with minimal teratogenic effects. Changing patients from polytherapy to monotherapy might also yield a benefit if their disease is stable. Patients should have rapid access to specialised services if they feel that their disease is not well controlled. Outside of pregnancy, neurologists and obstetricians should also unite to offer patients contraceptive advice. This is necessary to ensure that patients have secure contraception that is compatible with their antiepileptic treatment and to avoid unintended pregnancies, which put patients at high risk for poor outcomes.

Viale and colleagues have emphasised the high-risk nature of pregnant women with epilepsy and services should now be altered to help prevent unnecessary instances of morbidity in this patient group.

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Luz Viale and colleagues[1] should be commended for reviewing the evidence that both epilepsy and exposure to antiepileptic drugs induce a small increase in the risks of maternal and fetal complications during pregnancy. However, the accompanying Comment[2] could have addressed three clinical issues.

First, there is the question of how to provide clear information to women so that they can balance these small risks of maternal and fetal complications with the known risks of congenital malformations and cognitive-behavioural deficits in children exposed to antiepileptic drugs in utero. Second, is the very low rate of co-prescription of high-dose folic acid with antiepileptic drugs in Europe, varying from 1% in Italy to 33·5% in Wales.[3] Third, are the alarming differences in the prevalence and modality (product and time period) of antiepileptic drug prescriptions between pregnant women in European countries.[3] Guidelines for the management of pregnant women with epilepsy are unclear and poorly implemented, so many women are not adequately informed of the risks of taking antiepileptic drugs.

Although the first report of congenital malformation due to valproate was reported by a French team in *The Lancet* in 1982, it was only after a legal case in May, 2015, relating to this outcome, that the French Medicine Agency now restricts clinicians from prescribing valproate (and its by-products) to women of childbearing age, making them obtain signed consent before giving a prescription.[4] Clinicians should be better trained in drug safety issues and assessed in their practice. Women of childbearing age taking antiepileptic drugs must be better informed of the risks of this treatment. The French Medicine Agency initiative should be extended to include an appropriate regulation for prescription of antiepileptic drugs in women of childbearing age in Europe and elsewhere.[5]

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Health-care improvements in a financially constrained environment

Although the European Council agreed on common values such as good quality, universally accessible care in 1996,[1] those values are now under threat. Health expenditure in all European Union (EU) countries between 1996 and 2013 increased from 7·9% to 9·5% of gross domestic product.[2] There is a need to adapt to a financially constrained environment.

WE CARE is an EU Seventh Framework Programme consortium tasked to propose a research and development roadmap for innovative, cost-contained, quality care. The roadmap should not only consider efficacy from clinical trials but also community effectiveness, including the appropriateness of services provided.

WE CARE invited key players from among the pharmaceutical industry, technology sector, academic researchers, and health professionals, together with patient representatives and politicians, to five workshops in 2014 and a conference in April, 2015, to identify the principal areas where interventions and policies are required to address the major challenges for health-care systems. In interactive discussions, the participants (including

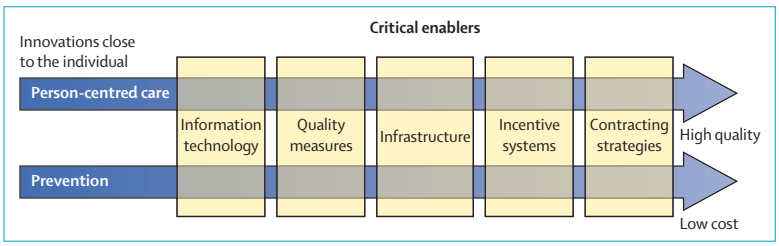

Figure: **The relation between the seven themes identified by WE CARE to be important for cost containment of future health care**

representatives from 28 European countries) identified seven themes (figure): quality measures of health care; patient/person engagement; health promotion and disease prevention; infrastructure, service delivery, and organisational models; information technology to support quality, effectiveness, and efficiency; incentive systems that give new impetus to innovation; and contracting strategies that promote efficient and high quality care.

If future cost containment and quality of care is to be achieved, the seven themes need to be addressed within a concerted action across stakeholders and EU member states. A large investment is needed—probably about €100 million—to explore the challenges and be able to produce actions for solutions. Such an investment might seem like a large sum but is in fact a very small part of the annual expenditure on health care in the EU (less than 0·01% or about 20 cents per EU citizen).

WE CARE proposes to establish several health-care laboratories, each of which will test prototypes of completely new ways of conducting health care in regions or networks across Europe. The laboratories should have common features while also differentiating from each other. Short-term results can be presented within the first 5 years, whereas larger, more comprehensive outcomes and policy propositions could be formulated in a long-term timeframe. The first 3 years will serve as a period of experimentation, iteration, and learning. In the last 2 years, each laboratory will be assessed and compared with an area that is similar in terms of population and health-care provision.

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Manochaitanya: integrating mental health into primary health care

Coinciding with World Mental Health Day, the Government of Karnataka, India, launched an ambitious programme: the Manochaitanya Programme,[1] in 2014. It covers a population of 61·1 million people.

The meaning of manochaitanya in the Kannada language is empowering the mind. The aim of this programme is to integrate mental health care in all public health-care institutions—eg, all taluk (administrative divisions in districts of India) hospitals, community health centres, and primary health centres of states. The Manochaitanya Programme was launched with use of the title super Tuesday, whereby every Tuesday is dedicated to the care of patients with mental health disorders in all public health institutions of the state. To the best of our knowledge, it is the first programme dedicated to integration of mental health care in Indian public health-care institutions, and possibly worldwide.

The salient components of this programme are as follows.[1] Every Tuesday is dedicated to the care of mental health disorders (using the name Manochaitanaya clinic) at taluk hospitals, community health centres, and primary health centres in Karnataka, but will also be available during the rest of the week at all primary health centres. A board will be displayed with the vernacular Kannada translation of Manochaitanya clinic, stating that every Tuesday dedicated mental health care will be available. Each clinic should have one consultation room and a waiting hall containing psychoeducation materials for patients.

These clinics will be able to dispense the following psychotropic medications to all patients free of charge: three oral (chlorpromazine, haloperidol, or risperidone) and