepines to anyone, except for the panic attack. When I diagnose panic attacks, I do prescribe benzodiazepines for the first month in line with the guidelines. However, beyond that, I do not prescribe them to anyone. I use phytotherapy, employing various products derived from valerian, chamomile, and other natural remedies, all properly formulated and not unconventional mixtures. I also encourage people to seek psychological support (GP9I).

An important consideration that often shapes GPs' decision-making, whether explicitly or subconsciously, is the age of the patient when prescribing medication for mental health disorders. Age plays a pivotal role in determining both the type of treatment and its dosage, as it influences factors such as the patient's physiological response to drugs, the risk of side effects, and the prevalence of specific mental health conditions within different age groups. This consideration reflects the nuanced approach required to tailor treatment to the unique needs of each age demographic. To further illustrate the impact of patient age on drug prescription practices, it is essential to understand the distribution of disorders among different age groups. One GP explains the varying prevalence of mental health conditions across ages, setting the stage for a discussion on how these variations influence prescription strategies.

> Anxiety disorders are undoubtedly the most common. Following that, mood disorders, particularly depression, are prevalent, along with a significant proportion of cognitive impairments, such as dementia in the elderly.

> However, the prevalence of these conditions varies by age group. Cognitive disorders in the elderly and anxiety disorders across all age groups are becoming increasingly common. Among younger individuals, anxiety disorders are more dominant, with depression being less prominent, though still present. In contrast, within older populations, both anxiety and depressive disorders are prevalent, alongside a growing incidence of cognitive impairments (GP8I).

The management of younger patients by GPs frequently involves a proactive, investigatory approach. Positioned at the frontline of public service, GPs can tailor their services to meet individual needs during direct interactions. In this role, GPs function as "sentinels on the ground" with the potential to identify early signs of mental distress and potential substance abuse among the youth. GP4I highlights this strategy, emphasising the importance of early detection and tailored intervention to address the specific challenges faced by younger patients.

> As "sentinels on the ground" we can often detect early signs by asking simple, everyday questions, even about something as routine as school. I always make a point of asking children how they're doing, as this can reveal subtle indicators of potential issues, such as the early stages of substance abuse or other concerning behaviours (GP4I).

Building on the proactive approach that GPs take with younger patients, the emphasis on fostering real-world connections and addressing relationship issues becomes dominant. One GP describes his strategy in managing a case involving a young girl with significant relationship problems. This approach underscores the importance of regular consultations and encouraging social engagement to help patients regain balance and improve their mental health.

> She is a fifteen-year-old girl with no physical health issues, but she faces significant relationship challenges. Her main struggle is her relationship with

> technology, she has unfortunately chosen to immerse herself in virtual reality, as her real-life experiences were too painful for her. Now, I ask her to check in with me once a month to discuss her progress. The goal is to see if she can begin to rebuild human connections, starting with simple things like going out for ice cream with friends (GP4I).

In contrast, older patients, who may have been on long-term medication regimes, often find it challenging to transition away from drugs like benzodiazepines. This difficulty highlights how GPs manage older patients' medication dependencies.

> In the cases of people in their eighties who have been taking them for 40, unfortunately, it is difficult to take them off (GP3I).

Furthermore, the issue is compounded by the lack of control over medication distribution, as some patients may obtain benzodiazepines from pharmacists without prescriptions. This lack of oversight requires GPs to use their discretion and judgment in addressing dependency and monitoring actual usage.

> I can't always keep track of their usage because I suspect pharmacists sometimes provide the medication, even without a prescription. This makes it hard to gauge how much they're actually using. I'll tell you, some people, especially older patients, were prescribed benzodiazepines far more easily in the past. They often say - But doctor, I've been taking them for twenty years - It's extremely challenging to wean them off. In some cases, I've tried, but the psychological dependence is strong, making it quite difficult to stop their use entirely (GP7I).

In managing the dependency on benzodiazepines, GPs must exercise significant discretion, particularly when considering the patient's age. The challenges and strategies involved in this process reflect the need for a tailored approach to different age groups. One GP elaborates on these complexities, discussing both the long-term risks associated

with benzodiazepine use and the proactive measures taken to address dependency in younger patients, which differ significantly from those used for older patients.

> Unfortunately, over the past twenty years, there has been a harmful trend of prescribing benzodiazepines to older adults, to the point where their receptors have become so accustomed to the drug that it's nearly impossible to discontinue its use. In younger patients who have started using benzodiazepines, I do my best to help them stop, often referring them to the Drug Addiction Service. It's impossible to wean someone off benzodiazepines without a gradual and careful approach. The first major issue is addiction. The second is that long-term use of benzodiazepines has been shown to severely impact cognitive function. In older adults, it increases the risk of falls, which in turn raises the risk of death. In my opinion, these drugs should be removed from the market, as they serve little purpose beyond short-term sedation and managing anxiety for the first month of treatment. The guidelines are clear, they are not meant for use beyond one month, yet this is often ignored. If the law were strictly enforced, we would all be held accountable, as someone on benzodiazepines shouldn't even be driving (GP9I).

The following testimony summarises these differences in management, extending the discussion from medication prescriptions to the type of treatment recommended to patients. Proactive management strategies are employed to engage with the community, particularly younger populations, to prevent issues like substance abuse. This testimony highlights the difference in approach between managing mental health problems in younger and older patients.

> So obviously it depends a bit on the age of the patient. I kind of have an age limit of say up to 60/65 my first approach, it's a psychotherapeutic approach. First, I've always had very positive feedback from colleagues whom I rely on and whom I recommend to patients. Following the psychotherapeutic approach there can also be a pharmacological one, but always in agreement.

> Here I work with two or three psychotherapists whom I trust and with whom I always interface every time I send a patient. Obviously, if I have a seventy-year-old with sadness, with depression, it's honestly more likely that I can then start with the medication, because in any case, in short, psychotherapy is possible, but it would be a bit too much to put it on the table (GP6I).

In conclusion, within the Italian case, the role of GPs as cautious prescribers reflects a significant shift towards prioritising non-pharmacological interventions and carefully managing drug use, particularly with potentially dependency-inducing medications like benzodiazepines. This careful approach is part of a broader strategy to offer sustainable, long-term health solutions that align with individual patient needs and public health goals. By favouring alternative treatments to drug consumption, GPs not only address the immediate symptoms of disorders but also work to minimise future dependencies and complications. Moreover, the distinct strategies adopted for different age groups, ranging from proactive psychosocial interventions for younger patients to more managed pharmacological approaches for older ones, illustrate a tailored method that respects the complex dynamics of mental health across the lifespan. This approach ultimately supports a more holistic, responsive healthcare service, reinforcing the critical role of GPs in navigating the challenges of mental health management within diverse populations.

7.1.2 Spain

The initial consultations in mental health settings are particularly delicate. Doctors generally avoid making drastic decisions during the first meeting unless the situation is urgent. This cautious approach allows for a better assessment of the patient's condition and avoids premature pharmacological interventions. Over time, many doctors find that their perspectives shift from a strong emphasis on medication to a more holistic view that considers the social determinants of health.

> What I normally do is not to make drastic decisions at the first appointment, except in extreme situations. We are talking about a spectrum that goes from a suicide attempt to a delusional state to a situation of psychological distress (GP2S).

As in the case of Italian GPs, Spanish GPs also report several testimonies on drug prescription. Prescribing drugs represents a core aspect of the work for many GPs and is a recurrent theme. It seems that experience modulates prescription habits significantly. Reflecting on this shift in approach, one Spanish GP remarked.

> I used to be much more *pro-pharma*, but now I look much more at the social determinants of disease and I have become more sceptical about many medical interventions (GP7S).

The management strategies of GPs often vary according to the patient's age, which significantly influences both the approach to treatment and the likely outcomes of medical interventions. In the context of mental health, the impact of medication can differ markedly between older and younger populations. Older patients may face increased risks such as falls and confusion due to drug interactions, while younger patients might be misled by the misconception of a "happy pill" that solves all problems.

> In older adults, we are contributing to a higher incidence of falls and confusion, often caused by drug interactions. Among younger people, we are perpetuating the false belief that a "happy pill" exists, something that can magically make decisions for them, when in reality, personal responsibility remains essential. For instance, if someone has trouble sleeping, especially at 60, it's unrealistic to expect to sleep for ten hours as they might have at a younger age. The growing trend of over medicalisation is problematic; by over-relying on medications, we are causing more harm than good. This is the unfortunate reality of current practices (GP7S).

Older individuals often have long-standing prescriptions that are so deeply embedded in their daily routines that making changes becomes particularly challenging. Benzodiazepines, frequently prescribed as hypnotics to aid with sleep, are a prime example. Many older patients develop a dependence on these medications, making them

an integral part of their everyday lives. Addressing long-term medications in older patients presents unique challenges, as these drugs become difficult to adjust or discontinue. This complexity arises mainly from the patients' reliance on the medication and its normalisation within their daily routines. The GP highlights the difficulties in negotiating medication reductions, particularly with patients who may not even recognise or acknowledge the potential harm caused by such dependencies.

> Of course, there are many patients in the practice, especially older patients, who use benzodiazepines as hypnotics for sleep. In those cases, they are already integrated in them. It is quite difficult, even if you try to make negotiations or attempts at reductions. It becomes particularly challenging to discontinue these medications when neither the patient nor their family perceives them as a problem, which is often the case. Without this recognition, it is rare to successfully remove such drugs from a patient's prescription. The lack of perceived harm makes it difficult to introduce change, even when the long-term use of these medications may pose significant risks (GP4S).

Managing prescriptions, particularly for older patients, involves a complex balance between advocating for medical interventions and promoting substantive lifestyle changes. The tendency for patients to favour immediate, pharmacological solutions over the potentially more beneficial, but challenging, lifestyle adjustments is a critical element of clinical practice. As populations continue to age, the number of older individuals dependent on medications is expected to increase, significantly impacting how GPs manage these conditions. This demographic shift calls for a critical reassessment of whether medication should always be the primary solution. It requires careful consideration of the long-term consequences of such dependency and the exploration of alternative strategies that may prove more effective and sustainable in addressing the health needs of older patients. This GP highlights a resigned acceptance of this scenario.

> Is it true that too many drugs are used? Yes. Often, instead of relying on a tranquilliser, it would be better to address the underlying issues, perhaps by

> making lifestyle changes to reduce stress. However, many people, particularly older individuals, are reluctant to take that route and prefer the convenience of taking a pill instead (GP5S).

When encountering patients who are taking high doses of benzodiazepines or using multiple medications that can lead to dependency, GPs play a crucial role in identifying the need for specialised care.

> Specialised treatment centres for dependency also manage cases involving benzodiazepine addiction. If patients are particularly complex, such as those taking high doses or multiple benzodiazepines, GPs can refer them to these centres for detoxification. These facilities are equipped to handle the intricate process of safely managing withdrawal and supporting recovery for those with severe benzodiazepine dependence (GP4S).

Considerations around the escalation of pharmacological treatments play a significant role in the decision to refer patients to specialised mental health services. Many GPs exercise caution with referrals, as there is a concern that such a step may lead to an inevitable increase in medication, often resulting in treatments that become difficult for them to manage or adjust later on. This apprehension stems from the fact that once a patient enters specialised care, GPs may have less control over the prescribed treatment plans, which can complicate ongoing management and holistic care. This concern is not just about the volume of drugs prescribed but also about losing control over the patient's treatment plan, as adjustments by other specialists might not align with the initial conservative approach favoured by the GP.

> Psychiatrists here give out drugs to death. One of the reasons why I try not to refer is because they give them so many medications, they always give the latest of the latest. When I think there are very good medications. It is not necessary to try the latest all the time (GP3S).

> If I refer to mental health services, there is going to be a drug. And my perception is that there will be more drugs than if I don't refer. Normally I don't refer precisely to contain the prescription, because from then on I don't control it. When the psychiatrist gives a drug or a combination of two or three drugs, I lose some power to modify it. Because up there is going to be a colleague who is not going to like it, I think. So, in this sense, I prefer not to refer. Whenever possible, of course (GP2S).

This apprehension is heightened by conflicts over medication management, where GPs frequently encounter resistance from both patients and specialists. For example, when GPs suggest adjusting dosages due to potential side effects, patients may resist these changes, deferring instead to the authority of their psychiatrists.

> - Let's try to cut down on this pill because I think it's making you sick. You stumbled the other day and fell down. I think it's this pill - Oh no, the psychiatrist, gave it to me. I have to wait for the visit with him - This happens to me sometimes. Most of the time, as they are patients who have known me all their lives, my judgement prevails (GP2S).

In conclusion, the initial consultations in mental health settings highlight the discretionary strategies that GPs often adopt to carefully navigate treatment options. GPs play a pivotal role in deciding whether to initiate pharmacological interventions, and their experience significantly shapes their approach, with many becoming increasingly sceptical of over-medicalisation. These strategies are particularly evident when managing older patients, where GPs must balance the complexities of long-term medication dependencies with advocating for lifestyle changes. The tendency to prioritise pharmacological solutions over non-medical alternatives remains a persistent issue, but GPs use their discretion to weigh the benefits and risks of such treatments carefully. Spanish GPs, in particular, demonstrate strategic caution with referrals to specialised mental health services. Many fear that these referrals may lead to an escalation in medication, which they will no longer be able to manage or adjust. This discretion in treatment decisions underscores the importance of a personalised, balanced approach,

where GPs consciously decide between medical and non-medical interventions, ensuring that patient care remains holistic and avoids unnecessary over-reliance on medication.

7.2 Building a welcoming environment for patients

This section includes quotes from interviews that highlight the importance of fostering a welcoming environment in the relationship between GPs and patients. Emphasis is placed on factors such as communication style, the significance of language, and, in the Italian context, the necessity of providing practical information on how to contact the physician. These elements contribute to cultivating a positive and supportive relationship. The interviews suggest that GPs' strategies often centre on patient care, even in cases of serious disorders, by utilising available community resources and facilitating access to specialised services.

7.2.1 Italy

Trust and responsibility

Trust is the cornerstone of any therapeutic relationship, especially in managing mental disorders where patient adherence to treatment plans is critical. GPs often assess and consciously work on building trust from the initial interaction. In instances where trust is lacking, GPs may take decisive actions, such as encouraging a patient to seek a different doctor, to ensure the patient's well-being and the integrity of care.

> The most important factor is the patient's trust in the doctor. Without it, I believe it is in the patient's best interest to step aside. In such cases, I remove the patient from my list and encourage them to find a new doctor. Of course, I don't immediately resort to this. I discuss it with the patient first, saying something like - I've noticed this lack of trust. For your wellbeing, I encourage you to seek out a doctor you feel comfortable with, as clearly, that isn't me - (GP5I).

The relationship between doctors and patients can often be complex. Doctors must navigate these relationships delicately to avoid damaging trust, particularly in sensitive

areas like weight management in patients with eating disorders. This delicate balance is crucial, as establishing a strong doctor-patient relationship is often the first step in effective treatment. One doctor shared his experience, highlighting the importance of relationship-building in managing such conditions.

> So, I was afraid of ruining the relationship, even before it started. Slowly I paid attention when she came about the weight, but unfortunately, they are pathologies in which it is very difficult, they have no consciousness of the disease. So, I realise that establishing a relationship is important. You establish a relationship with the patient, but it only holds until the conversation turns to discussing the actual condition. I explained to her that addressing the pathology is not the complete solution, and that she needs to begin treatment for it. However, she only contacts me when she's in the midst of a crisis (GP3I).

Trust is not merely a professional courtesy but a crucial element that significantly influences the outcomes of treatment. Particularly for patients grappling with mental health disorders, trusting in the GP assumes an even greater importance due to their vulnerability. The dynamics of this relationship are deeply affected by the physical presence of both parties; an element largely compromised during the COVID-19 pandemic. As isolation became a norm, many patients found themselves navigating their health crises alone, without the reassuring presence of their GP. This situation often exacerbated their conditions, underscoring the profound impact of physical isolation on mental health.

> The patient, while trusting their doctor to an extent, following advice like "Do this, do that", is still often fearful. This fear stems from the nature of their condition and the overwhelming amount of information coming from external sources. During the COVID period, particularly when they were infected, many patients found themselves isolated and dealing with this fear alone (GP6I).

A patient, currently receiving treatment for depression, reflects on how her doctor supported her through a period of severe personal loss, emphasising the vital role of empathy and understanding in building trust. The patient describes feeling a deep sense of comfort and a strong preference for her GP, who combines professional competence with a welcoming and familiar approach. This testimony highlights the importance of not only medical expertise but also the essential human connection that creates a safer, more trusting environment for patients facing mental health challenges.

> In that situation, we truly had the best of all worlds, a doctor who is competent, kind, and welcoming. When someone is unwell or struggling, a lack of trust in the doctor can be particularly difficult. The family doctor is usually very attentive and maintains a familiar, approachable attitude, which is so important. With the last psychologists I saw, I didn't feel comfortable; I had lost confidence in them. I had more trust in my GP on a general level than I did in the psychologists (P5I).

Communication styles and patient engagement

To foster trust, GPs must create an environment that encourages open communication, allowing patients to express their concerns and symptoms without hesitation. This openness is especially critical in mental health cases, where patients may feel particularly vulnerable when discussing their struggles. By promoting a dialogue-oriented approach, GPs can establish rapport and gain a deeper understanding of their patients' emotional and psychological states. Adapting communication strategies to meet the individual needs of patients is key to building trust and understanding. Italian GPs highlight the importance of tailoring their approach based on the educational and emotional backgrounds of their patients. This adaptability strengthens the therapeutic relationship, ensuring that care is aligned with the patient's unique circumstances and promoting a more effective, trusting interaction between doctor and patient.

> It is up to the doctor to find the most effective channel of communication with each patient. Sometimes, I use humour or casual language, and I see their eyes light up, they smile, and a sense of trust is established. They feel understood

> and welcomed. It might sound odd, but that's how it works. On the other hand, some patients, perhaps more educated or erudite, prefer a more formal approach, with the use of technical terms, as it inspires confidence by demonstrating a higher level of scientific knowledge. So, you have to observe and adapt, but it doesn't take much. In my experience, when patients speak for just five minutes, you can quickly get a sense of how best to interact with them and build that crucial rapport (GP5I).

> It is also to give oneself the possibility to say precisely that it is an open relationship where people can say a little what they want, in general, about their health. So also open to the possibility that people can talk a little bit about all their health needs. Not only the purely biomedical ones (GP1I).

> If, however, you are already by nature inclined to dialogue, you like to talk, you like to get inside people a bit. Then people really feel free to speak. For me that is a satisfaction (GP6I).

Trust is crucial for facilitating open communication and expression, especially in the effective treatment of disorders with less visible symptoms. Such disorders often manifest somatically, with physical symptoms that stem from psychological distress. An example involves a patient suffering from psychosomatic symptoms linked to a gambling addiction, as shared during the narrative part of an interview. After initially recounting his history, further questions helped elicit more detailed insights. This case highlights how frequently such conditions are overlooked, illustrating the challenges in identifying and addressing psychological distress that manifests physically. It also emphasises the importance of a trusting relationship between patient and practitioner, which can lead to more accurate diagnoses and improved management of underlying issues.

> I also have certificates. I even went to the hospital. Because my eyes were burning, they felt like pins. Then my stomach felt like I was dying. It felt very strange and I went to the hospital because I couldn't get it out, but it was just

> psychosomatic. The doctor didn't know anything. She got to know about it when I had depressions, big depressions, and I was going downhill a lot (P10I).

Essentially, if a patient does not disclose his issues, they remain unknown. This testimony underscores that management strategies hinge not only on the doctor's expertise but also on the quality of the relationship between doctor and patient. This is especially pertinent in cases of addiction, where patients often hide their struggles due to prevailing taboos around mental health and substance abuse. In this context, the patient further explains why he was reluctant to discuss his problems.

> Addictions are something you tend to hide, often out of shame. When you cross the line into dependency, you're aware that what you're doing is wrong, so you do everything possible to keep it hidden. Like most addicts, I concealed it from my family, my GP, and everyone around me. In my case, psychosomatic symptoms eventually started to show, gastritis, night-time vomiting, and a range of other issues. Unfortunately, because there's such a lack of awareness around mental health, you end up undergoing countless physical tests, stomach, head, and more, only to find no explanation. You're left thinking -What could it be? - Eventually, I realised it was a mental health issue, and once I addressed that, the physical symptoms diminished as well (P10I).

Expertise in communication is crucial, but it must be paired with medical knowledge to truly enhance patient care. In mental health treatment, the combination of empathy and expertise is essential, allowing patients to feel both understood on a personal level and reassured by the competence of their care. This balanced approach fosters trust and ensures that the patient feels supported, both emotionally and medically.

> I think the human side is the key part. I don't have a broken leg, so I need a slightly more pleasant human impact. But it's not enough to have a more

> human doctor who cuddles you. You also need the more professional part for sure. They have to go together, otherwise, it doesn't work (P10I).

The integration of communication skills with medical expertise is not only about enhancing patient comfort but also about ensuring that vital information is shared accurately and completely. This exchange of information is crucial for effective treatment planning and safety, particularly in managing conditions that carry a stigma, such as psychiatric problems. GPs are often limited to only the information that patients choose to disclose, highlighting the critical need for fostering a trusting environment where patients feel safe to share all relevant health details

> Unfortunately, I have patients who have never told me about psychiatric problems, out of shame, for a whole range of things. There is often no communication, even with specialists from public health services, not just private practitioners. As a result, if patients don't inform me about the medications they are taking, that information completely slips through the cracks, leaving me unaware of crucial aspects of their treatment (GP4I).

For this patient, with a long history of psychiatric disorder and living in a co-house, the qualities she values most in her caregivers and GP are deeply personal. She articulates her needs clearly, prioritising the human connection and expressing a strong preference for caregivers who demonstrate genuine concern, kindness, and a willingness to engage with her. These traits are not merely preferences but are essential components of the therapeutic relationship, allowing her to feel safe, understood, and supported in her care.

> What matters most to me is someone who takes me to heart a bit more. I am a very fragile person, having always been with my parents. The important things? Humanity, kindness, and availability. Someone who genuinely shows interest (P1I).

Effective communication in healthcare goes beyond simple exchanges of information. It requires a thoughtful approach to language that aligns with the patient's emotional and psychological state. GPs often adopt strategic language choices to foster a connection and encourage engagement with their patients. This is particularly important when discussing sensitive topics like mental health, where direct references can sometimes be counterproductive.

> I don't like to use the word "depression". I never use it because when you're dealing with the patient and you want to make him understand something, if you use that word there, you've already almost missed it. If, however, you give him some examples, on an up and down, of mood movement, then you can (GP6I).

Another GP discusses the necessity of maintaining a professional boundary that fosters respect while still being approachable, particularly important when personal characteristics such as age or appearance might affect the patient's perception of authority and expertise.

> I certainly learned to trust less, and to keep a bit more detachment. Because I have a different character, but it takes a bit to make it clear that I am the doctor. Then you laugh and joke, but you need respect. Because if not, they see me as a young woman, I look even younger than my age, and it becomes problematic (GP4I).

