World Health Organization

MENTAL HEALTH IN PRIMARY CARE: ILLUSION OR INCLUSION?

TECHNICAL SERIES

ON PRIMARY HEALTH CARE

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Executive summary

The issue

- Mental health is an <u>inherent element of health and well-being</u>.

- Mental health <u>problems are very common</u> and represent a significant proportion of <u>health-seeking</u> contacts in primary care *(1)*;

- There is a high degree of <u>multi-morbidity</u> between mental disorders such as depression or anxiety and other noncommunicable conditions, including cardiovascular disease, diabetes, cancer and alcohol use disorders (making their co-management in primary care a logical choice).

- Half of all mental illness begins by the age of 14; unfortunately, most cases go undetected and untreated *(2)*.

- The burden associated with mental disorders in children and adolescents is considerable, and it is made worse by lack of knowledge, <u>stigma and discrimination</u>. In many situations, mental disorders are poorly understood, and affected children and adolescents are mistakenly viewed as "not trying hard enough" or as troublemakers.

- Mental disorders are <u>treatable</u>, many in primary care through training of primary care doctors , nurses and other health workers; yet the treatment <u>gap remains enormous</u>, due to low detection rates and low prioritization given to these disorders. Even in high-income countries, nearly 50% of people with depression do not get treatment *(3)*.

Opportunities and challenges

- Increasing recognition of mental health losses / global burden of mental disorders as an unaddressed and important public health challenge at national and international levels, reflected in a number of policy documents (in particular the WHO Mental Health Action Plan, and the UN Sustainable Development Goals)

- Mental health promotion, prevention, care and protection is an essential element of universal health coverage. This refers not only to improved service access through better integration of mental health care into primary care services, but also greater financial protection.

- However, mental disorders pose several service and financial access challenges (stigma, low awareness, chronicity).

- Integration of mental health care in primary care services is important in ensuring accessible, affordable and acceptable services to people with mental health problems and their families.

Actions

- The actions required to support integration of mental health services in primary care include:

  o Governance and policy: Government policy, plans and laws need to incorporate primary care for mental health as part of universal health coverage efforts that is consistent with internationally agreed standards of human rights.

  o Financial and human resources: shoulds be directed towards mental health, matching the burden of disease that mental health contributes to.

  o Empowering and engaging individuals and communities: Advocacy to enhance prioritisation of mental health, awareness raising to reduced stigma and discrimination; and empowering and engaging people with mental disorders in key aspects of service planning and decision making are essential actions for providing mental health in primary care settings.

  o Redesigned models of care: Shifting care from institutions to ambulatory primary care settings with improved community-oriented quality services is an important part of integrated services for mental health.

  o Enabling environment: A coordinated response for improved mental health care will require collaboration with non-health sectors, nongovernmental organizations, village and community health workers and volunteers and many other stakeholders.

  o Investing in implementation research is required: To improve access and quality of mental health care through primary care services.

The issue

Mental health or psychological well-being is an integral part of an individual's capacity to lead a fulfilling life, including the ability to form and maintain relationships, to study, work or pursue leisure interests, and to make day-to-day decisions about education, employment, housing or other choices. Good mental health is put at risk by a range of factors including biological characteristics, social or economic circumstances and the broader environment in which individuals find themselves. Exposure to these risk factors or stressors can lead to a range of mental health problems, especially among more vulnerable population groups.

A particular concern for global public health and development is that mental health problems during childhood and adolescent period are on the rise, emerging as prominent causes of morbidity and mortality. Globally, depression is a leading causes of illness and disability among adolescents, and suicide is a leading cause of death in 15-19 year olds *(4)*.

Both sociocultural and biological factors drive mental health in adolescence; this is displayed as increased risk of depressive disorders among girls after puberty. Many behaviours that pose risks for good health, such as substance use or sexual-risk taking, start during adolescence. HIV infection, sexual and reproductive health issues and the consequences of early and unintended pregnancies have a disproportionate impact on adolescent girls, with maternal mortality being the leading cause of death among 15-19 year old girls globally *(5)*.

Across all age groups, schizophrenia, depression, epilepsy, dementia, alcohol dependence and other mental, neurological and substance use (MNS) disorders constitute 13% of the global burden of diseases and account for one in every ten years of lost health globally (10.4% of disability-adjusted life years) *(4)*. Alarmingly this burden has risen by 41% in the last 20 years. Three hundred million people globally have depression, close to 800,000 people die from suicide every year and dementia is among the top 10 global causes of death. People with severe mental disorders (i.e. moderate to severe depression, bipolar disorder, and schizophrenia and other psychotic disorders) have a two to three times higher average mortality compared to the general population, which translates to a 10-20 year reduction in life expectancy. This is most commonly due to physical health conditions which are unrecognised and untreated *(6)*.

