Comments on Rosenshein and Valentine, "The Role of Primary Care Providers in Mental Health Care" A Literature Review Submitted to the Myers-JDC-Brookdale/Brandeis Collaboration on Mental Health

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I read the article very closely – an in-depth review of the topic in the US with reference to a number of models developing in health plans in Israel.

I would like to introduce a highly important additional player into the models under review – the state ambulatory service: a strong, well-established service, with abundant professional, highly experienced manpower comprising a multi-disciplinary staff capable of treating every type of mental pathology.

For methodological purposes, I will divide mental health into three levels:

1. *Primary medicine*

2. *Secondary mental-health medicine – Mental-health clinics of the health plans or state clinics, consultation by mental-health professionals within the primary clinics of the health plans, various models of integrating mental health professionals into primary medicine at the health plans*

3. *Tertiary mental health – Specialized clinics dealing with special populations:*
   - *Forensic populations, violent patients potentially at high risk*
   - *Patients resistant to treatment and requiring distinct therapeutic methods – increased medication, ambulatory electric shock treatment, TMS*
   - *Patients requiring special teamwork (DBT, integrated treatment of sexual deviants, eating disorders).*

I suggest that the models be expanded to include an additional player – specialized clinics.

Primary Medicine:

1. *To intensify the training of family physicians in the area of mental health: To restore rotation in mental health in the specialization of family physicians and make it obligatory rather than an elective*

2. *To have family physicians trained by mental-health professionals at the health plans or by physicians from the state system (the Shalvata model)*

3. *To train social workers from primary medicine in the area of mental-health (crisis intervention, rehabilitation of the mentally handicapped).*

Secondary Medicine:

1. *The health plans will decide where to open mental-health clinics and additional services (self-employed professionals from the health plans).*

2. *Integrating mental-health professionals into primary clinics (either professionals from the health plans or the purchase of a liaison service from state clinics)*

3. *Strengthening personal contacts between family physicians and mental-health clinics at the health plans or state clinics (as per choice of the health plans)*

4. *Establishing integrated clinics (primary clinic and mental-health clinic)*

5. *Opening and supporting frameworks for daytime treatment by the health plans or purchasing these services from state frameworks.*

Tertiary Medicine:

1. *Defining the populations in need of these services*

    - *Forensic population, at high risk for violence*
    - *Sexual deviants*
    - *Patients with eating disorders*
    - *Patients suffering from severe borderline personality disorders requiring treatment from DBT staff*
    - *Patients resistant to treatment and requiring the use of special methods.*

2. *Opening specialized services by state clinics*

3. *Strengthening the contacts between mental health clinics and these clinics.*

In this way, we will achieve the following goals:

a. *Improved service availability and accessibility*

b. *Provision of assistance to patients who refuse to come to mental health clinics*

c. *Improved availability of daytime treatment frameworks in mental health*

d. *Shortening the waiting time for mental treatment from the health plans by purchasing secondary services from state clinics*

e. *Opening and strengthening services for populations requiring special treatment.*