Tailoring communication to patient understanding

Understanding the diverse backgrounds of patients is essential for tailoring communication and treatment strategies. GPs typically start their interactions with new patients by collecting detailed personal information, such as their profession and social circumstances. This GP describes the approach taken during initial consultations. Building this foundational knowledge from the start greatly improves the GP's

understanding of the patient's overall health, which is especially important in managing mental health conditions effectively.

> For example, during our initial fact-finding visit, I often find myself actively asking about the patient's profession. I inquire about what kind of work they do, if they engage in sports, and other questions that aren't typically asked by doctors. Sometimes, patients react with a bit of suspicion, so I explain to them that many factors, such as their job or even their home life, can influence their health. This broader approach helps me gain a more comprehensive understanding of their overall well-being (GP10I).

In managing mental health conditions, clear and inclusive communication is paramount. GPs often adapt their communicative style to meet the diverse needs of their patients, including those who may not be fluent in the local language or familiar with medical terminology. This is especially critical in settings with a not stabilised population, such as migrants, who face additional barriers in accessing healthcare. This approach not only facilitates better understanding and compliance with treatment plans but also plays a crucial role in building trust and rapport. A GP describes the necessity of simplifying language to ensure that all patients receive the care they need, regardless of language proficiency or cultural background.

> Half of my patients, who are very few, however, are temporary. So, there are people who tend to move and most of them are migrants. Foreigners who speak little Italian. It is often essential that I keep the language as non-technical as possible and sometimes there is a real need for cultural language mediation (GP10I).

When examining the accessibility of medical communication, it is crucial to consider the patient's perspective, particularly for those with severe mental health conditions who rely on clear and understandable information. Two patients share their thoughts on how they would feel if a doctor regularly used complex, technical language.

Their responses highlight the importance of simplicity and clarity in healthcare communication. The first patient describes feeling discomfort when confronted with medical jargon, which could lead to misunderstandings and anxiety during consultations. The second patient takes this concern further, expressing a willingness to seek another doctor if faced with incomprehensible language. This underscores that the primary goal of medical communication is not to demonstrate expertise but to ensure understanding and effective care.

> But a little uncomfortable if he used difficult words that I could not understand (P6I).

> I would go straight to the district and find a different doctor because I don’t think that’s the right approach. Even if I work at a hospital, I don’t visit the doctor to have grammar lessons. The goal is to communicate as clearly and simply as possible, regardless of whether the patient is a university graduate or a grandparent (P4I).

A patient with a severe mental condition, residing in a co-house with other patients, reflects on the elements that foster his trust in his GP. His testimony highlights the significant impact of clear and reassuring communication in building confidence between patient and doctor.

> How he explained things to me. He gave me confidence. I never doubted (P6I).

Operational transparency

The need for communication about operational procedures among Italian GPs is largely shaped by the fact that they are self-employed, which plays a key role in how they choose to engage with patients. This disclosure is not merely a consequence of their autonomy; rather, it is a strategic decision aimed at fostering patient trust. While not all

self-employed doctors adopt this approach, those who do believe it enhances the trust essential for effectively managing mental health issues. The decision by some Italian GPs to invest time in explaining their processes helps patients understand how to communicate more effectively with their doctor, establishing a supportive alliance and a professional contract that improves the overall healthcare experience. By integrating transparency into their practice, these GPs not only clarify their working methods but also offer reassurance, promoting a sense of security and partnership in the patient-doctor relationship. The next GP highlights the importance of clarity in explaining how his practice is organised, ensuring that patients understand exactly how to engage with the services provided. This transparency helps to establish clear expectations, fostering a more effective and trusting relationship between the GP and the patient.

> The organisation of the practice itself must be clearly explained to the patient. Since each GP operates in its own way, this being the challenge of self-employment, it's essential that patients know how to approach their doctor. They need to understand when to call, the surgery hours, how to arrange blood tests, whether they need to book an appointment, or if they should send results via email. Clear communication about these details is crucial, and patients must have accessible means to contact their GP. I believe that's the key to fostering an effective and smooth patient-GP relationship (GP7I).

Next patient, diagnosed with borderline personality disorder and experiencing violent manic episodes, emphasises the importance of his doctor's availability, which provides him with a sense of security, essential for managing his condition. Despite the GP's initial uncertainty, the patient chose to stay under his care, while the doctor, acknowledging his limitations, recommended a psychiatrist and remained accessible. Over time, medication helped stabilise the patient, who expressed satisfaction with the treatment.

> I have to say he is doing well. I'm honest, I'm comfortable because it's a good relationship. You can call him, he's very helpful. If you have to talk to him, you talk to him even in the morning I mean, leave him a message or not. So,

> he is very helpful with us patients. That I think is an important thing… What makes me feel better is this, that you can still call him, or even ask him, even to make a certificate at work to give me a few sick days. For me that's good. Because if it had been another doctor, it would have posed problems. It would have been more problematic, in my opinion (P3I).

In conclusion, this section underscores the critical importance of trust and effective communication in the GP-patient relationship focusing on the Italian case. Operational transparency is emphasised as essential for fostering trust and engagement. Testimonials from GPs and patients illustrate the challenges of treating sensitive conditions and the crucial role of empathy in healthcare. Overall, the narrative reveals how a balance of professional expertise and compassionate care is vital for successful mental health management

7.2.2 Spain

Trust and responsibility

As demonstrated in the Italian case, trust in a doctor can reveal hidden issues that might otherwise remain undisclosed. This GP notes that while some patients may struggle to open up, the root issue often lies in a lack of confidence. He encapsulates the various challenges reliant on GP management, underscoring their critical role in both general health and mental health management. Specifically, mental health presents unique challenges. For instance, without real communication about their feelings, patients might only receive treatment for the physical symptoms of a psychological disorder, rather than addressing the underlying issues.

> First of all, the trust a patient has in me is crucial. A patient who trusts me is more likely to open up and share everything. When it comes to personality, patients who are more inhibited, often due to general communication limitations, prejudices, or specific beliefs, tend to struggle with opening up. This lack of confidence can make it difficult for them to communicate effectively. Individuals from other cultures or deep rural areas, where there

> may be less openness about personal matters, often find it particularly challenging to share. These factors can significantly influence the patient's ability to engage. As a doctor, it's essential to know how to help these patients feel comfortable and encourage them to open up (GP3S).

This patient, with a history of violence and depression, states about the therapeutic relationship with her GP. This quote highlights how a supportive and attentive doctor can significantly impact a patient's feeling of security and their ongoing trust in medical professionals.

> We've always had a very good relationship. I'm not sure if it's because I enjoy talking and she's a good listener, but from my experience with my family, I believe it's incredibly important for a doctor to listen to you. Sometimes, you convey more through words than through symptoms or gestures. This gave me a great sense of security, and it made me decide to stay with her rather than look for another doctor (P4S).

The patient reports her GP's proactive management strategy, which centres on consistent follow-ups and open lines of communication. This approach underscores the GP's active role in the patient's care, ensuring that she feels supported throughout her treatment journey.

> From time to time, she checks in on me. She calls to ask how I'm doing and always says - If you ever need anything regarding this, just call me and we'll talk about it - She keeps an eye on my routine check-ups with mental health services and sees that I'm doing well in my consultations. For me, that's the best kind of support (P4S).

The next patient, who has a significant history in psychiatry, shares his experiences about being referred to mental health services. He highlights his GP's strong commitment to his health and the genuine interest he took in the progression of his clinical condition.

This attentive involvement reassures him, reinforcing the sense of trust and care in their relationship.

> No, I requested it as an emergency because I couldn't cope anymore. My doctor supported me and even encouraged me to go. When they call me with the results of my exams, he always follows up and asks about them. Right now, I'm very happy with him, and I feel the same about the health centre and mental health services. They take excellent care of me, and I'm doing very well (P9S).

The previous patient testimony highlights a GP's commitment and proactive involvement in monitoring and supporting a patient's mental health journey, demonstrating a personalised and attentive approach to care. This is possibly a modern practice that contrasts with the traditional, more hierarchical model discussed in the next quote. Indeed, the next GP reflects on the generational changes that have transformed these traditional structures. He describes how younger doctors have intentionally moved away from the formal and authoritative modes of interaction.

> That figure no longer exists. It has been lost for many reasons. We, the young people, broke with the archaic structures. We were breaking these moulds of dealings. They used to call you "*Don*" and you would say - No no, call me by my name - I mean, we also broke away, it's true. And this authority no longer exists. We don't have it, nor do we want it. I think that what you can ask for, in any place, is respect and education (GP6S).

The quote underscores how GPs' management strategies for patients with mental disorders potentially reshape cultural views of their role. Patients and society, in general, have moved away from the traditional model of subordination, but this transformation occurred in GPs' daily consultations, where they choose between maintaining traditional authority or adopting a more egalitarian approach, such as being addressed informally, reflecting a shift toward relationships based on mutual respect.

Continuing the discussion on the discretionary practices GPs employ to build a clinically effective relationship, trust remains a central pillar in the doctor-patient dynamic, shaping both interactions and management decisions. However, these dynamics often become more complex when a GP is required to reassess a patient's ongoing requests. This testimony, drawn from the storytelling section of the interview, illuminates the challenges of treating patients holistically, focusing not only on their medical needs but also considering the broader context of their lives. This approach underscores the delicate balance GPs must strike between medical care and a deeper understanding of the patient's personal and social circumstances.

> A young pregnant woman came in after her company attempted to relocate her to another city. She refused, citing her pregnancy, which appeared to escalate into a labour dispute. Clearly anxious and facing a conflict-ridden situation, likely involving workplace harassment, she was under significant stress. I signed her off work to help address the situation, as medication wasn't an option at the time due to her pregnancy. Later, I signed her off work again and prescribed an anxiolytic, while also recommending she see a primary care psychologist. She agreed, saying it was a good idea and had already planned to go. She is very anxious and struggling to manage, so I'm hopeful the psychologist can provide her with relaxation techniques and guidance to help her cope (GP1S).

This GP reflects on the challenging aspects of managing prolonged sick leave requests, which can sometimes raise doubts about their authenticity. The dilemma is not uncommon in medical practice, as balancing the genuine needs of patients with the potential for misuse of sick leave can be difficult. GPs must navigate this grey area carefully, ensuring both the patient's well-being and the integrity of the medical process are maintained.

> Sometimes, I face this dilemma with her and with others. With certain types of sick leave, for specific reasons and over extended periods, I begin to question whether the leave might be used to avoid certain issues. Yes, these

> thoughts do cross my mind, but I also wonder if I'm mistaken. These are situations of uncertainty, where it's difficult to know whether to take a balanced approach, approve the leave and move on, or reconsider the decision. It's a complex and challenging situation (GP2S).

Considering these quotes, trust emerges as a crucial factor that enables GPs to effectively manage patients with mental disorders. However, this trust is also highly fragile. Any doubts regarding the authenticity of a patient's claims can severely undermine the relationship, complicating the treatment process. The delicate balance between trust and suspicion highlights the challenges GPs face in navigating patient care, particularly in situations where mental health issues are involved.

Communication styles and patient engagement

Trust between a GP and a patient is often built through effective communication. While technical language may be precise, experience teaches doctors that it's not always the best way to establish a confidential and trusting connection with patients. Instead, adapting language to be more approachable and relatable can foster understanding and create a stronger bond. Over time, GPs learn that clarity, empathy, and a personalised approach to communication are key to building and maintaining trust with their patients.

> Experience also gives you a little bit of that. At the beginning, it tends to be more technical because you think that... but I think that to reach the patient, to transmit the information, it is better to use more colloquial language so that the patient understands (GP8S).

The shift toward a more colloquial language is not only a change in communication style but also a part of broader, more empathetic patient care. This approach can profoundly impact patient outcomes, as demonstrated by this patient's experience.

> What helped me a lot was the medication, talking to the psychologist, and my GP, who has been incredibly patient. The psychologist does her job well, but the GP often goes beyond what's expected of him. Honestly, they're both very good. My GP listens because he takes the time and is always available. Depending on how I look when I walk in, he'll already say - Don't cry, just hold it in - but he still lets me talk it out. He's great, very, very good with me (P2S).

This GP further elaborates on the practical aspects of facilitating good communication, emphasising the nuances that enhance the doctor-patient relationship, particularly for patients with mental disorders. This quote vividly illustrates the impact of communication style, showing how a warm and attentive approach can fundamentally influence the therapeutic relationship and patient outcomes.

> Communication style is fundamental. It's about conveying to the other person that you genuinely care about them. When you open the door, you greet them warmly, with a smile, even on a bad day. You show that you're there to listen and understand their problem, or at the very least, help guide them to someone who can. But in every case, the goal is to address the issue. If the patient feels that you truly care and are interested in what they're sharing, I believe that's the most important thing (GP2S).

As this patient confirms, the quality of the relationship with their GP significantly influences the disposition to communicate openly. The patient emphasises the role of trust and personal connection in their interactions.

> If you have more confidence with him, you tell him more things than if you don't. So, I think that, yes, closeness also does a lot, and the fact that he's nice also does (P6S).

In some cases, when psychological suffering becomes chronic, listening and a warm welcome are the only management strategies left to the GP. The therapeutic engagement extends beyond mere medical intervention, involving regular and meaningful interaction that supports the patient's mental and emotional well-being.

> I see him every three weeks. The consultation now takes me twenty minutes, we always talk about the same thing. This block he has, that he is not able to incapacitate the mother, to become the legal guardian. He knows it, he recognises it, but he is not able to make that decision. Well, my therapeutic framework is to leave the door open and to see him every three weeks and to listen to him (GP7S).

However, sometimes communication becomes unviable, and the demands of the GP and patient differ, leading to a mismatch in their ability to communicate effectively. The impossibility of communication is a common outcome in human relationships when complicity is absent. This could negatively impact the patient's mental health. In such cases, the GP might need to close the relationship by offering a referral to a specialist, as illustrated by this GP, or to another primary care physician, as seen in the Italian GP's case mentioned earlier.

> If it's a question about a health problem that I don't know about, I'll see them a week later and I'll study it. There are interviews that you don't know why, the conversation seems to be in two different languages. It's a bit of an absurd conversation and you know that when you don't establish the complicity that there has to be in an interview or when you see that communication is not bidirectional, I refer them to mental health (GP7S).

As this GP delves deeper into the complexities of managing patients with special requests or psychological situations, he highlights how these factors can sometimes lead to a breakdown in the relationship. Effective communication does not always depend solely on the actions of the GPs, whether they choose to act or not.

> It is not always the doctor's responsibility alone to create an environment of trust. Various circumstances can hinder effective communication, especially when a patient is not in the right mindset to listen. Patients may come in with a fixed idea, high levels of anxiety, or even frustration, which can complicate the interaction. For instance, aggressive patients or those in a bad mood due to difficulties in accessing the consultation, long waiting times, or a previous negative experience where they feel the doctor made a mistake, can make building trust more challenging. These factors can significantly affect the doctor-patient relationship (GP5S).

Tailoring communication to patient understanding

Trust is a fundamental objective in GP management, developed through a combination of factors, with effective communication being central. The previous quotes reflect the interviewees' insights on the significance of trust. This section explores how communication is continuously adapted by and for those involved in the relationship. Tailoring communication to align with each patient's educational and cognitive levels not only enhances understanding but also shows respect and consideration for their background. One key element of this tailored communication is the patient's age, which plays a significant role in shaping the language and approach used. This GP underscores the importance of adjusting language according to the patient's age and comprehension level, ensuring that communication remains both effective and respectful.

> According to the patient. If they are more knowledgeable, you can discuss things with them using more specific, specialised terms. For other patients who might not understand as much, I adapt more to what they can grasp. Age also plays a role. Communication is very different with a teenager compared to someone in their thirties or someone who is ninety (GP3S).

In rural areas, where the academic background of patients is often not very high, GPs must carefully tailor their communication adapting their language to suit the

characteristics of the community they serve, particularly considering the added factor of patients experiencing psychological distress. This approach focuses on ensuring effective communication rather than paternalism. By simplifying language, the GP aims to improve understanding and care, respecting the patient's ability to participate in their health decisions. It empowers patients rather than limiting their autonomy, as long as individual needs are assessed.

> You are trying to simplify. I work in a rural area where the academic background is not usually high. Obviously, you can't use very technical language because they won't understand you. On top of that, the patient is in a situation of fear (GP7).

Adaptability in communication also involves overcoming language barriers. This GP illustrates how he ensures effective communication even when the patient does not speak Spanish.

> I try to adapt the language as much as possible. Even if the patient doesn't speak Spanish and I don't speak their language, as I did a week ago, we pick up the phone and translate for each other (GP2S).

Similar to Italian patients, Spanish patients experiencing psychological distress also report that being treated by a GP who creates language barriers leads to negative feelings and compromised communication. These barriers can hinder the patient's ability to express their concerns, resulting in frustration and a weakened therapeutic relationship. Clear and accessible language is essential in fostering trust and ensuring that patients feel understood and supported, especially when dealing with psychological suffering.

> Wrong, inferior, because I don't know what you are talking about. I wouldn't understand. Like a little distance, colder. More of - What am I doing here if I don't understand what you're telling me? - (P2S).

According to this patient, the use of colloquial, easy-to-understand language is a hallmark of primary care physicians. This approach helps facilitate communication by bridging the gap between patient and doctor, fostering a closer and more personal relationship compared to what is often experienced in specialised services. By simplifying language, GPs can create a more approachable and supportive environment, which is crucial for effective patient care.

> The doctor is easy to understand. Sometimes that is more common among specialists, the matter of medical language. In primary care, I believe they speak in a more colloquial way (P7S).

In conclusion, as in the Italian case, trust and effective communication are vital components of Spanish GP-patient relationships, especially in managing mental health. GPs tailor their communication to align with each patient's level of understanding, and they place a strong emphasis on regular follow-ups and ongoing support. Generational shifts in medical practice have contributed to a more empathetic, patient-centred approach. However, challenges persist when communication barriers arise, underscoring the need for continual adaptation and sensitivity in doctor-patient interactions.

7.3 GPs as patient counsellor

In this section, the role of GPs as patient counsellors is examined, emphasising their critical contribution to primary healthcare in addressing the widespread issue of misinformation and lack of knowledge surrounding mental health. GPs are positioned not just as prescribers, but as educators who guide patients toward adopting healthier behaviours. This chapter suggests that the discretional strategies employed by GPs have the potential to reshape organisational and institutional frameworks from the ground up. These personalised management approaches, while addressing immediate patient needs, can also influence macro-level policies and meso-level organisational practices. By making individual, discretionary decisions in managing mental health, GPs actively

contribute to systemic change, potentially steering healthcare toward a more collaborative and patient-centred model of care.

7.3.1 Italy

One GP highlighted the crucial role of health promotion and the enhancement of patient qualities when discussing mental health. This perspective underscores the expanded role of GPs in not only addressing immediate health concerns but also in fostering long-term mental wellness through proactive and supportive counselling practices. This approach aligns with the broader goals of primary care, which seeks to empower patients and build resilience within the community

> In my opinion, the most important thing when talking about mental health now is to discuss health promotion and the strengthening of qualities (GP10I).

Some patients actively participate in constructing their clinical pathway with their GP, who supports this collaborative process. As a consequence, bottom-up approach generative mechanism in healthcare policy is genuinely shaped by patient requests and needs, both explicit and implicit, and the corresponding responses from the GP. Such negotiation is possible with patients whose cognitive conditions allow for active participation in their care decisions; however, patients with more serious impairing conditions may be more dependent on the physician's advice and guidance. Next quote illustrates how the patient's GP emphasises open dialogue and mutual understanding, considering his preferences.

> Let's say, she presents me an alternative, which she thinks is more suitable, explaining it well. If there's something that doesn't make sense to me, I might ask (P10I).

Another example highlights the GP's role in facilitating patient care through attentive listening and responsive action. This quote illustrates how the GP actively

engages with the patient's concerns, discussing issues openly and coordinating specialised follow-up care, when necessary, thereby ensuring comprehensive and tailored support for the patient.

> I ask her a few questions and let her know if I'm facing any issues. I specifically mention them, saying something like - Look, doctor, I think I need someone to follow up with me more closely, particularly in the psychiatric field - We discuss it openly, and I feel comfortable having those conversations with her. I have no problems addressing it (P3I).

The role of the GP in fostering a collaborative and respectful treatment process is further highlighted by another patient's experience. The patient underscores the GP's approach of discussing medication options thoroughly with the patient, ensuring they understand the potential benefits and limitations.

> Certainly, with the doctor, we have sometimes discussed these medications, to understand what can and cannot be done, but she has never been insistent on wanting, no, not that. But, I am fine with it. It's a mutual thing (P5I).

As previously mentioned, GPs play a vital role in preventive medicine, which includes educating patients. This commitment to patient education may be a discretionary decision or stem from a personal inclination. The key point is that some GPs choose to engage in these educational efforts, directly influencing how patients manage their conditions and encouraging them to take greater responsibility for their well-being. Equally important is addressing mental health with the same seriousness and acceptance as physical health, a critical aspect of the GP's role in patient counselling. By fostering an environment where mental health is destigmatised, GPs can help patients feel more comfortable seeking and adhering to treatment. This GP also actively instructs her patients to reduce the stigma associated with psychological conditions.

> For example, just this morning I went to see a patient at home who really needs support for a mood decline due to various events. He was surprised because he was followed by the cardiology department for serious health issues. He said - Do you realise that they requested a psychiatric visit for me? - I explained the reason to him, telling him - Look, the psychiatric visit is only to provide you with pharmacological support for your mood decline. Then, if you don't like seeing the word "psychiatrist" written, we can change it, we can go to a geriatrician, as the purpose is always the same - (GP6I).

The next GP narrates the story of a patient and his father from Eastern Europe, both experiencing depression following the loss of the mother. According to the GP, neither the patient nor his father could recognise what mental health issues were or could explain their condition. The GP's management approach, which focused on providing understanding and support, allowed the patients to navigate their grief without the need for medication, demonstrating the effectiveness of non-pharmacological interventions in mild disorders.

> The son, after I told him - It's normal to have such a concern - I never saw him again. So, I think he didn't have more problems. The father appreciated it... I didn't prescribe any medication. Simply discussing the issue and helping them realise that they might be experiencing somatisation was often enough. What they needed most was to talk about it... I explained what grief processing is and all that. In that moment, they left an impression on me, especially the boy. However, rather than feeling sadness, I was filled with a sense of tenderness (GP7I).

Indeed, GPs play a vital role in educating patients about drug consumption, especially when it comes to medications that carry the risk of dependency. Their guidance is crucial in helping patients understand the potential dangers and in promoting responsible use of such medications.

> For benzodiazepines, it’s very easy because you just need to explain to the patient... I mean, when you prescribe them for the first time, you can manage the description by explaining the side effects to the patient, that there must be an end date, etc. I managed to do this quite well. However, it’s very difficult to stop the consumption, almost impossible sometimes (GP1I).

Certainly, the role of GPs as health counsellors involves a deep understanding of human behaviour. To address this, one GP chose to undertake specialised psychotherapy training to be more effective.

> In the field of primary care, I felt that I could move freely in terms of relationships. I also attended a school of psychotherapy to specifically develop my skills in relationship-building and care through conversation. However, I am not currently practicing psychotherapy (GP10I).