Mental disorders constitute a significant proportion of morbidity seen in primary care. The WHO international study of psychological problems in general health care *(7)*, which was carried out in 15 primary care sites across the world, revealed that primary care physicians identified 23.4% of attendees as being a 'case' with a psychological disorder (while a research instrument identified 33%). However, a significant proportion of cases then were, and still are today, untreated due to a combination of factors including the somatic presentation of symptoms, low levels of detection by primary care providers and low

availability of psychosocial and pharmacological technologies. Findings from the WHO World Mental Health Survey showed that only one in five people in countries with high income and one in 27 in countries with low/lower middle income received at least minimally adequate treatment for major depressive disorder *(3)*.

The integration of mental health care into primary care has been advocated by WHO since an expert committee report on the *'Organization of mental health services in developing countries'* was published in 1975. Twenty years later, a large international WHO study on *'Mental Illness in general health care'* demonstrated the significance (and treatability) of psychological disorders in primary care across cultures and resource settings, to which new evidence and experiences have been added over time, including publication in 2008 of a joint WHO/WONCA report *'Integrating mental health into primary care - a global perspective'*.

Primary care is the platform for first-contact and ongoing health care services and interacts closely with the other platforms for mental health care: self-care , informal health care and specialist mental health care. The key advantages of delivering mental health care through primary care are that it is accessible, affordable and acceptable to people with mental health problems and their families addressing health inequities and ensuring continuity of care for this population. Most people with mental health problems access primary care and their disorders are more likely to be identified and appropriately treated, with less risk of stigma *(8)*. Furthermore, mental health integration in primary care promotes comprehensive, coordinated, and person- centred care for the many people with comorbid physical and mental health problems.

Yet despite the accumulated evidence around the need and mechanisms for appropriate inclusion of mental health care as a core element of primary care, it remains a largely unrealized goal in the majority of countries the world over and therefore a key driver of the enormous treatment gap that exists today for persons with MNS disorders.

Opportunities and challenges

In 2013, the Sixty-sixth World Health Assembly adopted the Comprehensive Mental Health Action Plan 2013–2020 *(9)* and thereby committed all Member States to work towards achieving WHO's vision of "a world in which mental health is valued, promoted and protected, mental disorders are prevented and persons affected by these disorders are able to exercise the full range of human rights and to access high quality, culturally-appropriate health and social care in a timely way to promote recovery, in order to attain the highest possible level of health and participate fully in society and at work, free from stigmatization and discrimination." This mental health action plan has provided a unifying framework for all stakeholders to work together towards an agreed set of objectives and targets that not only touch on improvements in service quality and coverage but also strengthened leadership, governance and information systems.

The intrinsic value of good mental health, the wide-ranging consequences of MNS disorders, and the multi-sectoral nature of a comprehensive approach to its formation, preservation and restoration, are among the key reasons for the inclusion of mental health and well-being, as well as the rights of persons with disabilities, in the Sustainable Development Goals (SDG) agenda. A major implication of target 3.4 of the SDGs for mental health policy and practice in all countries is the renewed emphasis on implementing a strong public health approach that addresses the known determinants of mental health as well as the needs of those already affected by mental disorders and psychosocial disabilities.

Addressing mental health in the context of care for noncommunicable diseases (NCD), HIV, maternal and child health provides an opportunity for integration and is in line with WHO's new strategy aimed at ensuring healthy lives and promoting well-being for all ages, including children and adolescents. While the impact of NCDs is growing globally, it is during adolescence that preventive measures are most effective and when healthy behaviours are developed. The WHO Independent High-level Commission on NCDs convened by the WHO Director-General in October 2017 provides recommendations on how countries can accelerate progress in the areas of NCD and mental health *(10)*.

MNS disorders pose several service and financial access challenges. First, persons with these disorders are too often subjected to discrimination and stigmatization, which can reduce their willingness to seek care. Second, individuals may be unaware of their condition and not seek or know about appropriate treatment. Third, MNS disorders are typically chronic and require ongoing treatment. Yet health care and treatment for mental disorders are often excluded from essential packages of care or insurance schemes. Without such coverage, people with mental health conditions and their families face a difficult choice: pay out-of-pocket for treatment by private providers of variable and sometimes poor quality–often by cutting other household spending and investment, or by liquidating assets or savings–or go without treatment altogether.