This GP noted that health counselling and patient education are modern aspects of family medicine, and she aligns herself more with the current generation of physicians who prioritise these practices.

> I g*et al*ong better with those younger than me. With those over fifty, not so much, but it’s neither their fault nor mine. We have different professions. Because in the last twenty years, general medicine in Italy has changed completely. So, it wasn’t conceivable that I could do the same job as someone who is now about to retire (GP9I).

In summary, these quotes underscore the discretionary management practices of GPs in Italy, with a strong emphasis on health counselling, patient education, and mental health support. Modern primary care involves GPs playing an active role in promoting long-term wellness by addressing both physical and mental health, while also fostering patient autonomy through collaborative care. Their efforts in educating patients, whether

in responsible medication use or in reducing the stigma surrounding mental health, are key to improving overall patient well-being and ensuring a holistic approach to care.

7.3.2 Spain

In discussing her approach to patient care, the next GP highlights the importance of thoughtful communication and careful prescription practices. She reports on the negotiation process involved in drug prescriptions, emphasising a strategic approach to management that aims to avoid unnecessary medication. The GP explains her method of addressing patient concerns through conversation and reassurance, rather than immediately resorting to prescribing tranquilisers. This strategy is particularly focused on younger patients, for whom the GP believes it is important to avoid early reliance on medication

> I try to talk with her a bit, trying to de-dramatize and de-medicalise, because many people ask for tranquilisers just because of a specific argument, especially young people for whom I don't think it's normal to start taking medication. You'll have to endure and get through it... In the end... Sometimes patients directly request a prescription (GP5S).

The next GP takes on the role of a health counsellor, helping patients navigate difficult emotional experiences by normalising natural responses like grief. Rather than immediately resorting to medical intervention, the focus is on guiding the patient through the process in a healthy way.

> For example, if a person is experiencing significant symptoms of sadness following the death of a parent, but there are no risk factors or signs that pathological grief may develop, I tend to focus on providing health education (GP9S).

When encountering young patients requesting medication, or in general when addressing psychological suffering, the next GP takes a clear and empathetic approach to normalise their experiences. His approach aims to counsel patients on the distinction between normal, non-pathological suffering and mental health issues, helping them understand that some forms of pain are a natural part of life and do not necessarily require medication.

> I explain clearly. I listen and normalise the situation. - Let's see, you have a problem, I understand your suffering - It's also an educational effort. And a bit of therapy too - My father died fifteen days ago and I am very sad - You have to tell them - This is normal; you are grieving. You've suffered a loss, it's painful, and you have to live through it, there's no other way - This pain cannot be relieved by drugs. If your girlfriend leaves you, it doesn't affect your mental health. It's normal suffering, not pathological suffering. The suffering of life has to be carried by each individual (GP6S).

GPs also have to challenge managing patient requests for medication. The next physician emphasises the importance of patient education in this process. The GP explains his approach to prescribing sleep aids with clear instructions to avoid daily use and to limit the duration to no more than two months. Despite these precautions, the GP acknowledges the difficulty in tapering off such medications later, often influenced by professional culture and patient demands. The quote highlights the ongoing challenge of balancing patient expectations with responsible prescribing practices and the need for continuous patient education.

> When I prescribe something for sleep, I do so with the intention that it not be used daily, trying not to exceed two months, and I make this clear to the patient. However, there is an accumulation of prescriptions, combinations, etc., that are very difficult to taper off later, and this sometimes forms part of our professional culture. It may also be something that the population requests from us (GP2S).

This reflects a typical dilemma faced by GPs as SLBs, who must navigate the tension between following medical guidelines and accommodating individual patient needs. They are on the front line of healthcare, where policy meets practice, and must make case-by-case decisions that balance professional responsibility with the immediate expectations and demands of their patients.

Another GP reflects on efforts to reduce drug consumption for the treatment of psychological problems. The GP has developed a work strategy to delve deeper into medication issues and actively works to minimise unnecessary drug use. Although the GPs' turnover can hinder their ability to thoroughly investigate a patient's history, the GP discretionally questions the necessity of continued medication and is committed to helping patients reduce unnecessary drug consumption.

> A patient comes in for something else, and I ask them - Oh, you're taking this - benzodiazepines or antidepressants - why are you taking it? - Oh, I don't know, they prescribed it to me once when my husband died about 10 years ago. I don't know - And you haven't stopped? – No - Why? - Because nobody has told me to - People take things just because they take them. And we fail to stop and ask - why are you taking this? - If they don't want to stop, that's fine, but if there's a possibility, I try. I am managing to get quite a few people off antidepressants, but removing a drug takes a long time (GP6S).

Further, the next patients, both with a long history of psychiatric disorders since childhood, highlight what they consider the most important qualities in a physician. Their perspective underscores the value of GPs as well-being counsellors, aligning with the broader need for accurate diagnosis and effective treatment. These quotes reinforces the idea that effective GPs not only diagnose and treat illnesses accurately but also engage in preventive and educational efforts, fostering long-term mental and physical well-being.

> I believe what matters in a doctor is that they are good, that they diagnose your illness accurately, and that they provide effective treatment so you don't have to visit them frequently to get rid of the illness or condition you have (P10S).

> For me, a doctor who is a good professional is empathetic. Someone who treats you well, who refers you if they see that they can't provide a solution, and refers you quickly to a specialist. In short, they are a good professional in the sense that they effectively attend to your needs (GP7S).

The next physician suggested that older GPs are generally less engaged in the role of patient counsellor. However, it appears that age is not the decisive factor. What truly seems to matter is the GP's attitude and their commitment to ethical accountability in medicine. A GP's willingness to take on a counselling role depends more on their personal interest and sense of responsibility towards patient care, rather than simply their age or experience level.

> I g*et al*ong better with people who are younger than me. Maybe it's because I see people my age, or a bit older, as more tired, more burnt out. So, the interaction is sometimes more from a place of exhaustion, and I relate more to the way people with more energy view things nowadays. I try to absorb more of that energy rather than the feeling of - I'm nearly at the end of my career -. But of course, there are all sorts of people at every age. I think I have a good relationship with people who, in the end, think similarly (GP2S).

Concluding, in this section, GPs from Spain highlight the importance of strategic and discretionary management in drug prescriptions and patient care. These GPs emphasise the need for exhaustive patient education and emotional support to avoid unnecessary medication, particularly among younger patients. They advocate for non-pharmacological approaches and stress the significance of understanding normal, non-pathological suffering as part of life. Despite structural constraints such as limited time and high healthcare demands, some GPs prioritise ethical patient care, focusing on accurate diagnosis, effective treatment, and long-term mental and physical well-being. Further, their efforts as well-being counsellors reflect a commitment to holistic and preventive healthcare, addressing both immediate and broader patient needs.

7.4 Discussion and conclusion

This chapter has examined the daily practices of GPs in managing patients with mental health disorders, with a particular emphasis on identifying patterns that may indicate innovative strategies. It also explores how frontline workers adjust their actions in response to situational demands and the specific needs of individual patients. A key element emerging from the analysis is how GPs use discretion (Hupe, 2013) to meet complex, individualised patient needs. GPs move toward patients (Gofen *et al*., 2019) by actively engaging with patients to provide more tailored and personalised care. This strategy, as presented in this chapter, positions GPs more as patient advocates than as mere agents of the State (Maynard-Moody & Musheno, 2000). By prioritising individualised care and using their discretion to navigate system constraints, GPs act in the best interest of the patient, rather than simply adhering to rigid State protocols. This approach strengthens their role as patient-centred providers, balancing the demands of both the healthcare system and the patient's personal needs. The findings suggest that characteristics such as the GP's age, gender, or background do not solely influence the adoption of innovative behaviours. Instead, the data from interviews reveal that these behaviours are shaped by a commitment to accountability and a sense of responsibility that transcends such demographic factors. What emerges is a strong emphasis on the personal engagement and professional judgement of GPs, which plays a crucial role in fostering trust and effective communication with patients. A notable aspect of the GPs' discretion is their ability to create a welcoming atmosphere, placing "care" on equal footing with "cure". Both Italian and Spanish GPs emphasise non-pharmacological interventions, patient education, and tailored communication, suggesting a broader trend within primary care towards a more holistic, sustainable approach to health management.

The discretion GPs employ can be evidenced in their decision-making processes, particularly in the management of younger versus older patients. For younger patients, GPs tend to adopt a proactive and investigatory approach, aiming to involve them more actively in their health management. This interactive "moving toward patients" (Gofen *et* al., 2019) strategy reflects a more collaborative and negotiated (Dixon-Woods *et al*., 2006) method of addressing mental health issues early on. Conversely, for older patients, GPs lean towards a more cautious, pharmacologically centred approach, carefully balancing medication prescription to avoid dependency, particularly in the case of

benzodiazepines. This broader role underscores how GPs' use of discretion influences patients' candidacy (Dixon-Woods *et al*., 2006), as they decide not only when to refer but also how to address complex health needs within the confines of primary care. By applying their professional judgement, GPs can either open or limit pathways for patients, shaping access to care based on a balance of clinical needs, system constraints, and their own problem-solving abilities. This highlights their critical function as both system navigators and direct providers of care, continually negotiating the best outcomes for their patients.

In conclusion, the analysis confirms that the discretion exercised by GPs in their management of mental health issues is a crucial component of innovative practice. It enables them to navigate the complexities of individual patient needs, balancing pharmacological and non-pharmacological interventions while maintaining patient trust and accountability. The role of GPs as both gatekeepers and problem solvers is fundamental to the delivery of comprehensive care in primary health settings, underscoring their capacity to manage an extensive range of health conditions with a high degree of autonomy. The exercise of discretion identified in this chapter exemplifies the essential role of frontline workers in driving innovation (Rice, 2013) where micro-level actions influence the evolution of institutional healthcare practices, suggesting that GPs' discretionary power is key to advancing innovative, patient-centred care, particularly in the realm of mental health management.

CHAPTER 8

CHANGING FROM PRACTICE

This chapter shows how GPs, through their management approaches and their relationships with patients with mental disorders, are potentially reshaping the organisational and institutional systems. The aim is to answer how the interactions between doctors and patients with mental disorders can lead to the development of new behavioural patterns which could potentially alter the institutional and organisational framework. It is important to note that the innovative or “agentic” behaviours highlighted in the interviews with doctors and patients are relatively uncommon and represent a fraction of the total participants. GPs’ discretional practices, though innovative, are not widespread by definition. Innovation involves creating something distinct that, if it were common from the outset, would not be considered innovative. These behaviours, while marking the early stages of potentially significant shifts in healthcare management, suggest a medium- to long-term progression. The impact of these innovative behaviours is gradual, as they face both structural and contextual constraints. As a result, they are unlikely to cause rapid, widespread changes in the short term, but they may pave the way

for more substantial institutional alterations over time, potentially resulting in a broader transformation of healthcare systems after years or even decades of incremental shifts.

"Agentic" behaviours involve individuals actively shaping their own experiences and interactions, rather than simply reacting to circumstances or following established guidelines. These behaviours, while potentially marking the beginnings of changes in healthcare, are limited in number due to structural and contextual constraints. The limitations on the widespread adoption of these innovative approaches often stem from entrenched institutional practices, such as the traditional reliance on pharmacological treatment or bureaucratic hurdles that prevent the broader integration of community-based care principles. For example, while some GPs experiment with reduced prescriptions and a more patient-centred approach, institutional norms and policies may still encourage more standardised, pharmaceutical-based care, limiting the full-scale impact of these individual initiatives. Therefore, this chapter is not just documenting changes but is observing the early stages of potentially significant shifts in healthcare management. However, these new directions are often personal to individual doctors. Some doctors may not accompany these changes and might instead direct, for example, their practices toward more pharmacological treatments. This contrast between innovators and more traditional practitioners highlights how uneven the uptake of these innovative strategies might be, further delaying broader systemic changes.

Indeed, within the mental health context, "innovative behaviour" could be defined by effective efforts to implement community care. This involves fostering patient responsibility for their health, deinstitutionalising care, activating local services, and reducing drug prescriptions. Such practices are considered innovative because they embody the practical application of community care principles, representing the directions most favoured by their adoption. For example, this exploration considers the role of patients with mental disorders not just as recipients of healthcare but as active producers of health. Innovative behaviours in this context are defined by the application of community care principles, such as encouraging patient responsibility, reducing reliance on pharmacological treatments, and engaging local services, approaches that, while uncommon, reflect potential future directions in healthcare. This chapter aims to answer which innovative strategies GPs employ to manage patients with mental disorders, and whether these strategies lead to the development of new behavioural patterns. If these innovative strategies are adopted more broadly, they could significantly shift the healthcare landscape, promoting a more holistic, community-centred approach to mental

healthcare that prioritises patient autonomy and reduces the overreliance on pharmacological solutions. These shifts, however, are likely to unfold over a medium to long term, as they confront established norms and institutional constraints.

The chapter is structured as follows. Section 8.1 examines how GPs exercise their autonomy to create innovative organizational forms. Section 8.2 discusses the evolving perceptions of mental health issues and the understanding of patients with mental disorders as active contributors to health, rather than mere recipients of cure. This analysis is enriched with insights into how these perceptions are changing the practice of mental health care. Section 8.3, explores the integration of social elements with medical care, highlighting the holistic approach to communitarian patient care. This section underscores how social determinants of health are considered alongside medical care, promoting a comprehensive approach to patient wellness. The chapter concludes with a comparison of national cases, a discussion of the findings, and their broader implications, illustrating how these micro-level changes may signal significant shifts in the overall healthcare landscape.

8.1 Taking advantage of autonomy

The degree of autonomy that GPs can exercise is shaped by the primary care model in place, with self-employed Italian GPs potentially finding it easier to implement changes. While their greater organisational autonomy compared to Spanish GPs allows for the possibility of transforming organisational functioning, this does not necessarily mean that all GPs will introduce new dynamics. Many may simply adapt their consultations without broader systemic change. In contrast, Spanish GPs face more restrictions due to their dependent employment status, limiting their ability to influence organisational decisions directly. This difference significantly impacts their capacity to initiate and sustain changes, as they must navigate various bureaucratic layers. However, this setup still allows for team-based initiatives aimed at enhancing patient care. Thus, this section shows how doctors may exercise their agentic power to transform organisational systems through the creation of innovative organisational forms.

8.1.1 Italy

The following quote outlines a communication approach adopted by GPs working in the same health centre. Despite working within a structure provided by the health organisation, these Italian GPs have significant autonomy. In this case, all patient communications are managed centrally through a secretary, using specialised software to sort and prioritise inquiries based on urgency, employing a colour-coded system for efficiency. This approach is uncommon among Italian GPs, who typically provide their personal phone numbers to patients for direct communication.

> I think the most influential thing is that the majority of doctors are not directly accessible to patients. This is a group choice. Nobody has our private number. The number that is given is the secretary's number. Anyone who wants to contact us has to go through the secretary…We have a little software and we and the secretary write there. We have all the flops for home visits and call-backs. She writes the person's name, the phone number, and colours it grey if it is not urgent or red if it is urgent. If it is urgent, she also informs us by phone if we are not there. Then we very quickly call the person. There are very few emergencies (GP10I).

In Italy, the autonomy and self-employed status of GPs often allow them to compensate for structural shortcomings, such as the lack of a primary care psychologist. It is up to the GPs themselves to establish contact with specialist services, fostering collaboration to ensure comprehensive care. By contrast, in Spain, when a primary care psychologist is available, they are integrated into the primary care team and more closely aligned with the organisational structure to which the GPs belong. The same GP shares her perspective on the matter.

> For more serious situations, I refer patients for a psychological consultation within the ASL. However, we have a bit of an advantage, as we established contact with the CSM (mental health centre) at the start of the pandemic, and even before that. As a result, we regularly discuss these cases during dedicated meetings. Every two months, we hold a meeting with all the health centre's

services, including the CSM, where we review and discuss the most serious cases collaboratively (GP10I).

The next GP illustrates how her clinic has concretely implemented teamwork, indeed facilitated by the organisational freedom inherent to their setup. Each team member takes responsibility for their specific role, with the ultimate goal of patient management. The possibility of choosing with whom to work, whether it be doctors or administrative staff, greatly enhances this dynamic. Moreover, young GPs, aware of the state of their profession, seem more inclined to engage in challenging objectives.

Our clinic, in particular, is on a path shaped by young colleagues. I'm the oldest one here, with two colleagues about to retire, but most of the team is younger. It's not that being young or old makes a difference, but they've pushed us toward a different future. We firmly believe that, while the number of patients may increase, so must our space. This is fundamental because we currently lack the necessary space. The team needs to grow, and the time dedicated to teamwork must also expand. This doesn't mean that I want to delegate tasks like triage to a nurse, secretary, or someone else just to lighten my load, but rather that the collaborative work we do together need to increase (GP9I).

The next quote examines the practical application of teamwork and autonomy within a health centre, where self-employed doctors collaborate with mental health specialists to deliver comprehensive care. The quote from the health centre coordinator highlights how GPs use their autonomy and initiative to drive organisational change, even within a structured environment.

In our approach to patient care, we've fostered collaboration through mental health initiatives, allowing for a more integrated system. Patients typically visit us two to three times a month, and depending on their needs, we coordinate their care and, if necessary, refer them to specialists. After these

> referrals, we hold a debriefing session between our team and the specialists. In more serious cases, we can even manage the patient together. Our focus is always on the quality, not the quantity, of cases. If a project is proposed and approved by the ASL (local health agency), we move forward with it. We establish an agreement, where a specialist, provided by the ASL, conducts outpatient clinics, either for our health centre's patients or for the wider district population (FLS1I).

In this health centre, the physicians have autonomously decided to place a GP in the role of administrative manager, underscoring their commitment to self-governance and proactive organisational management. This strategic choice highlights their preference to keep administrative oversight closely aligned with medical expertise, ensuring that operational decisions benefit from a practitioner's perspective.

> Lastly, we also have a doctor who acts as the administrative manager. She is in charge of organising and overseeing all the secretarial tasks (FLS1I).

In addition, GPs, utilising their autonomy, can proactively seek opportunities to enhance their skills and knowledge in mental health. This continuous professional development allows them to better address the complex needs of their patients and stay updated with the latest treatment approaches and best practices in mental health care.

> That sounds like a wonderful initiative. Being part of a Balint group where the focus was on discussing relationships must have been incredibly insightful. It's interesting how you used to engage in those sessions with other doctors, reflecting on the relational challenges you face. The fact that the group organised a supervisor, like a psychotherapist, added real value, allowing everyone to express and process so many things. It's true, there are countless relational issues that doctors often carry home, and having that space to unpack them must have been beneficial (GP1I).

> As a medical group, we also engage in psychological supervision with a psychologist. However, we might benefit from focusing specifically on the more challenging cases, as these often involve greater emotional complexity and can lead to more guarded responses. It seems natural to experience this kind of closure, but addressing it directly through supervision could provide valuable insights (GP10I).

By organising specialised training and supervision, these physicians show a strong commitment to enhancing their ability to manage complex mental health cases. The Balint group plays a pivotal role in fostering discussions among doctors about the doctor-patient relationship, helping to address the emotional and psychological challenges that arise in clinical practice. These sessions create a structured environment where GPs can reflect on their patient interactions, offering valuable insights that contribute to more effective mental health management.

8.1.2 Spain

In Spain, the autonomy to create and implement new approaches in healthcare settings is notably limited. Physicians often face restrictions due to their status as dependent employees, in contrast to their Italian counterparts, who, as self-employed professionals, have greater control over their organisational decisions. This distinction significantly influences the capacity to initiate and sustain changes, as Spanish GPs must navigate various bureaucratic layers to implement any meaningful modifications. Despite these constraints, the system allows for team-based initiatives that can improve patient care. One GP reflects on both the potential and the challenges of organising meetings with mental health specialists, highlighting that such collaborations were heavily reliant on participants volunteering to take part. This dependency on voluntary participation underscores the difficulties in establishing consistent interdisciplinary teamwork within the existing framework.

> Sometimes, the right people with a shared interest come together and make it happen. In one case, the mental health team had a tradition and a genuine desire to meet with primary care centres, and they held meetings once a

> month. However, I haven't seen this happen here. Occasionally, it's just a matter of two or three people suggesting - Hey, what if we do this? - Unfortunately, those meetings eventually disappeared, as they became a bit repetitive and dull, mostly focused on discussing patients in a way that lacked variety. The issue lies in the methodology. If these meetings were structured with a clear agenda, proper methodology, and a bit more enthusiasm, they could certainly be more effective and beneficial (GP2S).

Building on the previous discussions about the autonomy of GPs and its implications for innovating healthcare practices, the following quote directly addresses the necessity for increased autonomy to improve patient management, especially in mental health. By advocating for GPs to have the authority to directly coordinate urgent care with mental health specialists, GP10S underscores the critical need for a more integrated approach to healthcare that would allow for timely interventions.

> Because the traumatologist who is going to do the spine doesn't see you well? That's the way it is. You go to the orthopaedic surgeon who sends you for a spine and he won't see your foot. So of course, we have to give drugs for many things and at least they should give us the power, the competences, to be able to call the mental health specialist and say - Look, you have to see him tomorrow, during the week. It can't be, he can't wait three months - (GP10S).

8.2 Innovations in mental health understanding and practice

GPs play a crucial role in shaping public perceptions and practices surrounding mental health, often filling gaps left by national mental health plans. Indeed, laws and regulations typically advocate for a community-based and patient-centred approach, but they frequently lack detailed guidance on the specific role of GPs in daily practice. As a result, GPs must rely on their discretionary decision-making to manage patients with mental disorders effectively, often anticipating broader policy directions. In addition, through their clinical judgement and autonomy, GPs may anticipate future directives, implementing innovative practices and approaches. This section examines how GPs'

daily practices influence societal views on mental health and how they contribute to empowering patients with mental disorders to take greater responsibility for their health management. The analysis highlights the potential for GPs to redefine the traditional doctor-patient relationship, shifting patients from passive recipients of care to active participants in their treatment. Through the exercise of discretion in management strategies, GPs help bridge the gap between broad policy aims and practical, patient-centred care, advancing the understanding and management of mental health in their respective countries. The discretionary decisions made by GPs have the potential to shape cultural attitudes toward mental health. By examining their daily practices with patients with mental disorders, it is possible to understand how GPs foster patient empowerment and promote a normalisation of mental health care that does not rely solely on drug prescriptions. Through these efforts, GPs can influence public perception, encouraging a more open, holistic, and patient-centred approach to mental health care.

8.2.1 Italy

Evolving perceptions of mental health issues

Training patients by empowering them plays a pivotal role in the management of mental health conditions. By educating patients that their symptoms may be a somatisation of broader psychological or emotional issues, GPs can significantly influence their patients' perspectives on health and mental well-being. This approach not only improves patients' ability to recognise the root causes of their symptoms but also encourages a more comprehensive understanding of their mental health, leading to more effective and holistic care.

> However, if you take the time to sit down and explain to a patient why they are experiencing irritable bowel symptoms, you achieve much more than simply prescribing a pill to relieve the immediate discomfort. By explaining the underlying reasons, why their intestinal issues are linked to tension or stress, patients often open up. They might respond - It's true, doctor, I've been under a lot of pressure at work lately - and this begins to unravel the bigger picture. This more in-depth approach helps patients connect their physical

> symptoms to emotional or psychological causes, fostering a deeper understanding and paving the way for more effective treatment (GP6I).

This approach not only enhances medical understanding but also humanises the interaction between doctor and patient, fostering a more holistic approach to healthcare. By addressing mental health issues with care and understanding, rather than relying solely on medication, the doctor-patient relationship becomes more collaborative. Effective communication allows for a deeper exploration of the patient's condition, which is crucial for both accurate diagnosis and treatment. This method empowers patients, equipping them with the tools to better understand and manage their mental health, ultimately leading to more sustainable and effective outcomes. By shifting the focus from a purely clinical perspective to a more empathetic, patient-centred approach, GPs can tailor their care to the individual needs of patients, acknowledging the psychological and social dimensions of health. This not only fosters trust but also encourages patients to take an active role in their treatment, reinforcing the importance of mental health in the overall healthcare model. In the broader context of mental health management, this shift towards collaboration and empowerment helps challenge societal stigma around mental health. GPs, through their daily practice and patient interactions, become instrumental in promoting a normalisation of mental health care that is not limited to pharmacological solutions, thereby contributing to a cultural change in how mental health is understood and treated.

> Very often, sometimes, with patients, this can be done by a family doctor. They need time to talk. If I had to give, and sometimes it happens unfortunately, a pill for every anxiety problem or depression, it starts to become a problem. In the sense that sometimes you just have to talk about it and explain that these things are part of life, especially when they are reactive. People are scared of this anxiety because they don't know how to handle it. But if you explain to them that there is a triggering event, that they can learn how to manage it, maybe they can be cured and medicated less (GP7I).

The critical role of communication and patient training, as previously discussed, faces challenges in contemporary healthcare settings. In the context of mental health, effective communication and patient education are vital in empowering individuals to take control of their mental health, shifting the traditional dynamic between doctor and patient. By reinstating health training, GPs can help patients better understand the psychological aspects of their conditions, reinforcing the patient-centred approach that goes beyond medication. This, in turn, supports the broader goal of transforming public perceptions of mental health, encouraging patients to become active participants in their treatment and promoting a more holistic, community-based model of care. The next GP highlights the declining focus on health training, emphasising the need to revitalise this essential component of patient care.

> Nobody is interested in doing health training anymore. Health training no longer exists, and so the relationship has changed a lot in that sense. We are working so much *ad personam*; with every single patient, when I see a glimmer, I try to start doing some health training again... it would be important to explain what the role of the psychologist is, what the role of the psychiatrist is, what the role of the family doctor in mental health is, what a disorder is and what is not. As I said in response to the first question, in a way, everything is part of a person's health, but not everything is illness (GP9I).

Furthermore, addressing the stigma associated with psychiatric treatment remains a crucial challenge, as illustrated by another GP's experience with older patients. The fear of patient rejection and the associated prejudices around mental health treatment highlight the significant impact of societal perceptions on healthcare delivery. Training people could dismantle existing prejudices and continues the process of normalising mental health as a critical aspect of general well-being. By training patients, the GPs can foster a more supportive and understanding environment that encourages patients to seek the help they need without fear of stigma.

> I am sometimes afraid of patients in their fifties or sixties. I'm afraid - Now I have to tell them they have to go to the psychiatrist. Who knows how they

> will react - Actually in most cases they don't react badly and this gives me peace of mind. This allows them to be cured. If a patient does not want to go, because he is convinced that he is not crazy and has the idea that only crazy people go to the psychiatrist, it is a mess. It is a patient who does not want to be cured (GP7I).

In the ongoing effort to shift public perceptions of mental health, GPs play a vital role in normalising mental health conditions and reducing stigma. The following quote illustrates how one GP tackles the embarrassment and shame that often surround mental health issues, drawing parallels with physical health conditions. By doing so, he emphasises the importance of treating mental health with the same openness and seriousness as any other medical condition, and the need for greater societal awareness, starting from a young age.

> People shouldn't be embarrassed. I always use the example of those who are embarrassed by their condition, and I say - Excuse me, if you had diabetes, would you blame yourself? You have it, there are medicines, you take them. There's nothing to be ashamed of - Mental health is on par with endocrinological, cardiological, and all other branches of health. It's not a fault, it's a condition. Unfortunately, this has happened to you. Someone else might have had a myocardial infarction. However, society needs to be a bit more receptive. There should be awareness, even among younger groups because, unfortunately, this neglect still exists (GP5I).

As the role of GPs in mental health care expands, many patients are now actively seeking alternatives to traditional medication, such as benzodiazepines, especially in managing anxiety. This growing demand for non-medicinal approaches highlights the GP's critical role in guiding patients towards holistic, patient-centred care while ensuring the most effective treatment. The following quote illustrates how GPs must navigate patient preferences and exercise their discretion, balancing the need for innovative strategies with clinical expertise.

> So, it really is a big addiction. There again, though, because for me there is a lack of training. Because we were a group of young people, once the referral psychiatrist told us - Look, let's start taking off benzodiazepines. Let's give something else. Good. In the end, we can make the patient well without benzodiazepines - For me you also pay a bit of the old generation's price. Many years ago Xanax was not denied to anyone. Today, the mentality of the patient is also changing a bit. Because the patient is perhaps the first one to tell you that he or she does not want anything that can be medicinal. And so, you still try to find other strategies to keep him calm, to quell his anxiety a little bit, because then once you've given it to him it's difficult to take it away (GP6I).

The evolving relationship between GPs and patients offers a unique opportunity to reshape societal attitudes towards mental health. As patients increasingly seek alternatives to medication, GPs play a pivotal role in guiding them toward comprehensive, patient-centred care. Through collaboration and mutual understanding, GPs and patients can challenge the stigma surrounding mental health, promoting a more open, proactive approach that empowers individuals to take control of their well-being. This alliance not only enhances treatment outcomes but also helps bridge the gap between policy and practice in mental health care.

Patients with mental disorders as health producers

The role of patients is increasingly being redefined, not simply as recipients of care but as active participants or "health producers". This shift, supported by GPs who both educate patients and carefully manage their expectations regarding pharmaceutical interventions, reflects a crucial evolution in modern healthcare. Striking a delicate balance between offering necessary medical treatment and avoiding over-reliance on medication is central to this approach. It involves encouraging patients to engage with their own treatment, fostering a sense of responsibility and agency. Although this shift in mindset remains a subject of ongoing discussion, some GPs are already leading the way by providing patients with access to advisors, further empowering them to take an active

role in their health management. This is exemplified in the following reflection from a GP.

> I tend to prescribe them to patients who are extremely fearful of taking medication. I approach it cautiously because even convincing them to take just three drops of Xanax can be a struggle. I know that in many cases, the bottle will end up having a placebo effect, they'll carry it around in their bag but won't use it. Still, there's some benefit from that placebo effect. Some will take anything you prescribe them, and that becomes problematic. They may ask if they can take more, or they'll simply increase the dose without telling you, or mix medications, and the pharmacist ends up providing it to them (GP5I).

Transitioning patients into "health producers" requires more than just advising them on how medications work; it involves reshaping their expectations and interactions with healthcare professionals. This transformation is vividly illustrated by a patient with a long history of psychiatric conditions, who reflects on her journey from resistance to appreciating a more involved and conscientious approach to care. Initially hesitant to embrace change, she gradually recognised the value of thorough, attentive care and the importance of feeling heard and understood by her GP.

> Yes, my attitude changed because I came to appreciate it. At first, I was angry that this doctor wanted to see and examine me in person. I had been used to my previous doctor, who would prescribe whatever I asked for. I was a bit "spoiled" in that sense. So, when I was asked to come in for a visit, I initially felt frustrated. But later, I began to appreciate the fact that someone was taking the time to really assess my condition and listen to me. The process of going through the steps of a proper visit, which I resisted at first, eventually made me realise the value of it. I came to understand that behind it all was professionalism: dedicating time, and even what might feel like wasting time, to truly understand my health (P4I).

The proactive role of GPs in patient training is essential not only for effective treatment but also for preventing dependency on medications like benzodiazepines. This approach involves helping patients understand their conditions and the underlying causes of their symptoms, rather than just treating them with medication. Patients who are marginalised, socially excluded, and lack meaningful roles in society often struggle to develop a sense of identity beyond their mental health challenges, reinforcing their isolation. In this context, GPs act as more than just treatment providers, they become supporters in the patient's journey of self-discovery and recovery. Through "scaffolding care" GPs offer support that helps patients build on their strengths and develop coping strategies that aren't reliant on medication. This empowers patients to manage their conditions, redefine their identities, and reclaim control over their lives. A patient recovering from severe gambling addiction illustrates this, showing a desire to regain agency over his life and health.

> Absolutely. If I hadn't gone through the suffering, I would have stayed the same as I was before. Yes, I enjoyed it at the time, but I now realise it was only a surface-level understanding of who I truly am. It happened, and here we are, fighting through it. There's no changing the past, so I choose to focus on my personal growth and well-being. Though, what "being well" truly means is something that's always evolving and uncertain (P10I).

GPs play a crucial role in helping patients become "health producers" actively shaping their own health and life paths through comprehensive care that extends beyond conventional medical interventions. This is exemplified by a patient living in a shared independent setting with other psychiatric patients, whose journey highlights the profound impact of structured medical and social support. With clear, consistent guidance from healthcare professionals, this patient has made significant strides toward personal health goals, such as quitting smoking. This approach has not only facilitated recovery but also empowered the patient to create a new, autonomous direction in life.

> The difficulties are still there… Right now, my biggest challenge is quitting smoking, which feels quite significant. But I'm gradually cutting back, little

> by little. The last advice I received at the hospital was very clear and helpful. One of the major things is that, although my life hasn't completely changed from when I was living at home, it has started to take its own path, its own direction (P8I).

Another patient emphasises her efforts to quit smoking, taking charge of this aspect of her life with the guidance of her GP. The holistic care provided by GPs often includes supporting patients in overcoming specific challenges like smoking, a habit particularly common among psychiatric patients and crucial to improving overall well-being. This highlights the importance of addressing not just mental health, but the wider health needs of patients, recognising that well-being is multifaceted and requires a comprehensive approach.

> But the difficulties... I have one now, quitting smoking, which is quite a challenge. But I am gradually reducing my smoking. My GP is helping me with this (P1I).

This empowerment is closely linked to respecting patient autonomy, enabling them to make informed choices about their treatment. This approach reflects a shift towards collaborative, patient-centred care, moving away from institutionalised, paternalistic models. It is particularly important as mental health issues become more prevalent, fostering an environment where patients are encouraged to understand their conditions and make decisions that align with their personal health goals. By allowing patients to decide whether to pursue psychological therapy, continue certain medications, or explore other options, GPs encourage responsibility and engagement, treating patients as active participants rather than passive recipients of care.

> The patient should be left free to decide - You always want benzodiazepines; I keep an eye on you – The patient must decide – I want to go to the psychologist – or - I want to stay as messed up as I – So, it should not be the

system that decides for the patient. In recent years, there has been an explosion of discomfort, but also of consciousness (GP8I).

8.2.2 Spain

Evolving perceptions of mental health issues

Positioned on the front line of the health system, GPs have long been responsible for informing and educating patients, a fundamental aspect of primary care. This role involves not only addressing medical concerns but also offering guidance on lifestyle choices, mental health, and preventive care. However, as the next GP explains, this role has somewhat diminished over time due to various factors, such as the increasing reliance on technology and changes in healthcare structures. Despite this, some GPs remain committed to providing essential information and support to their patients, ensuring that education continues to be a core part of patient care.

> I don’t know. How do you train people now? How much information do we have available? We used to go into schools to teach sex education; we did a lot of community medicine in the 90s because, back then, people lacked information. Now, we have all the information in the world, yet people still come to us without knowing how to put on a condom. Everything is there, on their mobile phones, but they can’t seem to find the right information. I think a series of mechanisms are failing: the family, social groups (GP6S).

Despite the structural lack of time, the next GP is reinforcing the shift from patients being passive health consumers to becoming active health creators, taking responsibility for their own well-being. Rather than simply offering a quick prescription, the GP encourages patients to adopt healthier habits and take an active role in managing their mental health.

> I believe the main factors influencing this are the limited time we have, due to the high demands on healthcare, and the complexity of mental health. You could easily tell someone in two minutes - Take the anxiolytic and that’s it -

> but that's not the approach. While prescribing an anxiolytic might be quicker, I prefer to have a conversation and say - Let's try some alternatives—exercise, skip the nap, and see how that helps - Our goal is to educate rather than just provide a quick fix (GP10S).

The evolution of mental health care and the corresponding diagnostic criteria, such as those outlined in diagnostic manuals, have significant implications for how conditions are perceived and treated over time. These changes greatly influence treatment strategies and the therapeutic relationship with patients. As medical professionals, GPs navigate the changing landscape of mental health diagnoses, acting as both interpreters and creators of meaning. They not only apply these changes pragmatically but also critically assess their impact, ensuring their clinical practices align with both the latest standards and the best interests of their patients. The next GP, however, express scepticism towards evolving protocols, acknowledging that such shifts can significantly shape his approach to patient care.

> We are talking about the DSM, for example. It is laughable. How can I have a diagnostic manual that creates or changes an illness for me? The DSM 5, 'compulsive shopping disorder', well it didn't exist before. When I studied, in DSM 3, homosexuality was considered a disease. Then the gay lobby said - What's going on? We have power - Don't worry, I'll take it away - I mean, it's a disease and now it's not a disease. Can you explain it to me? The thing makes it very bad for me. The mourning. It has changed, I mean, pathological grief used to be pathological after a year, but now it's six months or three. I don't care. This kind of "now yes, now no" can't go on (GP6S).

Patients with mental disorders as health producers

GPs could be pivotal in transforming patients into active participants in their health management. They can emphasise the importance of lifestyle changes as foundational to mental well-being, challenging the growing reliance on pharmacological solutions. Next GP's strategy not only challenges the immediate resort to medication but also places a significant emphasis on the role of personal example in health training. By demonstrating

their own commitment to physical health, the GP not only addresses the benefits of exercise but also practices them, reinforcing the message that maintaining mental health is also an active, ongoing personal effort.

> They create absolute dependency. People are increasingly unable to manage their problems with traditional methods such as physical exercise and healthy eating, which are fundamental for good mental health but often neglected. I see patients who feel low and exhausted, and when I suggest exercise, they often say - I don't have time - I respond - If you work in the afternoon, you can do something in the morning - I even give them my own example: I start work at 8 am, but I get up at 6 am and go to the gym at 7 am until 7:40 am. I tell them - I'm not asking you to do the same, but we all have to make some effort - I assure them that the endorphins and the sense of well-being are worth it. Of course, there are days when I don't feel like it either, but it's the only way to keep going. Unfortunately, it's easier for many to just take pills (GP10S).

The shift towards community-based support services for patients with psychiatric conditions has encouraged a more personalised, less institutionalised approach to mental health care. However, based on the testimonies of both patients and GPs in this study, this transition is still ongoing. This model not only addresses the clinical aspects of mental disorders but also helps patients build fulfilling lives beyond their psychiatric conditions. Younger GPs often play a key role in this transformation by offering tailored guidance and support. Yet, it is important to note that no direct correlation can be made between a GP's age and this proactive approach. Instead, it appears to originate from the ethical accountability inherent in the profession, which is just as evident in more experienced GPs. Senior GPs also uphold these responsibilities, ensuring patient care meets evolving standards and ethical best practices.

The next patient, with a long history of psychiatric disorders, highlights the importance of a support system that goes beyond traditional treatment and medication, focusing on overall personal development. Through structured guidance, GPs help this patient manage both his mental health challenges and his ambitions for personal growth.

> They are helping me a lot by giving me clear guidelines. All the improvements I'm experiencing are thanks to their support and guidance. They're not only helping me manage my illness but also supporting my growth as a person (P7S).

As mentioned, autonomy plays a pivotal role in the lives of individuals with severe mental health conditions, fostering a sense of control and normality despite their challenges. This empowerment is essential, as it enables patients to lead lives that are not solely defined by their conditions. The desire to be treated as equals and engage fully with life highlights the broader importance of autonomy in mental health care. It underscores the need for healthcare providers to not only address the clinical aspects of mental illness but also support the patient's overall well-being and integration into society. A patient with a psychotic condition since childhood reflects on his mental health treatment, emphasising his longing for equality and the ability to participate in everyday activities. These insights were shared during the storytelling portion of the interview, offering a deeper understanding of the patient's experiences and perspectives.

> I really dislike knowing what I have and having to go there. I feel very normal, if they don't tell me, I don't notice any difference from one person to another because I feel very normal. But of course, I was diagnosed with it and I have to go every so often. I have to take a treatment every day in the morning, just two pills. Practically it doesn't prevent me from doing anything, because I can move well and the only thing I have is something psychological, some psychological impediment. That may well be. But my hands and feet are fine and it doesn't stop me from driving or working, or anything else... I don't care about the other things. As I have to go there, I have no choice because it seems I have to go there for life. So it's important that they behave well with me. Let them diagnose me well and let me be a normal person. That I be like everyone else and that they correct all the defects I have. What I want most of all is to be a normal person and to be able to live with everyone. I suppose that's what we go there for, to correct the defects (P10S).

8.3 Integrating social and medical care

In this section, the focus shifts to the coordination of services in Italy and Spain, where the role of the GP is critical in bridging the gap between medical care and community resources. In Italy, this coordination is often at the discretion of the doctor, with no consistent presence of support services in health centres. Some GPs take the initiative to connect patients with community services, thereby filling the continuity gap between medical care and broader health services. This approach places the GP at the centre of the patient’s navigation through the healthcare system. In Spain, not all health centres have social workers, and referrals to these and other community services are coordinated through social services. Here, GPs who adopt a more involved approach, dedicating time in understanding patient needs and building a support network around them, are effectively creating a model of community care. This method, while not universally practised, exemplifies how GPs can foster a more integrated care system, particularly in mental health, where the shift towards community-based care is still developing.

8.3.1 Italy

The integration of social and medical care, particularly in mental health, is increasingly recognised as a crucial strategy. By prioritising early intervention and community-based support, this approach enables timely and effective management of health issues. A coordinator of an Italian health centre reflects on the significance of these changes, offering insight into the ongoing shift in Italy. However, until these reforms are fully realised, GPs are stepping in to bridge the gap, ensuring patients receive the essential support they need within the community.

> Everyone has come to understand that it is at the community level where we need to intervene to reach patients early, especially in mental health. Waiting until they arrive at the hospital is often too late. The focus is shifting towards earlier, territory-based interventions. The integration of specialists into health centres may seem like a minor change, but in reality, it represents a

> fundamental and significant shift in how care is delivered. This shift is crucial for improving outcomes, particularly in mental health care (FLS1I).

Building on the idea of leveraging community resources for early mental health intervention, there is also great potential to enhance support for conditions that, while not requiring intensive psychiatric care, still benefit from structured assistance. In this model, the GP could play a key role as a connector, guiding patients to appropriate community resources and support systems that address their mental health needs before they escalate, thus expanding care beyond traditional clinical settings. The next GP reflects on the potential of utilising neighbourhood and environmental resources more effectively.

> In my view, we need to develop more pathways for disorders that may not be strictly psychiatric but still require support. These cases don't necessarily need to follow clinical routes but could benefit from other types of assistance, utilising community and local resources. This means Mental health centres, SERT, and similar structures, which were originally created for clinical management, should broaden their scope and take a more holistic approach (GP9I).

Indeed, in situations where traditional care pathways prove inadequate or are absent, GPs can adopt innovative approaches to meet the diverse needs of their patients. The next GP shares his proactive involvement in the care of a particularly challenging patient, demonstrating how medical, social, and familial support can be integrated through community care initiatives. By working closely with social workers and utilising local social services, the GP effectively addresses both the immediate and broader needs of the patient, embodying the principles of community-based care.

> We've never been able to keep her on a consistent care pathway. Most of what we do is emergency management, not just psychiatric, but also medical and social work involving her family. I made home visits with social workers,

> including a local social worker I knew personally, and together we visited her at home (GP1I).

In practical terms, the next GP played a crucial role in coordinating care by connecting patients with the appropriate services, such as affordable mental health support. By recommending an organisation that offers psychological services at reduced rates based on income, the GP demonstrates a strong commitment to accessible and holistic care. This approach ensures that all aspects of a patient's well-being, including their financial circumstances, are taken into account, fostering a more inclusive and supportive healthcare environment. ISEE is an indicator used in Italy to assess an individual's economic situation.

> Being the first point of contact for the health service means truly understanding people's needs. It's about not only welcoming them but also guiding them through the healthcare system, helping them access the right services. It's not just about prescribing medication; it's about coordinating all the services that revolve around the patient to support their well-being. Sometimes, we would refer patients to a cooperative that offered discounted rates based on their ISEE (economic status). People facing financial difficulties could pay as little as ten euros for a psychological consultation. I'm not sure how they manage it, but the feedback has been very positive (GP10I).

As GPs become more integrated with community services, their role increasingly intersects with public health policy and community engagement. This evolution is particularly evident in their collaboration with Mental health centres (CSM), where their involvement often goes beyond clinical duties, extending into shaping health policies that directly impact the local community. The next reflection from a GP highlights the shift from traditional clinical meetings to those with a more political and proactive focus, illustrating how GPs are beginning to recognise their potential influence on community health beyond the conventional scope of medical practice.

> We have always needed to discuss situations with the CSM, and over time, these meetings, which began as clinical discussions, have increasingly taken on a more political dimension. We are becoming more aware of the role we play within the neighbourhood. In these meetings, we explore opportunities to collaborate with or support the local community. For instance, at our last meeting with the CSM, the idea of forming low-threshold groups emerged. These wouldn't be mono-pathological or focused solely on severe psychiatric distress, but rather aimed at helping people experiencing more common or mild psychological challenges develop their strengths. I think this is a promising idea; it really gives a sense of the group's evolving purpose (GP10I).

8.3.2 Spain

GPs hold a unique position to influence health outcomes, not only through medical interventions but by understanding the social factors that affect their patients' well-being. By gaining an intimate knowledge of their patients' environments and contexts, GPs can tailor their care to meet each individual's specific needs, improving both the effectiveness of their treatment and the overall health of the community. These Spanish GPs express a clear vision of this transformative role. By integrating a deep understanding of patient's social circumstances, GPs can directly impact mental health outcomes by addressing not just the symptoms but also the underlying social determinants. This comprehensive approach enables GPs to activate local resources and provide more sustainable and effective interventions, promoting better mental health across the community.

> However, in primary care, the unique advantage is that you see the patient repeatedly over time. While an endocrinologist may know more about diabetes than I do, when it comes to this specific person and their diabetes, I am the one who knows them best. I understand their environment, their social determinants, who they live with, whether their flat has a lift, and even their financial situation. This deeper, more personal knowledge shapes how I care for them (GP6S).

> Primary care is a unique speciality, there's nothing quite like it. We work within the patient's environment, getting to know where they live, their circumstances, their economic situation, and even the challenges of their neighbourhood. In this way, we blend the community aspect with the medical and clinical side of care. For example, internal medicine is also a generalist field, but it operates in a hospital setting. While it considers the patient as a whole, it doesn't engage with the patient's home or community in the way primary care does (GP2S).

The integration of a deep understanding of patients' social environments into their care can have a direct impact on mental health outcomes, addressing not just the symptoms but also the underlying social determinants. This comprehensive model enables GPs to provide tailored interventions, such as activating local resources, resulting in more effective and sustainable care that improves overall mental well-being within the community. The following quote exemplifies how GPs put the community-based model into practice, addressing not only medical needs but also the socio-economic factors affecting a patient's health. By connecting the patient to social services and legal aid, the GP helps create a support network that addresses the root causes of stress and anxiety, illustrating the role of GPs in activating community resources and facilitating holistic care.

> A patient comes to consult us, 38 years old, female, separated with a daughter. Her problem is that she is working and has a complex situation. She can't cope anymore, she is on the point of cracking up. So, I explain the problems to her, of all the problems, which one can I solve? The job. Can you leave the job? No, out, I'm not interested if you can't change it, forget it. Do you need it to live? Yes, you have to live it, you have to accept it, there's no other way. Are they harassing you? Yes. Well, what can we do? We can report it, fine. We'll offer you help. Go to the social worker, he can offer you all the possibilities he has to solve this problem. It's solvable. Let's get on with it. The issue of your partner. The same thing. He won't give you the money, you'll have to go to court. Then I ask - If I give you a pill, will it solve the

> problems? – No - they tell you that they won't. If they say - Well, it might help me to rest a bit because I don't sleep - Ok, right - (GP6S).

The next GP played a pivotal role in activating local resources to support the mental health of his patients, extending care beyond traditional medical treatments to incorporate social and recreational activities. By encouraging a patient to join a mountain hiking group, the GP facilitated not only physical activity but also essential social interaction, which can be crucial for individuals facing mental health challenges. This approach highlights how integrating community resources into a patient's care plan can effectively enhance both psychological well-being and social engagement, demonstrating a holistic approach to healthcare that addresses both mind and body.

> This boy never left the house before, he was in bed all the time. We have managed to get him to join a mountain group, for example, and he goes for micro walks of 2 or 3 hours. We have managed to get him to go back to work and little by little to try to keep him entertained. If he wasn't thinking about the same thing all the time, these repetitive ideas didn't lead him to any decision. We've more or less dealt with it in every way we could (GP7S).

However, a community-based approach involves more than just the role of GPs. The interplay between medical, social, and economic factors requires a multifaceted strategy that integrates both social support systems and healthcare interventions. This GP highlights the importance of targeted social solutions to address the underlying economic and social determinants of health. By advocating for appropriate non-medical responses to these challenges, the GP underscores the limitations of healthcare interventions in resolving issues that are primarily social or economic in nature.

> The issue is to ensure that the problems that come from the social and employment spheres have a social or employment solution. In other words, if a person's minimum wage is low, there must be solutions, not health care solutions, but social solutions. Let them see this, let them alleviate it, not let

them have to go to the health sector so that I can help them to be calmer with five hundred euros a month. This makes no sense at all (GP2S).

8.4 Discussion and conclusion

The analysis in this chapter draws on comparisons between Italian and Spanish GPs to explore how their management approaches might reshape healthcare's organisational and institutional frameworks. The comparison highlights the potential for innovative practices introduced by GPs to generate change, particularly in the management of patients with mental disorders. Italian GPs exhibit a significant degree of organisational autonomy due to their self-employed status, allowing them to adopt innovative practices such as forming collaborative groups for consultations and leveraging technology to manage patient interactions more efficiently. These practices promote teamwork and ensure personalised care without adding excessive administrative burdens. In contrast, Spanish GPs, being more constrained by their dependent employment status, face greater bureaucratic hurdles, limiting their ability to implement changes autonomously. Despite these challenges, Spanish GPs value integrating community and social services in mental healthcare and strive to incorporate these elements into their practice where possible.

The age of the physician also appears to influence the adoption of innovative practices, with younger doctors more frequently engaging in these initiatives. This trend could be attributed to younger GPs being less institutionalised within the existing healthcare system and thus more open to exploring new methods. Indeed, age initially appears to be a significant factor in shaping management practices and the differences between younger and more experienced GPs tend to narrow as physicians gain more years of experience (Charles *et al.*, 2006). Regarding this study, those who continue to adopt innovative, patient-centred approaches after many years in practice often do so because they have found these methods to be more efficient and effective in managing patient care. Thus, while these initiatives are partly driven by an ethical commitment to improving patient care, the innovations are also driven by practical reasons. Many GPs find these "not-replicating" approaches, *i.e.,* those that deviate from standard, routine practices and involve more innovative, personalised strategies, more convenient and efficient. This allows them to manage their workload better while providing more personalised and effective care. However, innovations, while promising, are not yet

widespread and are still relatively rare within the broader healthcare system. Instead of becoming the norm, they are implemented by a small number of practitioners who are pioneering new methods. Indeed, the "agentic" behaviours (Rice, 2013) demonstrated by GPs represent a small but impactful part of the broader healthcare landscape. These early shifts in practice suggest a potential evolution in healthcare management, but they remain constrained by the larger organisational framework, which can inhibit the pace of adoption. Furthermore, these innovations tend to be personal and discretionary, reflecting the autonomy of individual doctors. While some GPs are pioneering new approaches and integrating broader social and health services, others remain more aligned with traditional methods, influenced by the inertia of established systems.

In conclusion, this chapter explores how GPs, as SLBs, actively shape healthcare systems through their management approaches, effectively embodying and enacting the health policies that patients experience first-hand (Lipsky, 2010). These changes, particularly in the care of patients with mental disorders, signal a shift towards more collaborative and holistic care. Both Italian and Spanish GPs play an important role in transforming mental health management by involving patients as active participants in their care. This collaborative approach extends beyond the traditional healthcare model, incorporating community resources to address social determinants of health. However, the success of these efforts varies significantly between the two countries due to differences in healthcare systems and national contexts. GPs navigate a complex dual role, acting both as "patient agents" and "state agents" (Maynard-Moody & Musheno, 2000), shifting along a continuum where they either replicate established practices or innovate new approaches (Rice, 2013). In this dynamic, they balance the pressures of adhering to system-wide policies while responding to the individual needs of their patients (Gofen *et al*., 2019). Patients, in turn, are not passive recipients of care and actively engage in their own "candidacy" (Dixon-Woods *et al*., 2006). Rather than simply accepting or rejecting medical recommendations, they assume an empowered role, co-participating in their healthcare journey. This active involvement highlights the importance of collaborative relationships between GPs and patients, as they together shape the healthcare experience within the constraints of institutional frameworks.

However, innovative strategies remain constrained by systemic factors, and their impact depends on the ability of GPs to struggle with limitations. The chapter suggests that while the changes are meaningful, they are still in their early stages, and it will take

time for them to become fully integrated into the healthcare system. The future of healthcare management will likely be shaped by the delicate balance between innovation and tradition, with GPs playing a central role in driving these changes forward. As GPs navigate the competing demands of innovation and tradition, they will remain pivotal in translating policy into practice for patients, while actively shaping the future of healthcare management.

CHAPTER 9
CONCLUSION

This chapter presents the conclusion of the comparative analysis of GPs' management of patients with mental health disorders in Italy and Spain, synthesising the various elements discussed throughout this thesis. The role of primary care emerges as increasingly central in this context, with GPs positioned at the frontline, playing a crucial role in the early detection of mental health issues and in navigating the healthcare system to ensure timely and appropriate care for patients. Moreover, this chapter proposes several avenues for future research, as many aspects of GP-patient interactions and mental health care still warrant further investigation.

This chapter is structured as follows: the "General discussion and implications" section synthesises the key findings of the research and discusses their broader impact on healthcare practices and policy. The "Contributions to literature" section outlines the original contributions this study makes to the existing body of knowledge, particularly regarding the role of GPs in mental health care. The "Limitations of the research" section acknowledges the methodological and contextual constraints of the study, highlighting areas where caution is needed in interpreting the results. In the "Suggestions for policies"

section, practical recommendations are provided to policymakers to improve the management of mental health in primary care settings. Finally, the "Directions for future research" section proposes potential avenues for further investigation, identifying gaps and opportunities for continued exploration of GPs' management and mental health care.

9.1 General discussion and implications

This dissertation intended to explore the interactions between GPs and patients with mental health disorders, underscoring their importance for accessing specialised services. It examined how institutional and organisational factors affect these relationships and the possibilities for such dynamics to induce bottom-up changes. Moreover, the thesis specifically focused on mental health as a case study, seeking to understand how GPs operate in general adopting a specific lens to draw broader conclusions about health management practices

The shift towards the medicalisation of society, particularly evident in the increased global consumption of pharmaceuticals for mental health (Diaz-Camal *et al.*, 2022), underscores a significant evolution in healthcare approaches. Shaped by the pandemic and management styles prioritising measurable outcomes, there is a growing emphasis on efficiency, which can sometimes overshadow the focus on patient-centred care (Diaz-Camal *et al.*, 2022; Nettleton, 2021). This trend is further exemplified by how patients with mental health issues, historically managed under paternalistic models during the asylum era, are now viewed as consumers. This consumer model significantly affects the doctor-patient relationship, transitioning doctors from counsellors to primarily dispensers of medication. This transformation poses risks to patient autonomy as it emphasises compliance with prescribed management over individualised care, potentially undermining therapeutic outcomes (Fava, 2023; Stacey, 1974). The prevalence of untreated mental disorders remains a critical concern, with significant implications due to the associated stigma and rising healthcare costs. This situation was exacerbated by the COVID-19 pandemic, which put additional strain on mental health systems and underscored the need for robust, responsive healthcare strategies (Di Monte *et al.*, 2020; Kessler *et al.*, 2005; Serafini *et al.*, 2020; Wittchen *et al.*, 2011). Furthermore, the global ageing population is projected to significantly increase, with the number of individuals over 60 will rise by 56% in the next 15 years, and those over 80 will triple by 2050. This demographic shift is expected to heighten the prevalence of diseases, especially cognitive

impairments, which have been shown to occur at a median incidence ranging from 22 to 76.8 per 1000 person-years worldwide (Pais *et al.*, 2020).

Among these challenges, the role of primary care has become increasingly central. In systems like the modern NHS, with a community-based approach toward *care* and *cure*, primary care acts as a frontline, facilitating early detection of mental health issues and ensuring that patients can navigate the healthcare system effectively to receive appropriate services (Dixon-Woods *et al*., 2006; Petmesidou *et al*., 2020). Primary care's integration into the mental health framework is pivotal. It enhances accessibility and ensures timely intervention, playing a crucial role in both treating common mental disorders and managing the broader implications of mental health within the community (Becchi, 2015; Louma *et al.*, 2002). GPs often serve as the initial point of contact for patients within the healthcare system (Grandes *et al.*, 2011; Lora, 2009; Louma *et al.*, 2002). In this role, they exercise significant discretion in diagnosing medical conditions, selecting appropriate treatments, and determining when to refer patients to specialists. This level of care not only addresses immediate health symptoms but also tackles larger societal issues related to healthcare equity and access, enhancing the overall effectiveness of healthcare systems (Grandes *et al.*, 2011; Lora, 2009).

Considering these arguments, the research aimed to explore how the institutional environment and organisational context influence GP interactions with patients and how these interactions might lead to the development of new management patterns at the micro-level that could potentially transform the institutional framework. The theoretical framework that guided the research was primarily based on Michael Lipsky's SLB theory and complemented by Deborah Rice's micro-institutionalist theory of policy implementation. These frameworks were instrumental in examining the role of GPs as SLBs within the context of managing patients with mental health disorders. Lipsky's SLB theory elucidates the significant role of frontline public service workers, including GPs, who directly engage with citizens and make crucial policy implementation decisions (Lipsky, 2010). This theory emphasises the discretionary power of these workers, which can lead to variations between intended policy and its execution on the ground. The autonomy granted to GPs allows them to make significant decisions regarding patient care, which directly impacts access to specialised mental health services. This discretion, however, is double-edged as it can either facilitate or hinder patient access to needed care depending on how it is exercised. Rice's micro-institutionalist approach, building on

Lipsky and Giddens' Structuration theory, highlights how individual actions and institutional structures interact to shape welfare state outcomes. It emphasises that welfare states are not uniform or static, but vary across local contexts, with policy outcomes influenced by caseworker-client interactions. This perspective views welfare states as dynamic systems constantly evolving through micro-level actions within diverse organisational settings (Rice, 2013). This theoretical synthesis offered a deeper understanding of how GPs' decisions and actions at the micro-level influence and are influenced by broader institutional and organisational contexts. Throughout the study, these theories were utilised to examine how GPs, as SLBs, manage the complexities of patient care amidst constrained resources and high demand. GPs face a dual role, balancing their obligations to the State with their commitment to individual patient care, creating a dynamic interaction between top-down institutional pressures and bottom-up individual actions. This interaction between macro-level institutional structures and the micro-level decisions of GPs as SLBs forms a complex environment where policies are both shaped and implemented. The theories of Lipsky and Rice provided a valuable framework for analysing the role of GPs within the healthcare system, shedding light on how their actions can either enhance or limit access to mental health services.

Based on the theoretical framework, three principal assertions were developed regarding the management of primary care physicians of patients with mental health issues. These assertions have been thoroughly explored in the core chapters of this thesis. The first assertion examined how institutional and organisational contexts shape the interactions between primary care physicians and patients with mental disorders, investigating how different structural frameworks influence the dynamics of these interactions, potentially affecting both the accessibility and quality of mental health services. Central to this analysis was the focus on the coping mechanisms that GPs, as SLBs, use to navigate resource constraints, and how these strategies in turn influence the management of patients with mental health issues. Secondly, the investigation explored whether the micro-level interactions between doctors and patients give rise to identifiable trends in the management approaches employed by healthcare professionals. By examining the day-to-day engagements of GPs with their patients, this hypothesis proposed to uncover if consistent patterns in treatment approaches emerge from these interactions. A key focus of this analysis was the discretionary decision-making of GPs in managing patients with mental disorders, highlighting how these individualised

choices shape care within the broader constraints of the healthcare system. Thirdly, the research considered whether these emergent management trends contributed to changes within the institutional and organisational model. This hypothesis examined the broader implications of the identified trends, assessing how they might have influenced shifts in the overall structure and functioning of healthcare services.

The study utilised two methodological tools: a cross-national narrative comparison and primary data collection. This approach facilitated the identification of key mechanisms influencing access to mental health services at multiple levels and highlighted differences in GP management across Spain and Italy, providing a comparative perspective on their respective welfare systems (Hill & Hupe, 2019). In-depth biographical interviews, central to the primary data collection, allowed for a nuanced collection of data, enabling GPs and patients to reflect and interpret their experiences profoundly (Lindseth & Norberg, 2004; Rosenthal, 1993). The hermeneutic-phenomenological approach has offered profound insights. Rooted in Heidegger's notion of care, this methodology underscores the intrinsic care aspect in the everyday professional activities of GPs, providing a deeper understanding of their actions beyond mere functionary roles (Ehrich, 2005). A total of 22 patients and 20 doctors from Spain and Italy, along with 6 GP coordinators, shared their experiences. The narrative approach preserved the authenticity of their testimonies while also revealing the diverse interpretative possibilities inherent in this qualitative framework (Gofen, 2014; Maynard-Moody & Musheno, 2000).

In considering the case studies of Spain and Italy, both countries transitioning from occupation-focused to universal healthcare models. Spain's General Health Act of 1986 established its NHS with Universal Coverage principles (Kringos *et al.*, 2015). Spain's deinstitutionalisation of mental health, outlined in the 1985 Report for Psychiatric Reform and solidified by the 2007 NHS Strategy for Mental Health, integrated psychiatry into the health system (Aparicio Basauri, 1993; Guillén & Cabiedes, 1997; Juliá-Sanchis *et al.*, 2020). Italy's reform began with Law 180 in 1978, halting psychiatric hospital admissions and fostering a patient-centred approach (Barbui *et al.*, 2018). Both countries face challenges in coordinating mental health, primary healthcare, and social services, crucial for community-based treatment (Salvador-Carulla *et al.*, 2005). Decentralisation in Spain involved transferring public service management from the central Government to regional Governments for political stability post-dictatorship (Guillén & Cabiedes,

1997; Vázquez-Barquero *et al.*, 2001). Italy's regionalisation, culminating in 1999, maintained universal coverage and free service delivery, though co-payment strategies introduced periodic dynamics (Kringos *et al.*, 2015). Regarding drug consumption, Spain leads in benzodiazepine use with 110 daily doses per 1,000 inhabitants in 2021, a trend that increased during the pandemic (INCB, 2022; Ministerio de Sanidad, 2022). Italy's psychotropic drug use has remained stable, with slight increases in benzodiazepine use and consistent consumption of antidepressants and antipsychotics (AIFA, 2022). Professionally, Spanish GPs are salaried public servants employed full-time in multidisciplinary health centres, where a coordinator manages shift organisation. While some centres operate 24/7, not all provide urgent care services (Kringos *et al.*, 2015). Italian GPs, as public self-employed workers, ensure basic levels of care and 24/7 service through "aggregated functional local units" (SISAC, 2024). Despite efforts to mirror the Spanish model with multidisciplinary health centres, Italy reports higher unmet healthcare needs compared to Spain (Pavolini *et al.*, 2015; Petmesidou *et al.*, 2020). Spain's primary care, marked by more bureaucratised health centres aligns with the "Public Hierarchical Normative" model (Kringos *et al.*, 2015). Italy's primary care, with its capitation-based pay and fiscal regulation, reflects a hybrid of "Public Hierarchical Normative" and "Professional Hierarchical Gatekeeper" models, highlighting the blend of innovation within a traditional bureaucratic framework (Kringos *et al.*, 2015).

Comparing these two countries was valuable for understanding different approaches within similar welfare models. This comparison allowed for the identification of key institutional and organisational structures and dynamics that influenced GPs' management of patients with mental disorders. Differences in management practices were traced to variations in these institutional and organisational factors, while similarities were attributed to shared dimensions. By examining two comparable welfare states, the study explored these variables, suggesting possible cause-and-effect relationships and offering insights into the underlying mechanisms shaping GPs' management practices.

The healthcare systems of Italy and Spain, though characterised by distinct features, share significant similarities, particularly in their struggles with resource limitations and administrative burdens. Both countries prioritise efficiency and cost reduction, possibly related to structural shortcomings and a growing reliance on prescription medications. GPs operate within institutional and organisational constraints that limit their managerial capacity, a concept Hupe (2013) refers to as "discretion as

state". However, as SLBs, GPs exercise what is known as "discretion as used", which, according to theoretical models, shapes the implementation of public policy. This includes the immediate decisions made to address specific situations, emphasising the adaptability and judgement required to navigate the complexities of real-world practice.

Thus, the management behaviour of GPs is significantly influenced by the presence of waiting lists. To bypass these delays, GPs can directly contact public mental health services, a practice more common among Italian GPs due to their greater autonomy. By seeking shortcuts to assist their patients (Wells, 2007) they discretionarily leverage their informal inter-organisational networks to tailor care and advocate on behalf of their patients (Dunham *et al.*, 2008; Loyens, 2019). Time constraints also play a major role in the increased reliance on drug prescriptions (Thornicroft, 2008). Interviews with GPs reveal that prescribing medication has become a frequent strategy to cope with limited time, a problem exacerbated by the growing shortage of personnel in primary care. This situation forces GPs in both Italy and Spain to manage a high volume of patients, further intensifying the issue. Another key factor influencing GPs' management of mental health disorders is the level of training they receive (Thornicroft, 2008). Effective care requires a combination of specialised medical knowledge and emotional skills. However, GPs often perceive patients with severe mental disorders as dangerous, feeling inadequately trained to manage such cases. This gap in training undermines universal access to quality mental health services, leaving it almost to chance whether a patient encounters a GP with a comprehensive understanding of psychological dynamics.

The increased reliance on prescriptions in the healthcare systems of Italy and Spain can be attributed to a combination of factors, including a lack of resources, limited time, inadequate training, and personnel shortages. This issue is further intensified by the growing demand for mental health services, driven by the gradual normalisation of mental health discussions in society (Doblytė, 2020). These constraints leave GPs with few alternatives, often leading to over prescription as a quick solution in the face of overwhelming patient needs (Fava, 2023; Stacey, 1974). This reliance on pharmacological solutions rather than comprehensive treatment plans result in a routinised management of patients, where the depth and quality of care may be compromised (Lipsky, 2010). Both countries demonstrate a pressing need for a more structured supervisory approach that respects and guides clinical decisions to ensure care is both effective and economically prudent. Thus, creating a supervisory system that

actively fosters responsibility, rather than merely imposing sanctions, could lead to more consistent and high-quality care across both nations. Regarding differences, Italian GPs in a self-employed model often show a less corporate perspective, while Spanish GPs in the salaried model demonstrate strong organisational commitment. Despite these divergent models, GPs in both nations strive for efficient national resource management, evidenced by cost-conscious decisions regarding prescriptions and specialist referrals. Italian GPs, enjoying greater autonomy, sometimes refer patients privately, while Spanish GPs typically eschew such practices due to their salaried status. Italian GPs' schedule flexibility and patient interaction possibly aid mental health management. Spanish GPs' health centre ties restrict their scheduling flexibility but maintain significant autonomy.

The systemic pressures and constraints GPs face are counterbalanced by their capacity to exercise discretion effectively. This dynamic interplay is vital for understanding how healthcare objectives are met on the ground, revealing the inherent flexibility within systems that are often perceived as rigid and uniform. Following this, the next research hypothesis aimed to identify the patterns of GPs in managing patients with mental disorders. The convergence of practices between Italian and Spanish GPs, despite the different healthcare systems, highlights a universal trend in GP management of mental health disorders that transcends national boundaries. Indeed, the second hypothesis aimed to demonstrate how, through the exercise of "discretion as used", GPs become citizen agents (Maynard-Moody & Musheno, 2000). The third hypothesis focused on how GPs are reshaping organisational and institutional frameworks within healthcare through innovative practices in the management of patients with mental disorders. GPs tailor their interventions to meet individual patient needs, reflecting a deep understanding of the complexities inherent in mental health care. This practice not only supports the SLB theory's assertion of the autonomy of front-line public service workers but also aligns with Rice's (2013) observation of the dynamic interaction between macro-structural elements and individual agency within institutional settings (Rice, 2013). The consistent use of non-pharmacological interventions and holistic care approaches across both Italy and Spain corroborates Lipsky's (2010) concept of discretionary power exercised by SLBs. The strategy of employing customised communication and emphasising patient training as a core aspect of treatment underscores the role of GPs as a critical counsellor in the healthcare system. This approach enhances patient engagement and compliance, crucial for effective mental health management, and fosters a better

understanding of mental health issues among the population. These findings suggest a trend toward patient-centred care, indicative of a shift in the institutional practice that values patient autonomy and informed decision-making. Moreover, the analysis of management strategies based on patient age groups reveals a nuanced understanding of the diverse needs of different demographics. For younger patients, GPs focus on engagement and proactive interventions, which are vital for early detection and management of mental health issues. In contrast, the care for older patients tends to be more conservative, with a significant emphasis on monitoring and managing long-term medication use to prevent dependency and adverse effects.

Regarding the hypothesis on shaping broader organisational and institutional contexts, Italian GPs, as self-employed practitioners, enjoy considerable organisational autonomy. This independence enables them to adopt innovative practices, such as forming collaborative groups and utilising technology to manage patient care more efficiently. These innovations foster enhanced teamwork and personalised care management without imposing excessive administrative burdens. In contrast, Spanish GPs, constrained by their dependent employment status, face greater limitations in implementing organisational changes independently. They must navigate through more layers of bureaucracy, which can stifle innovation. Despite these obstacles, Spanish GPs acknowledge the importance of integrating community and social services into mental health care and strive to incorporate these elements into their practice whenever possible. Both groups of GPs are pivotal in shifting perceptions of mental health by involving patients as partners in health production, supported by training that fosters a collaborative and empowered approach to care. They extend their services beyond traditional models by integrating community resources to effectively address social determinants of health. The innovative, or “agentic”, behaviours of GPs are not widespread but are crucial indicators of early shifts within the healthcare landscape, signalling potential broader evolution in healthcare management. These innovations are often deeply personal to individual doctors, reflecting their professional autonomy and discretion. While some practitioners are pioneering new methodologies and integrating broader social and health services, others may adhere to more traditional approaches. This care-oriented approach challenges the prevailing narratives of bureaucratic detachment and impersonality in public administration. Central to this is the recognition that all understanding involves some prejudice, which allows primary care to appreciate how its methods and practices are

influenced by its socio-historical context. This insight helps situate and make intelligible patients' emotional suffering (Aho, 2008; Chodoff, 2002).

In Italy and Spain, younger GPs tend to adopt more innovative, patient-centred practices, particularly with younger patients less favourable to drug prescriptions. This preference for alternatives may be because younger doctors are less institutionalised by the system, allowing them to explore more holistic, efficient approaches that still align with systemic convenience. The concept of "moving toward the patient and moving away" (Gofen *et al.*, 2019) encapsulates the tension between patient-centred care and the managerial drive for efficiency. In healthcare management, efficiency is often interpreted in terms of cost reduction, resource optimisation, and streamlined service delivery. However, GPs, operating on the front lines, interpret and balance efficiency in more nuanced ways, considering both ethical and personal dimensions in their decision-making. When GPs move toward the patient, they prioritise holistic, personalised care that takes into account the individual's emotional, social, and health needs. This approach involves understanding efficiency not just in economic terms but also in terms of patient outcomes, satisfaction, and long-term well-being. It aligns with an ethical commitment to treating patients as partners in their care, respecting their autonomy and preferences, often extending beyond the rigid frameworks of standardised treatments. Conversely, "moving away" reflects the organisational pressures that encourage GPs to adhere to institutional goals, such as reducing consultation times, and resorts to a routinised drugs prescription. In this mode, efficiency is narrowly defined by immediate outputs, such as prescribing medications quickly to manage symptoms, or complying with policy guidelines that prioritise measurable, short-term success over patient-centred approaches. The balance between these two poles, patient-focused care and systemic efficiency, requires GPs to exercise discretion, as they navigate what it means to be both effective and ethical. Thus, for some, efficiency might mean taking the time to explore alternatives to medication, especially for younger patients, seeking to address root causes rather than offering quick fixes. For others, institutional pressures may push them towards adhering strictly to predefined processes that may not always align with the patient's best interests.

In conclusion, this research studied the intersection of institutional frameworks and accessibility to mental health services, revealing how structural and personal factors shape service engagement and outcomes. By integrating innovative approaches that position patients as active participants or "health producers" in their care, there's potential

to significantly enhance service delivery and engagement. This paradigm change not only addresses the dynamic interactions highlighted by the "candidacy concept" (Dixon-Woods *et al.*, 2006), where policies and healthcare providers play crucial roles in facilitating access, but also advocates for patient empowerment and clinical autonomy, setting the stage for transformative changes in mental health care management. Indeed, GPs not only diagnose and treat mental health conditions but also play a critical role in determining which patients are referred to specialised services or managed within primary care. The interactions between GPs and patients can thus shape the "candidacy" of patients for certain treatments, influencing their ability to access the care they need.

This thesis has explored the evolving role of GPs in managing mental health, highlighting a shift towards more community-centric and patient-focused practices. Traditionally viewed as gatekeepers, GPs are increasingly pivotal in driving bottom-up reforms that incorporate broader healthcare perspectives. The research underscores the need for policies that enhance GPs' autonomy and support patient-centred care, fostering innovations that could reshape the healthcare landscape. Crucially, it emphasises the potential of GP-patient interactions to influence systemic change, advocating for a model where GPs are central to truly collaborative care. Furthermore, this dissertation reveals how GPs experience and navigate institutional and organisational constraints, such as resource shortages and limited autonomy. Their daily practices often diverge from official policy, shaped by the practical realities of the healthcare environment. The strength of this research lies in its ability to demonstrate that theoretical frameworks and public discourse, such as policies on preventive medicine and community care, are often at odds with the realities GPs face. While policies advocate for grand ideals like universal healthcare, GPs must adapt their management strategies to contend with the practical challenges they encounter. Rather than drawing deterministic cause-effect conclusions, this thesis highlights how GPs perceive and respond to these limitations, exposing the significant gap between policy ideals and the practicalities of clinical care.

9.2 Contribution to literature

This dissertation examined the broader institutional environment and specific organisational contexts in which GPs operated, analysing how these factors shaped their interactions with patients experiencing mental health disorders. While previous research had touched upon these dynamics, this study offered a comprehensive analysis, providing

a nuanced understanding of the interplay between macro-level structures and micro-level interactions. The study further developed SLB theory by demonstrating how professional frameworks influence the discretionary practices of GPs in Italy and Spain. It also explored how GPs' management of patients with mental health disorders can initiate policy-making processes that, in turn, shape broader institutional and organisational frameworks. The research identified gaps in mental health training and examined how professional expertise impacts discretionary decisions. By focusing on the under-researched contexts of Southern Europe, characterised by limited resources and decentralised service management, the study expanded the comparative scope of the theory. This approach provided a deeper understanding of how GPs operate within different institutional frameworks and suggested wider applications for global health management practices. Moreover, the dissertation addressed gaps in the literature by demonstrating the potential for micro-level interactions to act as catalysts for systemic change. It traced the feedback loops from individual GPs' management to larger institutional contexts, highlighting the adaptive and emergent behaviours within these dynamics. This perspective offered new insights into the ability of frontline healthcare workers to drive bottom-up changes within healthcare systems.

Furthermore, the SLB theory has been applied to a profession that was previously relatively underexplored (Dixon *et al.*, 2020) and within a critical and widespread management domain: mental health. This research was timely and pertinent for contemporary societies grappling with escalating mental health challenges. By applying SLB theory in this context, the study provided valuable insights and recommendations for policy-makers and practitioners involved in mental health management. It highlighted the dynamic interplay between top-down and bottom-up implementation processes, offering a deeper understanding of how the discretionary practices of GPs can shape policy outcomes. Moreover, the dissertation contributed to the broader field of health management by using mental health as a case study to derive more general conclusions about healthcare practices. It demonstrated that the individual decisions and actions of GPs could significantly impact policy implementation, with wider institutional and organisational structures being shaped as a result. This finding holds particular relevance for future developments in healthcare, underscoring the potential for GPs to drive systemic changes through their everyday interactions and practices.

9.3 Limitations of the research

Primary limitations of this study arise from its methodology and the specific variables focused on. The sampling process may have yielded an unrepresentative sample, potentially skewing the depiction of the phenomenon under investigation. Given the decentralisation and regional differences between the two NHS services, these results could vary significantly. Responses might be influenced by desirability bias (Bergen and Labonté, 2020); however, efforts were made to minimise this by ensuring anonymity and creating a welcoming atmosphere (Lindseth and Norberg, 2004).

From a quantitative perspective, certain limitations of the qualitative approach become evident, particularly the difficulty in directly comparing multiple studies of this nature. In qualitative research, standardisation of procedures is not the primary aim; rather, the focus is on developing a deeper understanding of specific phenomena. The interpretation of researchers, combined with the varying contexts and circumstances encountered during data collection, inevitably influences both the interviews and the subsequent analysis (Gobo, 2002; Griffiths *et al.*, 2011). Each qualitative research is unique due to these subjective elements. While this uniqueness may limit the generalisability of findings, it should not be considered a drawback. Rather, it is a natural result of the qualitative approach, which prioritises rich, detailed insights over broad generalisations or the statistical validation of hypotheses. This emphasis on context-specific understanding allows qualitative research to capture the complexities and nuances of human experience that are often overlooked in more standardised, quantitative methodologies. In qualitative research, the time investment required for data collection and analysis is substantially greater than in quantitative approaches, where tests or questionnaires can be administered to many participants in a short time frame. In this study were interviewed 48 participants, among them 20 patients diagnosticated with mental disorders. Due to the unpredictable availability of subjects and the time required for contacts, interviews, and hermeneutic analysis, participants were sampled through convenience sampling (Etikan *et al.*, 2016) and subsequently through a snowball strategy (Biernacki & Waldorf, 1981). The researcher made efforts to ensure a balanced representation of subjects by gender and age. GPs were also asked if they could facilitate interviews with some of their patients. However, this was not always feasible; in some cases, patients with mental health issues were interviewed without their GP being involved. The complexity of the research object (Goggin, 2021; Hill & Hupe, 2019) and

the researcher's inability to eliminate his influence on the choice of techniques and data analysis (Roulston & Shelton, 2015) were acknowledged. It is essential to recognise that, in qualitative research, the researcher's sensitivity to specific themes can influence both the conduct of interviews and the analysis of results. This influence, although managed carefully, cannot be entirely excluded.

9.4 Suggestions for policies

The research provides a foundation for several key recommendations to policy-makers. Firstly, it is necessary to implement targeted training programmes for GPs, focusing on the latest advancements in mental health care, including non-pharmacological treatments and holistic care approaches. Integrating comprehensive mental health modules into medical education curricula will ensure that GPs are well-prepared from the start of their careers, with ongoing competence maintained through continuous professional development. Enhanced collaboration between GPs, mental health specialists, and social services is essential. Policies should support the co-management of patients through multidisciplinary teams that address all aspects of patient health. Such frameworks not only improve care coordination but also ensure that mental, physical, and social needs are managed in a holistic manner. Prioritising investments in primary care services is crucial, providing GPs with the tools and resources necessary to manage mental health disorders effectively. This includes adequate training, sufficient time for patient care, and sufficient staffing to meet the growing patient demand. Moreover, embracing digital health technologies can greatly enhance diagnostic accuracy, treatment monitoring, and patient engagement, improving overall care delivery.

Healthcare models that promote patient autonomy and informed decision-making should be encouraged, moving away from paternalistic approaches to care. Establishing patient advocacy groups would ensure that patient preferences and voices are integrated into policy development and healthcare delivery, empowering patients in the process. It is also critical that policies address the needs of an ageing population by improving access to psychotherapeutic mental health care for older adults. This approach should aim to reduce the reliance on pharmacological treatments alone, promoting a more balanced approach that includes a range of therapeutic options. For younger populations, early screening and intervention programmes should be implemented in schools and community centres. Training for young people can help to counteract the tendency to

normalise mental health issues as a mere “medicalisation of normality.” These initiatives should emphasise that while medications may offer rapid symptom relief, they should not be the FL of treatment for mild disorders and common emotional distress, where psychological interventions may be more effective.

Several GPs interviewed in both Italy and Spain emphasised the need for improved clinical supervision and the introduction of sanctions to ensure adherence to best practices and guidelines. Enhanced clinical supervision would involve more structured oversight of GP practices, with supervisors providing regular feedback and support to improve treatment outcomes. Sanctions, whether economic, disciplinary, or related to employment supervision, could be introduced to reinforce accountability without undermining the professional discretion of GPs, instead addressing deviations from standard practices in a constructive and fair manner. Furthermore, current developments in Italy indicate a shift towards a more centralised model in health centres while retaining the self-employed status of GPs. This evolution has sparked an internal debate among GPs regarding the choice between continuing as self-employed practitioners or transitioning to employee status. This research could provide valuable insights for Italian policy-makers by examining a similar NHS with organised health centres and salaried GPs. This would help fully understand the implications of both models, aiding in the formulation of informed decisions that best support the efficiency, satisfaction, and stability of the healthcare system.

9.5 Next research’ direction

The research findings suggest several directions for future research. One potential avenue is to investigate the effectiveness of a training programme aimed at improving GPs’ ability to manage mental health issues, particularly by incorporating insights from this study. The intervention could involve establishing regular reflective practices and peer discussions among GPs to promote continuous learning and improvement. This approach may also enhance job satisfaction and resilience when dealing with complex cases. Furthermore, aligning with the hermeneutic-phenomenological methodology, the research could include opportunities for physicians to provide feedback on the study’s conclusions, evaluate the interpretation of the results, and complete the hermeneutic circle (Dowling, 2007; Kafle, 2013; Warnke, 2011). Moreover, this approach aligns with SLB theory, which emphasises the importance of strong, horizontal relationships among SLBs.

Such relationships foster collaboration and contribute to the development of innovative management strategies, enabling GPs to work more effectively in addressing mental health issues (Hupe & Hill, 2007; Loyens, 2019). To assess the effectiveness of the intervention, a mixed-methods approach could be utilised, including pre- and post-intervention surveys to capture changes in knowledge and attitudes, supplemented by follow-up interviews to collect in-depth feedback and personal experiences from participants.

Furthermore, applying the same approach and methodology of this research to different national contexts would be valuable. This could include exploring settings where primary care does not serve as the gatekeeper for specialised services, where deinstitutionalisation has progressed at different rates, or where psychiatric hospitals still operate. Such comparisons could provide important insights into how varying institutional and organisational contexts influence GPs' approaches to treating patients with mental health disorders. Thirdly, future research could broaden its scope to other areas of health management, examining how similar discretionary practices affect patient outcomes across different medical specialties or healthcare settings. This exploration could show if personalised treatment approaches and physician discretion contribute to improved health outcomes, patient satisfaction, and overall treatment efficiency. By extending the generalisation efforts of this study, the goal would be to identify universal principles of healthcare management that can enhance care quality and operational effectiveness in diverse healthcare environments.

CONCLUSIONES

En este capítulo se presentan las conclusiones del análisis comparativo sobre la gestión de los pacientes con trastornos de salud mental por parte de los médicos de AP en Italia y España, resumiendo así los diversos elementos discutidos a lo largo de esta tesis. En este contexto, el papel de la Atención Primaria (AP) ha ido adquiriendo una mayor centralidad, con los médicos de AP, situados en la primera línea, desempeñando una función crucial en la detección temprana de problemas de salud mental y en la navegación por el sistema sanitario, asegurando así una atención oportuna y adecuada a los pacientes. Además, este capítulo sugiere distintas líneas para futuras investigaciones, considerando que muchos aspectos de las interacciones entre médicos de AP y pacientes, especialmente en el área de la salud mental, requieren aún una mayor exploración.

La estructura del presente capítulo es la siguiente: la sección "Discusión general e implicaciones" sintetiza los hallazgos clave de la investigación y discute su impacto más amplio respecto a las prácticas de gestión y las políticas sanitarias. La sección "Contribuciones a la literatura" expone las aportaciones del estudio respecto a la literatura de referencia, en particular en relación al rol de los médicos de AP en la gestión de la salud mental. La sección "Limitaciones de la investigación" presenta las restricciones metodológicas y contextuales del estudio, subrayando las áreas en las que se debe tener precaución al interpretar los resultados. En la sección "Sugerencias para la formulación de políticas" se ofrecen indicaciones prácticas para los gestores políticos con el fin de mejorar la gestión de la salud mental en AP. Por último, la sección "Propuestas de investigación para el futuro" ofrece sugerencias para estudios futuros, destacando oportunidades para profundizar en el análisis de la gestión por parte de los médicos de AP y su papel en el cuidado de la salud mental.

9.1 Discusión general e implicaciones

Esta tesis tenía como objetivo explorar las interacciones entre los médicos de AP y los pacientes con trastornos de salud mental, subrayando su importancia para acceder a servicios especializados. Se examinó cómo los factores institucionales y organizativos afectan estas relaciones y las posibilidades de que estas interacciones induzcan cambios de abajo-arriba. Además, la tesis se centró específicamente en la salud mental como

estudio de caso, buscando además comprender cómo operan los médicos de AP en general, adoptando una perspectiva específica para extraer conclusiones más amplias sobre las prácticas de gestión de la salud.

El cambio hacia la medicalización de la sociedad, particularmente evidente en el aumento global del consumo de fármacos para la salud mental (Díaz-Camal *et al.*, 2022), señala una evolución significativa en los enfoques de atención sanitaria. Debido a la pandemia y a los estilos de gestión que priorizan los resultados medibles, existe un creciente énfasis en la eficiencia, que a veces puede eclipsar el enfoque en la atención centrada en el paciente (Díaz-Camal *et al.*, 2022; Nettleton, 2021). Esta tendencia se ejemplifica aún más en cómo los pacientes con problemas de salud mental, históricamente gestionados bajo modelos paternalistas durante la época de los hospitales psiquiátricos, son vistos ahora como consumidores. Este modelo consumista afecta significativamente la relación médico-paciente, transformando a los médicos de consejeros a dispensadores de medicamentos. Esta transformación plantea riesgos para la autonomía del paciente, ya que enfatiza la adherencia a las prescripciones sobre la atención individualizada, lo que podría debilitar los resultados terapéuticos (Fava, 2023; Stacey, 1974). La prevalencia de trastornos mentales no tratados sigue siendo una preocupación crítica, con implicaciones significativas debido al estigma asociado y al aumento de los costes sanitarios. Esta situación se vio agravada por la pandemia de COVID-19, que ejerció una presión adicional sobre los sistemas de salud mental y subrayó la necesidad de estrategias sanitarias sólidas y receptivas (Di Monte *et al.*, 2020; Kessler *et al.*, 2005; Serafini *et al.*, 2020; Wittchen *et al.*, 2011). Además, a nivel global, se prevé un envejecimiento global de la población, con un incremento del 56 % en el número de personas mayores de 60 años en los próximos 15 años, mientras que las personas mayores de 80 años se triplicarán para 2050. Este cambio demográfico se espera que aumente la prevalencia de enfermedades, especialmente los deterioros cognitivos, que, globalmente, tienen una incidencia anual media que varía entre 22 y 76,8 por cada 1000 personas (Pais *et al.*, 2020).

Entre estos desafíos, el papel de la AP ha adquirido una importancia cada vez mayor. En servicios como los modernos Sistemas Nacionales de Salud, los cuales poseen un enfoque comunitario hacia el cuidado y la cura, la AP actúa en primera línea, facilitando la detección temprana de problemas de salud mental y asegurando que los pacientes puedan navegar de manera efectiva por el sistema sanitario para recibir los

servicios adecuados (Dixon-Woods *et al.*, 2006; Petmesidou *et al.*, 2020). La integración de la AP en el marco de la salud mental es fundamental; mejora la accesibilidad y garantiza intervenciones oportunas, desempeñando un papel crucial tanto en el tratamiento de los trastornos mentales comunes como en la gestión de las necesidades comunitarias de los pacientes (Becchi, 2015; Louma *et al.*, 2002). Los médicos de AP a menudo son el primer punto de contacto de los pacientes dentro del sistema sanitario (Grandes *et al.*, 2011; Lora, 2009; Louma *et al.*, 2002). En este rol, ejercen una considerable discrecionalidad al diagnosticar condiciones médicas, seleccionar tratamientos adecuados y determinar cuándo derivar los pacientes a los especialistas. Este nivel de atención no solo aborda los síntomas de salud inmediatos, sino que también afronta cuestiones sociales más amplias relacionadas con la equidad y el acceso a la atención sanitaria, mejorando la eficacia general de los sistemas de salud (Grandes *et al.*, 2011; Lora, 2009).

Considerando estos elementos, la investigación tuvo como objetivo explorar cómo el entorno institucional y el contexto organizativo influyen en las interacciones de los médicos de AP con los pacientes y cómo estas interacciones podrían conducir al desarrollo de nuevos patrones de gestión a nivel micro que potencialmente podrían transformar el marco institucional. El marco teórico que guio la investigación se basó principalmente en la teoría de la Burocracia a Nivel de Calle (BNC) de Michael Lipsky, complementada por la teoría microinstitucionalista de implementación política de Deborah Rice. El marco teórico resultó eficaz para examinar el papel de los médicos de AP como burócratas a nivel de calle en el contexto de la gestión de pacientes con problemas de salud mental. La teoría de la BNC de Lipsky detalla el papel significativo de los trabajadores de los servicios públicos de primera línea, incluidos los médicos de AP, quienes interactúan directamente con los ciudadanos y toman decisiones cruciales sobre la implementación de políticas (Lipsky, 2010). Esta teoría subraya el poder discrecional de estos trabajadores, lo que puede generar variaciones entre la política establecida y su implementación. La autonomía otorgada a los médicos de AP les permite tomar decisiones importantes sobre el cuidado de los pacientes, lo que impacta directamente en el acceso a los servicios especializados de salud mental. No obstante, esta discrecionalidad implica tanto oportunidades como riesgos, ya que puede facilitar o dificultar el acceso de los pacientes a la atención necesaria, dependiendo de cómo se ejerza. El enfoque micro-institucionalista de Rice, que se basa en el trabajo de Lipsky y

en la teoría de la Estructuración de Giddens, destaca cómo las acciones individuales y las estructuras institucionales interactúan para dar forma a los resultados del estado de bienestar. Este marco analítico enfatiza que los estados de bienestar no son uniformes ni estáticos, sino que varían según los contextos locales, con las interacciones entre el funcionario de primeria línea y el usuario influyendo en los resultados de las políticas. Esta perspectiva considera los estados de bienestar como sistemas dinámicos que evolucionan constantemente a través de las acciones de los individuos que se desarrollan dentro de contextos organizativos específicos (Rice, 2013). Esta síntesis teórica ofrece una comprensión más profunda de cómo las decisiones y acciones de los médicos de AP a nivel micro influyen y son influenciadas por los contextos institucionales y organizativos más amplios. A lo largo del estudio, estas teorías se utilizaron para examinar cómo los médicos de AP, como burócratas a nivel de calle, gestionan las complejidades del cuidado de los pacientes con recursos limitados y una alta demanda. Los médicos enfrentan un doble rol, equilibrando sus obligaciones con el Estado y su compromiso con el cuidado individual del paciente, creando una interacción dinámica entre las presiones institucionales de arriba-abajo y las acciones individuales de abajo-arriba. Esta interacción entre las estructuras institucionales a nivel macro y las decisiones a nivel micro de los médicos como burócratas a nivel de calle, forma un entorno complejo en el que las políticas son tanto moldeadas como implementadas. Las teorías de Lipsky y Rice proporcionaron un marco valioso para analizar el papel de los médicos dentro del sistema de salud, arrojando luz sobre cómo sus acciones pueden mejorar o limitar el acceso a los servicios de salud mental.

Basado en el marco teórico, se desarrollaron tres afirmaciones principales sobre la gestión de los médicos de AP con pacientes que presentan problemas de salud mental. Estas afirmaciones se han explorado a fondo en los capítulos centrales de esta tesis. La primera afirmación exploraba cómo los contextos institucionales y organizativos configuran las interacciones entre los médicos de AP y los pacientes con trastornos mentales, investigando cómo los diferentes marcos estructurales influyen en la dinámica de estas interacciones, afectando potencialmente tanto la accesibilidad como la calidad de los servicios de salud mental. El análisis se centró en los mecanismos de afrontamiento que los médicos, como burócratas a nivel de calle, utilizan para navegar entre las limitaciones de recursos, y cómo estas estrategias, a su vez, influyen en la gestión de los pacientes con problemas de salud mental. En segundo lugar, la investigación exploró si

las interacciones a nivel micro entre los médicos y los pacientes generan tendencias identificables en los enfoques de gestión empleados por los profesionales de la salud. Al examinar los encuentros cotidianos de los médicos de AP con sus pacientes, esta hipótesis propuso descubrir si surgen patrones consistentes en la gestión. Un enfoque clave de este análisis fue la toma de decisiones discrecional de los médicos en la gestión de pacientes con trastornos mentales, destacando cómo estas elecciones individualizadas configuran la atención dentro de las limitaciones más amplias del sistema de salud. En tercer lugar, la investigación consideró si estas tendencias emergentes de gestión contribuyen a cambios dentro del modelo institucional y organizativo. Esta hipótesis examinó las implicaciones más amplias de las tendencias identificadas, evaluando cómo podrían haber influido en cambios en la estructura y funcionamiento general de los servicios de salud.

El estudio utilizó dos herramientas metodológicas: una comparación narrativa transnacional y la recopilación de datos primarios. Este enfoque facilitó la identificación de mecanismos clave que influyen en el acceso a los servicios de salud mental en múltiples niveles y destacó las diferencias en la gestión de los médicos de AP en España e Italia, proporcionando una perspectiva comparativa sobre sus respectivos estados de bienestar (Hill & Hupe, 2019). Las entrevistas biográficas en profundidad, fundamentales para la recopilación de datos primarios, permitieron una recolección matizada de datos, lo que permitió a los médicos y pacientes reflexionar e interpretar sus experiencias a fondo (Lindseth & Norberg, 2004; Rosenthal, 1993). El enfoque hermenéutico-fenomenológico ofreció valiosas ideas. Basado en la noción de cuidado de Heidegger, esta metodología subraya el aspecto intrínseco del cuidado en las actividades profesionales cotidianas de los médicos de AP, proporcionando una comprensión más profunda de sus acciones más allá de su función puramente administrativa (Ehrich, 2005). Un total de 22 pacientes y 20 médicos de España e Italia, junto con 6 coordinadores de AP, compartieron sus experiencias. El enfoque narrativo preservó la autenticidad de sus testimonios, al mismo tiempo que reveló las diversas posibilidades interpretativas propias de este enfoque cualitativo (Gofen, 2014; Maynard-Moody & Musheno, 2000).

Considerando los estudios de caso de España e Italia, ambos países han pasado de modelos de atención sanitaria centrados en la ocupación a modelos de salud universal. La Ley General de Sanidad de España de 1986 estableció su Sistema Nacional de Salud (SNS) con principios de cobertura universal (Kringos *et al.*, 2015). La desinstitucionalización de la salud mental en España, descrita en el Informe para la

Reforma Psiquiátrica de 1985 y consolidada por la Estrategia en Salud Mental del SNS de 2007, integró la psiquiatría en el sistema sanitario (Aparicio Basauri, 1993; Guillén & Cabiedes, 1997; Juliá-Sanchis *et al.*, 2020). La reforma en Italia comenzó con la Ley 180 de 1978, que detuvo las admisiones en hospitales psiquiátricos y promovió un enfoque centrado en el paciente (Barbui *et al.*, 2018). Actualmente, ambos países enfrentan desafíos en la coordinación de la salud mental, la AP y los servicios sociales, fundamentales para el tratamiento comunitario (Salvador-Carulla *et al.*, 2005). En España, la descentralización, necesaria para lograr estabilidad política tras la dictadura, implicó la transferencia de la gestión de los servicios públicos del Gobierno central a los Gobiernos regionales (Guillén & Cabiedes, 1997; Vázquez-Barquero *et al.*, 2001). En Italia, la regionalización sanitaria culminó en 1999, manteniendo la cobertura universal y la prestación gratuita de servicios; aunque las estrategias de copago introdujeron desafíos periódicos a esta gratuidad (Kringos *et al.*, 2015). En cuanto al consumo de fármacos, España lidera el consumo de benzodiacepinas, con 110 dosis diarias por cada 1.000 habitantes en 2021, tendencia que aumentó durante la pandemia (INCB, 2022; Ministerio de Sanidad, 2022). El consumo de fármacos psicotrópicos en Italia se ha mantenido estable, con ligeros aumentos en el de benzodiacepinas y un consumo constante de antidepresivos y antipsicóticos (AIFA, 2022). Profesionalmente, los médicos de AP en España son empleados públicos asalariados que ejercen sus funciones a tiempo completo en centros de salud multidisciplinarios, donde un coordinador gestiona la organización de los turnos. Aunque algunos centros operan las 24 horas del día, no todos ofrecen servicios de urgencias (Kringos *et al.*, 2015). En Italia, los médicos de AP son trabajadores públicos autónomos y aseguran niveles básicos de atención y servicios continuados a través de "unidades locales agregadas" (SISAC, 2024). A pesar de los esfuerzos por replicar el modelo español con centros de salud multidisciplinarios, Italia reporta mayores necesidades sanitarias no satisfechas en comparación con España (Pavolini *et al.*, 2015; Petmesidou *et al.*, 2020). La AP en España, marcada por centros de salud más burocratizados, se alinea con el modelo "*Public Hierarchical Normative*" [Normativo Jerárquico Público] (Kringos *et al.*, 2015). La AP en Italia, con su remuneración basada en la capitación y regulación fiscal, refleja una combinación de los modelos "*Public Hierarchical Normative*" [Normativo Jerárquico Público] y "*Professional Hierarchical Gatekeeper*" [Puerta-de-acceso Jerárquico Profesional], lo que destaca la mezcla de innovación dentro de un marco burocrático tradicional (Kringos *et al.*, 2015).

Comparar estos dos países fue valioso para comprender diferentes enfoques dentro de modelos de bienestar similares. Esta comparación permitió identificar estructuras y dinámicas institucionales y organizativas clave que influyen en la gestión de los médicos de AP de pacientes con trastornos mentales. Las diferencias en las prácticas de gestión se remontaron a variaciones en estos factores institucionales y organizativos; mientras que las similitudes se atribuyeron a dimensiones compartidas. Al examinar dos estados de bienestar comparables, el estudio exploró estas variables, sugiriendo posibles relaciones de causa y efecto y ofreciendo una visión de los mecanismos subyacentes que moldean las prácticas de gestión de los médicos.

Los sistemas de salud de Italia y España, aunque presentan características distintas, comparten similitudes significativas, particularmente respecto a la escasez de recursos y la carga administrativa. Ambos países priorizan la eficiencia y la reducción de costos, posiblemente relacionadas con carencias estructurales y una creciente dependencia hacia los medicamentos recetados. Los médicos de AP operan dentro de limitaciones institucionales y organizativas que restringen su capacidad de gestión, un concepto que Hupe (2013) denomina "*discretion as stated*" [discrecionalidad definida]. Sin embargo, como burócratas a nivel de calle, los médicos ejercen lo que se conoce como "*discretion as used*" [discrecionalidad implementada], que, según los modelos teóricos, da forma a la implementación de las políticas públicas. Esto incluye las decisiones inmediatas tomadas para abordar situaciones específicas, destacando la adaptabilidad y el juicio necesarios para navegar por las complejidades de la práctica real.

Así, el comportamiento de gestión de los médicos de AP está significativamente influenciado por la presencia de listas de espera. Para evitar estos retrasos, los médicos pueden contactar directamente con los servicios públicos de salud mental, una práctica más común entre los médicos italianos debido a su mayor autonomía. Al buscar atajos para ayudar a sus pacientes (Wells, 2007), los médicos aprovechan de manera discrecional sus redes interorganizacionales informales para adaptar la atención y abogar en nombre de sus pacientes (Dunham *et al.*, 2008; Loyens, 2019). Las limitaciones de tiempo también juegan un papel importante en la creciente dependencia de las prescripciones de medicamentos (Thornicroft, 2008). Las entrevistas con médicos revelan que la prescripción de medicamentos se ha convertido en una estrategia frecuente para hacer frente al tiempo limitado, un problema exacerbado por la creciente escasez de personal en la AP. Esta situación obliga a los médicos en Italia y España a gestionar un alto

volumen de pacientes, lo que intensifica aún más el problema. Otro factor clave que influye en la gestión de los trastornos mentales por parte de los médicos de AP es el nivel de formación que reciben (Thornicroft, 2008). Una atención efectiva requiere una combinación de conocimientos médicos especializados y habilidades emocionales. Sin embargo, los médicos a menudo perciben a los pacientes con trastornos mentales graves como peligrosos, sintiéndose insuficientemente capacitados para manejar tales casos. Esta brecha en la formación socava el acceso universal a servicios de salud mental de calidad, dejando en gran medida al azar que un paciente sea atendido por un médico con una comprensión profunda de las dinámicas psicológicas.

El aumento de las prescripciones en los sistemas de salud de Italia y España puede atribuirse a una combinación de factores, como la falta de recursos, tiempo limitado, formación inadecuada y la escasez de personal. Este problema se ve aún más intensificado por la creciente demanda de servicios de salud mental, impulsada por la normalización gradual de las discusiones sobre la salud mental en la sociedad (Doblytė, 2020). Estas limitaciones dejan a los médicos de AP con pocas alternativas, lo que a menudo conduce a una sobre prescripción, siendo esta una solución rápida ante las necesidades de los pacientes (Fava, 2023; Stacey, 1974). El enfoque en soluciones farmacológicas, en lugar de tratamientos integrales, lleva a una gestión rutinaria de los pacientes, poniendo en riesgo la profundidad y calidad de la atención (Lipsky, 2010). Ambos países destacan la necesidad urgente de un enfoque de supervisión más estructurado que oriente y respete las decisiones clínicas, garantizando una atención efectiva y económicamente sostenible. Así, la creación de un sistema de supervisión que fomente activamente la responsabilidad, en lugar de imponer sanciones, podría conducir a una atención más coherente y de mayor calidad en ambos países. En cuanto a las diferencias, los médicos italianos, dentro de un modelo de trabajo autónomo, a menudo muestran una perspectiva menos corporativa; mientras que los médicos españoles en el modelo asalariado demuestran un mayor compromiso organizativo. A pesar de estos modelos divergentes, los médicos de ambos países gestionan eficientemente los recursos, reflejándose en decisiones ponderadas sobre los costes de prescripciones y derivaciones a especialistas. Los médicos italianos, con mayor autonomía, a veces derivan los pacientes a especialistas privados; mientras que los médicos españoles generalmente evitan tales prácticas, posiblemente debido a su condición de trabajador dependiente. La flexibilidad horaria y la interacción con los pacientes de los médicos italianos posiblemente faciliten la gestión de la salud mental. En

el caso de los médicos españoles, las condicionantes organizativas de los centros de salud limitan su flexibilidad horaria, ofreciendo igualmente una autonomía clínica significativa.

Las presiones y limitaciones sistémicas que enfrentan los médicos de AP se ven contrarrestadas por su capacidad para tomar decisiones discrecionales de manera efectiva. Esta interacción dinámica es vital para comprender cómo se logran los objetivos de salud en la práctica cotidiana, revelando la flexibilidad inherente en sistemas que a menudo se perciben como rígidos y uniformes. A partir de aquí, la siguiente hipótesis de investigación tuvo como objetivo identificar los patrones de gestión de pacientes con problemas de salud mental por parte de los médicos. La convergencia de prácticas entre los médicos italianos y españoles, a pesar de los diferentes sistemas de salud, destaca una tendencia universal en la gestión de los trastornos mentales que trasciende las fronteras nacionales. De hecho, la segunda hipótesis buscaba demostrar cómo, mediante el ejercicio de la “discrecionalidad implementada”, los médicos se convierten en agentes al servicio de los ciudadanos (Maynard-Moody & Musheno, 2000). La tercera hipótesis se centró en cómo los médicos de AP están transformando los marcos organizativos e institucionales dentro del sistema sanitario a través de prácticas innovadoras en la gestión de pacientes con trastornos mentales. Los médicos adaptan sus intervenciones para satisfacer las necesidades individuales de los pacientes, lo que refleja una comprensión profunda de las complejidades inherentes a la atención de la salud mental. Esta práctica no solo respalda la conceptualización de la teoría de la BNC sobre la autonomía de los trabajadores públicos de primera línea, sino que también se alinea con la observación de Rice (2013) sobre la interacción dinámica entre los elementos macroestructurales y la agencia individual dentro de los entornos institucionales. El uso constante de intervenciones no farmacológicas y enfoques de atención holística tanto en Italia como en España corrobora el concepto de poder discrecional ejercido por los burócratas a nivel de calle (Lipsky, 2010). La estrategia de emplear una comunicación personalizada y enfatizar la capacitación del paciente como un aspecto central del tratamiento subraya el papel de los médicos como consejeros críticos dentro del sistema sanitario. Este enfoque mejora la participación y la adherencia clínica del paciente, lo que es crucial para una gestión efectiva de la salud mental, y fomenta una mejor comprensión de los problemas de salud mental entre la población. Estos hallazgos sugieren una tendencia hacia la atención centrada en el paciente, indicativa de un cambio en la práctica institucional que valora la autonomía del paciente y una toma de decisiones informada. Además, el análisis de las

estrategias de gestión basadas en los grupos de edad de los pacientes revela una comprensión matizada de las diversas necesidades de diferentes grupos demográficos. Para los pacientes más jóvenes, los médicos se centran en la participación y las intervenciones proactivas, vitales para la detección temprana y la gestión de los problemas de salud mental. En contraste, el cuidado de los pacientes mayores tiende a ser más conservador, con un énfasis significativo en el monitoreo y la gestión del uso prolongado de medicamentos para prevenir la dependencia y los efectos adversos.

En cuanto a la hipótesis sobre la influencia de los contextos organizativos e institucionales más amplios, los médicos de AP en Italia disfrutan de una considerable autonomía organizativa. Esta independencia les permite adoptar prácticas innovadoras, como la formación de grupos de colaboración y la utilización de tecnologías para gestionar la atención al paciente de manera más eficiente. Estas innovaciones fomentan un mayor trabajo en equipo y una gestión personalizada de la atención sin imponer excesivas cargas administrativas. En contraste, los médicos de AP en España, limitados por su condición de funcionarios dependientes, enfrentan mayores restricciones para implementar cambios organizativos de manera independiente. Deben navegar a través de más capas de burocracia, lo que puede frenar la innovación. A pesar de estos obstáculos, los médicos españoles reconocen la importancia de integrar los servicios comunitarios y sociales en la atención de la salud mental y se esfuerzan por incorporar estos elementos en su práctica siempre que sea posible. Ambos grupos de médicos desempeñan un papel crucial en cambiar las percepciones sobre la salud mental al involucrar a los pacientes como socios en el proceso de cuidado, respaldados por una formación que promueve un enfoque colaborativo y de empoderamiento en la atención. Extienden sus servicios más allá de los modelos tradicionales al integrar recursos comunitarios para abordar eficazmente los determinantes sociales de la salud. Los comportamientos innovadores o “de agencia” de los médicos no son generalizados; pero son indicadores cruciales de posibles cambios futuros en el panorama de la atención sanitaria, señalando una posible evolución en la gestión de la salud en su totalidad. Estas innovaciones a menudo son profundamente personales para cada médico, reflejando su autonomía profesional y discrecionalidad. Mientras algunos médicos están innovando en nuevas metodologías e integrando servicios sociales y de salud más amplios, otros pueden adherirse a enfoques más tradicionales. Este enfoque orientado al cuidado desafía las narrativas predominantes de desapego burocrático e impersonalidad en la administración pública. El aspecto central

de este proceso es reconocer que toda comprensión conlleva algún prejuicio, lo que permite a la AP valorar cómo sus métodos y prácticas están moldeados por su contexto sociohistórico. Esta perspectiva, además, ayuda a situar y hacer comprensible el sufrimiento emocional de los pacientes (Aho, 2008; Chodoff, 2002).

Tanto en Italia como en España, los médicos más jóvenes tienden a adoptar prácticas más innovadoras y centradas en el paciente, especialmente con pacientes más jóvenes que son menos propensos a aceptar prescripciones de medicamentos. Esta preferencia por alternativas puede deberse a que los médicos jóvenes están menos institucionalizados por el sistema, lo que les permite explorar enfoques más holísticos y eficientes que, no obstante, siguen alineándose con la eficiencia (no conveniencia) sistémica. El concepto de "acercarse y alejarse del paciente" (Gofen *et al.*, 2019) captura la tensión entre la atención centrada en el paciente y el impulso gerencial hacia la eficiencia. En la gestión de la salud, la eficiencia a menudo se interpreta en términos de reducción de costos, optimización de recursos y prestación de servicios más rápida. Sin embargo, los médicos de AP que operan en la primera línea interpretan y equilibran la eficiencia de manera más matizada, considerando tanto dimensiones éticas como personales en su toma de decisiones. Cuando los médicos "se acercan" al paciente, priorizan una atención personalizada y holística que tiene en cuenta las necesidades emocionales, sociales y de salud del individuo. Este enfoque comprende la eficiencia no solo en términos económicos, sino también en términos de resultados para el paciente, satisfacción y bienestar a largo plazo. Se alinea con un compromiso ético de tratar a los pacientes como socios en su atención, respetando su autonomía y preferencias, y muchas veces yendo más allá de los marcos rígidos de tratamientos estandarizados. Por el contrario, "alejarse del paciente" refleja las presiones organizativas que impulsan a los médicos a adherirse a los objetivos institucionales, como reducir el tiempo de las consultas, y recurrir a la prescripción rutinaria de medicamentos. En este sentido, la eficiencia se define de manera más limitada por resultados inmediatos, como prescribir rápidamente medicamentos para manejar los síntomas, o cumplir con las directrices políticas que priorizan el éxito medible a corto plazo sobre los enfoques centrados en el paciente. El equilibrio entre estos dos polos, la atención centrada en el paciente y la eficiencia sistémica, requiere que los médicos ejerzan su discrecionalidad, navegando entre lo que significa ser eficiente y ético. Para algunos, la eficiencia puede implicar tomarse el tiempo para explorar alternativas a la medicación, especialmente con pacientes

más jóvenes, buscando abordar las causas subyacentes en lugar de ofrecer soluciones rápidas. Para otros, las presiones institucionales pueden empujarlos a adherirse estrictamente a procesos predefinidos que no siempre se alinean con los mejores intereses del paciente.

En conclusión, esta investigación estudió la intersección entre los marcos institucionales y la accesibilidad a los servicios de salud mental, revelando cómo los factores estructurales y personales moldean el compromiso con los servicios y los resultados. Al integrar enfoques innovadores que posicionan a los pacientes como participantes activos o “productores de salud” en su propia atención, existe el potencial de mejorar significativamente la prestación de servicios y el compromiso de los pacientes. Este cambio de paradigma no solo aborda las interacciones dinámicas resaltadas por el concepto de “candidatura” (Dixon-Woods *et al.*, 2006), donde las políticas y los proveedores de atención sanitaria juegan un papel crucial en facilitar el acceso, sino que también aboga por el empoderamiento del paciente y la autonomía clínica, preparando el terreno para cambios transformadores en la gestión de la salud mental. De hecho, los médicos de AP no solo diagnostican y tratan condiciones de salud mental, sino que también desempeñan un papel fundamental en la determinación de qué pacientes son derivados a servicios especializados o gestionados dentro de la AP. Las interacciones entre los médicos y los pacientes pueden, por lo tanto, definir la “candidatura” de los pacientes para ciertos tratamientos, influyendo en su capacidad para acceder a la atención que necesitan.

Esta tesis ha explorado el papel en evolución de los médicos de AP en la gestión de la salud mental, destacando un cambio hacia prácticas más centradas en la comunidad y en el paciente. Tradicionalmente vistos como “guardianes” del sistema, los médicos de AP son cada vez más fundamentales para impulsar reformas de abajo-arriba que integren perspectivas más amplias de atención sanitaria. La investigación subraya la necesidad de políticas que aumenten la autonomía de los médicos y apoyen la atención centrada en el paciente, fomentando innovaciones que podrían transformar el panorama sanitario. De manera crucial, se enfatiza el potencial de las interacciones entre médicos y pacientes para llevar a cabo cambios sistémicos, abogando por un modelo en el que los médicos de AP sean centrales para una atención verdaderamente colaborativa. Además, este trabajo de investigación revela cómo los médicos de AP experimentan y navegan por las limitaciones institucionales y organizativas, como la escasez de recursos y la autonomía

limitada. Sus prácticas diarias a menudo divergen de la política oficial, moldeadas por las realidades prácticas del entorno sanitario. La fortaleza de esta investigación radica en su capacidad para demostrar que los marcos teóricos y el discurso público, como las políticas sobre medicina preventiva y atención comunitaria, a menudo están en desacuerdo con las realidades que enfrentan los médicos. Mientras que las políticas abogan por grandes ideales como la atención sanitaria universal, los médicos deben adaptar sus estrategias de gestión para enfrentar los desafíos prácticos con los que se encuentran. En lugar de ofrecer conclusiones deterministas de causa-efecto, esta tesis destaca cómo los médicos perciben y responden a estas limitaciones, exponiendo la significativa brecha entre los ideales de las políticas y las realidades prácticas de la atención clínica.

9.2 Contribuciones a la literatura

Esta disertación examinó el entorno institucional y los contextos organizativos en los que operan los médicos de AP, analizando cómo estos factores moldean sus interacciones con pacientes que experimentan trastornos de salud mental. Si bien investigaciones previas habían abordado estas dinámicas, este estudio ofreció un análisis exhaustivo, proporcionando una comprensión matizada de la interacción entre las estructuras a nivel macro y las interacciones a nivel micro. El estudio desarrolló además la teoría de la BNC al demostrar cómo los marcos profesionales influyen en las prácticas discrecionales de los médicos en Italia y España. También exploró cómo la gestión de los pacientes con trastornos mentales por parte de los médicos de AP puede iniciar procesos de formulación de políticas que, a su vez, configuren marcos institucionales y organizativos más amplios. La investigación identificó brechas en la formación en salud mental y examinó cómo la experiencia profesional impacta en las decisiones discrecionales. Al centrarse en los contextos poco investigados del sur de Europa, caracterizados por recursos limitados y una gestión descentralizada de los servicios, el estudio amplió el alcance comparativo de la teoría. Este enfoque proporcionó una comprensión más profunda de cómo operan los médicos dentro de diferentes marcos institucionales y sugirió su aplicación a las prácticas de gestión sanitaria en su totalidad. Además, la disertación abordó vacíos en la literatura al demostrar el potencial de las interacciones a nivel micro como catalizadores del cambio sistémico. Se han analizado los procesos de retroalimentación que parten de la gestión individual de los médicos de cabecera y se extienden a contextos institucionales, destacando cómo cada nivel se adapta

en respuesta a la influencia mutua. Esta perspectiva ofreció nuevas ideas sobre la capacidad de los trabajadores de la salud posicionados en primera línea para impulsar cambios de abajo-arriba dentro de los sistemas sanitarios.

Además, la teoría de la BNC se aplicó a una profesión que previamente había sido relativamente poco explorada (Dixon *et al.*, 2020) y dentro de un dominio crítico y extendido de gestión: la salud mental. Esta investigación fue oportuna y pertinente para las sociedades contemporáneas que enfrentan crecientes desafíos en salud mental. Al aplicar la teoría de la BNC en este contexto, el estudio proporcionó valiosos conocimientos y recomendaciones para los responsables de políticas y profesionales involucrados en la gestión de la salud mental. El estudio destacó la dinámica interacción entre los procesos de implementación de arriba-abajo y de abajo-arriba, ofreciendo una comprensión más profunda de cómo las prácticas discrecionales de los médicos pueden moldear los resultados de las políticas. Además, la tesis contribuyó al campo más amplio de la gestión sanitaria al utilizar la salud mental como un estudio de caso para extraer conclusiones más generales sobre las prácticas de atención sanitaria. Demostró que las decisiones y acciones individuales de los médicos pueden tener un impacto significativo en la implementación de las políticas, y que, como resultados, las estructuras institucionales y organizativas pueden ser moldeadas. Este hallazgo es especialmente relevante para los futuros desarrollos en la atención sanitaria, subrayando el potencial de los médicos de AP para impulsar cambios sistémicos a través de sus interacciones y prácticas cotidianas.

9.3 Limitaciones de la investigación

Las principales limitaciones de este estudio surgen de su metodología y de las variables específicas en las que se centró. El proceso de muestreo podría haber generado una muestra no representativa, lo que potencialmente sesga la representación del fenómeno investigado. Dada la descentralización y las diferencias regionales entre los dos servicios de salud nacionales, estos resultados podrían variar significativamente. Las respuestas pueden verse influenciadas por el sesgo de deseabilidad social (Bergen & Labonté, 2020); sin embargo, se hicieron esfuerzos para minimizar este efecto, asegurando el anonimato y creando un ambiente acogedor (Lindseth & Norberg, 2004).

Desde una perspectiva cuantitativa, ciertas limitaciones del enfoque cualitativo se hacen evidentes, en particular la dificultad de comparar directamente múltiples estudios de esta naturaleza. En la investigación cualitativa, la estandarización de los procedimientos no es el objetivo principal; si no que el foco está en desarrollar una comprensión más profunda de fenómenos específicos. La interpretación de los investigadores, combinada con los diversos contextos y circunstancias encontrados durante la recolección de datos, influye inevitablemente tanto en las entrevistas como en el análisis posterior (Gobo, 2002; Griffiths *et al.*, 2011). Cada investigación cualitativa es única debido a estos elementos subjetivos. Si bien esta singularidad puede limitar la generalización de los hallazgos, no debe considerarse una desventaja. Más bien, es un resultado natural del enfoque cualitativo que prioriza conocimientos ricos y detallados sobre generalizaciones amplias o la validación estadística de hipótesis. Este énfasis en la comprensión contextual específica permite que la investigación cualitativa capture las complejidades y matices de la experiencia humana que a menudo se pasan por alto en metodologías más estandarizadas y cuantitativas. En la investigación cualitativa, la inversión de tiempo necesaria para la recolección y el análisis de datos es sustancialmente mayor que en los enfoques cuantitativos, donde se pueden administrar pruebas o cuestionarios a muchos participantes en un corto período de tiempo. En este estudio se entrevistó a 48 participantes, entre ellos 20 pacientes diagnosticados con trastornos mentales. Debido a la disponibilidad impredecible de los sujetos y al tiempo requerido para los contactos, entrevistas y análisis hermenéutico, los participantes fueron seleccionados mediante un muestreo por conveniencia (Etikan *et al.*, 2016) y, posteriormente, mediante una estrategia de bola de nieve (Biernacki *y* Waldorf, 1981). El investigador hizo esfuerzos para asegurar una representación equilibrada de los sujetos por género y edad. A los médicos de AP también se les pidió que facilitaran entrevistas con algunos de sus pacientes; sin embargo, esto no siempre fue posible, y en algunos casos, los pacientes con problemas de salud mental fueron entrevistados sin que su médico estuviera involucrado. Se reconoció la complejidad del objeto de investigación (Goggin, 2021; Hill & Hupe, 2019) y la incapacidad del investigador para eliminar completamente su influencia en la elección de técnicas y el análisis de los datos (Roulston & Shelton, 2015). Es esencial reconocer que, en la investigación cualitativa, la sensibilidad del investigador hacia ciertos temas puede influir tanto en la conducción de las entrevistas como en el análisis de los resultados. Esta influencia, aunque manejada con cuidado, no puede ser completamente excluida.

9.4 Sugerencias para la formulación de políticas

La investigación ofrece una base sólida para varias recomendaciones clave dirigidas a los legisladores. En primer lugar, es necesario implementar programas de formación dirigidos a los médicos de AP, centrándose en los últimos avances en el cuidado de la salud mental, incluidas las terapias no farmacológicas y los enfoques de atención holística. Integrar módulos completos de salud mental en los planes académicos de formación médica garantizará que los médicos estén bien preparados desde el inicio de sus carreras, manteniendo su competencia a través del desarrollo profesional continuo. Además, una mayor colaboración entre los médicos de AP, los especialistas en salud mental y los servicios sociales es esencial. Las políticas deben apoyar la cogestión de pacientes a través de equipos multidisciplinarios que aborden todos los aspectos de la salud del paciente. Estos marcos no solo mejoran la coordinación de la atención, sino que también aseguran que se gestionen de manera integral las necesidades mentales, físicas y sociales de los pacientes. Es crucial priorizar las inversiones en los servicios de AP, proporcionando a los médicos las herramientas y recursos necesarios para gestionar eficazmente los trastornos de salud mental. Esto incluye formación adecuada, tiempo suficiente para la atención al paciente y personal suficiente para satisfacer la creciente demanda. Además, adoptar tecnologías de salud digital puede mejorar significativamente la precisión diagnóstica, el monitoreo del tratamiento y el compromiso del paciente, mejorando la prestación general de atención.

Los modelos de atención sanitaria que promuevan la autonomía del paciente y la toma de decisiones informada deben ser fomentados, alejándose de los enfoques paternalistas en la atención. La creación de grupos de pacientes aseguraría que sus preferencias y voces se integren en el desarrollo de políticas y la prestación de atención, empoderando a los pacientes en el proceso. También es fundamental que las políticas aborden las necesidades de una población envejecida mejorando el acceso a la atención psicoterapéutica para los adultos mayores. Este enfoque debería reducir la dependencia exclusiva de los tratamientos farmacológicos, promoviendo un enfoque más equilibrado que incluya una gama de opciones terapéuticas. Para las poblaciones más jóvenes, se deben implementar programas de cribado e intervención temprana en escuelas y centros comunitarios. La formación para jóvenes puede ayudar a contrarrestar la tendencia a normalizar los problemas de salud mental como una mera “medicalización de la

normalidad". Estas iniciativas deben subrayar que, aunque los medicamentos pueden ofrecer un alivio rápido de los síntomas, no deberían ser el primer recurso para trastornos leves o malestar emocional común, donde las intervenciones psicológicas pueden ser más efectivas.

Varios médicos entrevistados en Italia y España enfatizaron la necesidad de mejorar la supervisión clínica e introducir sanciones para garantizar el cumplimiento de las mejores prácticas y directrices. La supervisión clínica mejorada implicaría una vigilancia más estructurada de las prácticas de los médicos, con supervisores que ofrezcan retroalimentación y apoyo regular para mejorar los resultados del tratamiento. Las sanciones, ya sean económicas, disciplinarias o relacionadas con la supervisión del empleo, podrían introducirse para reforzar la responsabilidad sin socavar la discrecionalidad profesional de los médicos, abordando desviaciones de las prácticas estándar de manera constructiva y justa. Además, los desarrollos actuales en Italia indican un cambio hacia un modelo más centralizado en los centros de salud, manteniendo igualmente el estatus de profesional autónomo para los médicos. Esta evolución ha generado un debate interno entre los médicos sobre la elección de continuar como profesionales autónomos o hacer la transición al estatus de empleados. Esta investigación podría proporcionar perspectivas valiosas para los legisladores italianos, ya que se ha examinado un sistema de salud similar con centros de salud organizados y médicos asalariados. De esta manera se contribuiría a la formulación de decisiones informadas que apoyen de la mejor manera la eficiencia, la satisfacción y la estabilidad del sistema sanitario.

9.5 Propuestas de investigación para el futuro

Los hallazgos de la investigación sugieren varias propuestas para futuras investigaciones. Una posible línea es investigar la efectividad de un programa de formación dirigido a mejorar la capacidad de los médicos de AP para gestionar problemas de salud mental, incorporando las ideas de este estudio. La intervención podría incluir el establecimiento de prácticas reflexivas regulares y discusiones entre los médicos para promover el aprendizaje continuo y la mejora de la atención. Este enfoque también podría mejorar la satisfacción laboral y la resiliencia al tratar casos complejos. Además, alineándose con la metodología hermenéutica-fenomenológica, la investigación podría incluir oportunidades para que los médicos proporcionen retroalimentación sobre las

conclusiones del estudio, evalúen la interpretación de los resultados y completen el círculo hermenéutico (Dowling, 2007; Kafle, 2013; Warnke, 2011). Esta perspectiva también concuerda con la teoría del BNC, que enfatiza la importancia de relaciones horizontales sólidas entre los burócratas a nivel de calle. Dichas relaciones podrían fomentar la colaboración contribuyendo al desarrollo de estrategias de gestión innovadoras, y permitiendo que los médicos trabajen de manera más efectiva en la atención de problemas de salud mental (Hupe & Hill, 2007; Loyens, 2019). Para evaluar la efectividad de la intervención, se podría utilizar un enfoque de métodos mixtos, el cual podría incluir encuestas realizadas antes y después de la intervención para medir los cambios en conocimientos y actitudes de los participantes. Además, se podrían realizar entrevistas de seguimiento para obtener una retroalimentación más detallada y conocer las experiencias personales de los participantes.

Asimismo, sería interesante aplicar el mismo enfoque y metodología de esta investigación en diferentes contextos nacionales. Esto podría incluir la exploración de contextos donde la AP no actúe como puerta de acceso a los servicios especializados, donde la desinstitucionalización haya avanzado a diferentes ritmos o donde los hospitales psiquiátricos aún operen. Comparaciones de este tipo podrían proporcionar información importante sobre cómo los diferentes contextos institucionales y organizativos influyen en los enfoques de los médicos para tratar a pacientes con trastornos de salud mental. En tercer lugar, futuras investigaciones podrían ampliar su alcance a otras áreas de la gestión sanitaria, examinando cómo prácticas discrecionales similares afectan la "candidatura" de los pacientes en diversas especialidades médicas o entornos de atención sanitaria. Esta exploración podría arrojar luz sobre si los enfoques de tratamiento personalizado y la discrecionalidad de los médicos contribuyen a mejorar los resultados de salud, la satisfacción del paciente y la eficiencia general del tratamiento. Al extender los esfuerzos de generalización de este estudio, el objetivo sería identificar principios universales de gestión sanitaria que puedan mejorar la calidad de la atención y la eficacia operativa en entornos de salud diversos.

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APPENDICES

1. IN-DEPTH INTERVIEW GUIDE WITH GP

(English version)

Thank you for agreeing to participate in this research.
In summary, the main objective is to gain an in-depth understanding of how GPs manage patients with mental health issues. In particular, it will be important to highlight the organisational and cultural factors that may facilitate or hinder this management.
Please remember that there are no right or wrong answers, and at no point during the research will your words be subject to judgment by the researcher.
With your permission, I will record the audio of this interview, which will then be transcribed to help analyse the content and pay closer attention to your words. Your anonymity and the confidentiality of everything shared during the interview will be fully protected.
If you are interested in receiving the study results, once the interview has concluded and the recorder is turned off, I will ask for your email address so I can send them to you. Let's begin the interview.

1) What motivated you to become a general practitioner?

2) Would you agree with those who define you as a public servant, given that you work for the NHS? Why?

3) Do you see yourself as the gatekeeper to the NHS? If so, what are your reflections on this role? If not, could you explain your perspective?

Relationship with Patients Now I will ask you a few questions about your relationship with your patients.

1) Considering your experience, what characteristics in a patient help facilitate or complicate the therapeutic relationship?

2) And what about the characteristics of a doctor?

3) More generally, what organisational characteristics, in your opinion, influence the relationship with the patient?

4) Personally, what type of language do you typically use with your patients (if unclear, add: "more technical, informal, or a mix of both")? What factors influence your choice, and why?

5) Compared to when you first started as a doctor, have you noticed any differences in your relationship with patients? If so, what differences have you observed?

6) How did your work change with the pandemic? What difficulties arose? Did they change over time?

7) How has your relationship with patients changed during the pandemic?

8) How would you rate communication with healthcare organisations during the pandemic? Could you explain your answer?

Mental Health. Moving on to questions about the mental health of patients and its management.

1) What are the most common symptoms you encounter?

2) What are your thoughts on the process of normalising mental health that is happening today, particularly among younger people? Do you think this is a completely positive development, or could it also have some negative effects?

3) How do you manage patients with symptoms attributable to psychological issues? Are there differences in your approach for mild versus severe symptoms?

4) What factors do you consider when beginning a therapeutic relationship with a patient who may have a mental disorder?

5) Do you have protocols in place that regulate the management of patients with this type of disorder?

If so, do you consider them an efficient way to manage patients, or do they complicate your work?

If not, do you think that managing patients with this type of disorder through protocols would be more efficient, or would such protocols complicate your work?

6) Do you believe there is prejudice and stigmatisation towards mental health? I'm referring both to doctors and the general population.

7) Storytelling - Could you describe an episode involving a patient with psychological symptoms? One that particularly stands out in your memory. How did you manage the situation, and why did you choose to share this specific case? If you don't have a personal case, you may share one that you know of and that made a strong impression on you.

8) If you have doubts about how to treat a patient with psychological problems, how do you usually proceed?

9) In recent years, the consumption of benzodiazepines and anxiolytics has increased considerably. In your opinion, what effects is this having on the mental health of the population?

10) More generally, what are your thoughts on their use?

Relationship with Colleagues, Coordinators, and Mental Health Professionals

1) Is your work subject to supervision? By whom?

If yes, do you consider this a necessary measure?

If not, how would you react if your work were to be supervised?

2) What is your relationship with other primary care doctors?

3) What do you think about the possibility of holding regular meetings where each doctor can discuss their difficulties or suggest improvements in patient management? Would you participate in them?

4) What is your relationship with the family doctor organisations?

5) How is your relationship with doctors from a different generation?

6) Do you think there are differences between senior and junior doctors in how patients are managed, particularly in terms of mental health care? If so, what are these differences?

7) Is there any organisational mechanism through which you can suggest improvements in patient management to the relevant Health Area? Particularly in the case of mental health.

8) What is your relationship with professionals from the mental health service? Would you improve that relationship? How?

9) Would you like to add anything to the points raised earlier? Do you think any topics haven't been addressed?

This was the final question. Thank you once again for agreeing to participate in the study.

2. IN-DEPTH INTERVIEW GUIDE WITH PATIENTS (MENTAL HEALTH)

(English version)

Thank you for agreeing to take part in this research.
The main aim of this study is to explore in detail the patient's role in their relationship with their primary care physician, specifically within the context of mental health.
Please remember, that there are no right or wrong answers, and your words will not be judged at any point during the research.
With your permission, I will record the audio of this interview, which will then be transcribed to help analyse your responses more thoroughly. Your anonymity and the confidentiality of everything shared during the interview will be fully protected.
If you are interested in receiving the study's findings, I will ask for your email address at the end of the interview, after the recording is stopped, so I can send them to you. Let's begin the interview

Choosing the Doctor

1) Were you able to choose your family doctor?

2) What motivated your choice?

3) Do you prefer your doctor to be male or female? Why?

4) And who would you choose if you had to choose between a younger doctor or one of older age? Could you explain your decision?

Relationship with the Doctor

1) What are the reasons you usually visit the doctor? Have the reasons for your visits changed before and after the pandemic?

2) How would you rate your doctor's care? Are you satisfied with their work?

3) Do you trust your doctor? Why?

4) Do you think being close to the patient and building trust are important characteristics for a doctor? Are they as important as their medical competence?

5) When speaking with your doctor, do they tend to use more technical or informal language? Which do you prefer?

6) What would you think if your doctor used technical terms that you found difficult to understand? How would that make you feel?

7) Do you ask your doctor questions about your health condition or the treatments they prescribe?

If yes, how does your doctor usually respond?

If no, why not? Do you think it could be helpful?

8) Does your doctor involve you in decisions about your treatment?

If yes, why do you think they do so? How do you usually participate in these decisions?

If no, why not? Do you think it could be helpful?

Presence of Psychological Symptoms.

1) Storytelling - Mental Health. Could you briefly describe your clinical journey? From the moment you felt you needed psychological assistance to your current state. What were the most significant moments?

2) What difficulties did you face after being diagnosed with the problem?

3) On the other hand, what helped you?

4) What can you tell me about how your family doctor has managed this specific health issue? What do you think about it? Do you have anything you'd like to share?

5) It is generally thought that experiencing mental health problems only brings negative aspects. What do you think about that? Considering your personal experience, has that been the case? In your opinion, are there any positive factors that might arise?

Would you like to add anything else?

This was the final question. Thank you once again for agreeing to participate in the study.

3. IN-DEPTH INTERVIEW GUIDE WITH FLS

(English version)

Thank you for agreeing to participate in this research.
In summary, the main objective is to gain an in-depth understanding of how GPs manage patients with mental health issues. In particular, it will be important to highlight the organisational and cultural factors that may facilitate or hinder this management.
Please remember that there are no right or wrong answers, and at no point during the research will your words be subject to judgment by the researcher.
With your permission, I will record the audio of this interview, which will then be transcribed to help analyse the content and pay closer attention to your words. Your anonymity and the confidentiality of everything shared during the interview will be fully protected.
If you are interested in receiving the study results, once the interview has concluded and the recorder is turned off, I will ask for your email address so I can send them to you. Let's begin the interview.

Supervision Work

1) What are your responsibilities as a coordinator? If this doesn't specifically refer to your role as a supervisor, ask directly: Do you carry out any supervisory work over primary care doctors?

2) Regarding your supervisory work, what difficulties do you encounter daily?

3) Do you think your role has changed over time? If so, how has it changed?

4) What factors influence your work as a coordinator?

5) What factors do you consider when making decisions about the work of the professionals under your supervision?

6) Do you notice differences based on age or gender, even in your work? If so, what differences do you notice, and to what do you attribute them?

7) Storytelling: Have you ever sanctioned a doctor, or are you aware of any case where a doctor was sanctioned? Could you briefly describe the reason for the sanction and the procedure through which it was carried out? How did the doctor react? Thank you.

8) What sanctions are foreseen if a doctor is found to have mishandled the management of a patient?

9) Would you say that doctors have full autonomy in carrying out their duties? Could you explain your reasoning?

10) How would you assess the relationship between your unit and the GPs under your supervision?

Organisation of Services

1) Regarding the organisation of healthcare services, especially the transition from primary care to specialised care, such as mental health services, what do you think are the most significant challenges that might lead to difficulties in patient access?

2) The general ageing of the population is leading to an increase in the prevalence of cognitive impairment disorders. At the same time, the ongoing normalisation of mental health, particularly among younger people, is driving more individuals to seek primary care services as a necessary step to access specific healthcare services. Given this situation, do you think that more resources, both human and material, are being allocated to cope with the rising demand? If not, what might happen?

Would you like to add anything to the points raised earlier? Do you think there are any topics that haven't been addressed?

This was the final question. Thank you once again for agreeing to participate in the study.

4. SOCIODEMOGRAPHIC QUESTIONNAIRE

(English version)

General practitioner (GP)

Patient (P)

First-Line Supervisor (FLS)

Interview with ……. number …… Date ……………… ...

1. Gender

2. Age

3. Place of residence

4. Nationality

For the doctor:

1. Years of experience

2. Number of patients that can be assigned

3. Current number of patients

4. Number of daily visits

5. INFORMED CONSENT FOR PARTICIPATION IN RESEARCH

(English version)

By means of this document, we request your consent for the processing of the information you will provide during your interview, which is part of the research project of PhD student Roberto Giosa, conducted under the supervision of Professor Ana M. Guillén Rodríguez and Professor David Luque Balbona from the Department of Sociology at the University of Oviedo, Principality of Asturias, Spain.

Research Title Access to mental health and the primary care: management and handling strategies in Spain and Italy.

Research Aim: To enhance the understanding of how primary care doctors in Spain and Italy manage mental disorders. This research aims to pave the way for more effective strategies in identifying and managing mental health issues, ultimately improving access to necessary mental health services. A particular focus will be on evaluating how organisational and institutional factors impact this management.

Contact:
Roberto Giosa,

I, Roberto Giosa, researcher from the Department of Sociology at the University of Oviedo, Spain, declare the following:

1) The research, should you choose to participate, will involve a meeting of approximately 40 minutes. During this time, a brief description of the research project will be provided, followed by an explanation of this document, a socio-demographic questionnaire, and a semi-structured interview featuring open-ended questions. (ONLY in the case of doctors: At the end of the results analysis, a collective meeting will be held, on a date to be agreed, which will also be recorded and where the research findings will be discussed.)

2) The research involves the use of audio recording systems. That is, the interview will be recorded to allow for transcription and analysis of the content.

3) Your participation is completely voluntary. Therefore, you are entirely free to grant or refuse consent, or to withdraw any previously given consent at any time. If the interview has already taken place and you wish to withdraw your participation, the recording, transcription, and your data will be deleted and not used.

4) Not granting or withdrawing your consent will not cause you any harm or disadvantage in any case.

5) By Article 13 of the Italian Legislative Decree 30/06/2006 No. 196, Spain's Organic Law 3/2018, and the GDPR (EU Regulation 2016/679), your right to privacy, non-identification, and anonymity is guaranteed. Therefore, the data collected will be presented and disseminated strictly anonymously.

6) There are no risks associated with participation. There will be no financial benefits for participating. The main benefit is contributing to a better understanding of the subject of study. Likewise, no fee will be required for participation.

7) The research protocol was approved by the "Regional Clinical Research Ethics Committee of the Principality of Asturias" which ensures the protection of the rights, integrity, and well-being of the individuals involved in the research.

Please read the contents of this form carefully before signing it.

I, ____________________, I declare that I have received sufficient information from Roberto Giosa, researcher at the University of Oviedo, regarding the objective of the research, and that I have understood the information contained in this document. Therefore, I give my consent to participate.

Signature of the declarant   Place and date