Current coverage of essential health care and treatment services for MNS disorders is limited, in terms of access and financial protection or benefit inclusion. As emphasized in the principle of universal health coverage, a health system functions fully only if it protects the right to health for everyone, including people with mental disorders. That right to health includes physical or geographical access to essential services, as well as financial access, so that those requiring care can use and benefit from services without risking financial hardship *(11)*.

Efforts to scale up the integration of mental health into primary care services for these conditions can contribute strongly to greater equality of access, because such services will serve more people in need, with less reliance on direct out of pocket spending.

The growing global emphasis on promotion of mental health and prevention of mental disorders has led to identification of adolescence as an important entry point for interventions to be delivered – labelled as a second chance in the second decade (of life). WHO, UNICEF and other partners continue to build evidence around interventions that can prevent mental disorders, promote mental health and support adolescent health by reducing risk behaviours and self-harm.

Actions

Integrated mental health care within primary care has the potential to enhance access to mental health services that are provided in a way that is coordinated around people's needs, respects their preferences, and is safe, effective, timely, affordable, and of acceptable quality.

Core principles for integration of mental health into primary health care *(9)*:

- <u>Equity</u>: Persons with MNS disorders should be able to access, without the risk of impoverishing themselves, essential health and social services that enable them to achieve recovery and the highest attainable standard of health.

- <u>Human rights</u>: Mental health strategies, actions and interventions for treatment, prevention and promotion must be compliant with the Convention on the Rights of Persons with Disabilities and other international and regional human rights instruments, ensuring that the independence and dignity of persons with MNS disorders and psychosocial disabilities is not infringed.

- <u>Evidence-based practice</u>: Mental health strategies and interventions for treatment, prevention and promotion need to be based on scientific evidence and/or best practice, taking cultural and contextual considerations into account.

- <u>Life course approach</u>: Policies, plans and services for mental health need to take account of health and social needs at all stages of the life course, including infancy, childhood, adolescence, adulthood and older age.

- <u>Multisectoral approach</u>: A comprehensive and coordinated response for mental health requires partnership with multiple public sectors such as health, education, employment, judicial, housing, social and other relevant sectors as well as the private sector to advance a whole of society response, as appropriate to the country situation.

- <u>Empowerment of persons with MNS disorders and psychosocial disabilities</u>: Persons with MNS disorders and psychosocial disabilities should be empowered and involved in mental health advocacy, policy, planning, legislation, service provision, monitoring, research and evaluation.

The actions required to support integration of mental health services in primary care include:

- **Strengthening governance and policy:** Governmental policy, plans and laws need to incorporate primary care for mental health that is in line with UHC objectives and consistent with internationally agreed human rights standards. Since mental health promotion and protection requires a multisectoral response, a whole-of- government approach is very much required. Articulation and implementation of a strategic vision for integration of mental health in primary care needs to include links to and engagement with a range of constituencies in and beyond government as well as in and beyond the health sector such as those for disaster and emergency preparedness. To further implementation efforts and to strengthen commitment and accountability, mental health plans should include specific goals, dedicated budgets and agreed timelines as well as defined roles and responsibilities.

- **Empowering and engaging individuals and community:** Advocacy is required to shift attitudes and behaviour. World Mental Health Day is observed on 10th October every year, with the overall objective of raising awareness of mental health issues around the world and mobilizing efforts in support of mental health. It provides an opportunity for all stakeholders working on mental health issues including persons with personal experiences of MNS disorders and psychosocial disabilities to raise awareness, share progress and identify what more needs to be done to make mental health promotion and care a reality for people worldwide. Much more is required for overcoming the myths and prejudices and for reducing stigma and discrimination. Empowering and engaging people with mental disorders in key aspects of service planning and decision making is essential such as self-care, carer support, community support groups and training of community care providers such as community health workers, teachers, traditional healers. There needs to be dedicated advocacy and campaigning prioritisation and capacity among agencies and actors focused on mental health.

- **Redesigning the model of care:** Shifting care from institutions to communities with improved community-based services is an important part of integrated services for mental health. Primary care services are thus supported by specialist services in hospitals and community mental health services to take referrals, with an efficient referral and back-referral system. This needs to be supported by implementation of approved guidelines on psychosocial treatments and prescribing practices for psychotropic medicines with a reliable supply system to ensure essential medicines are available in all parts of the country. There are certain models of care available such as collaborative care that have been implemented mainly in high income countries that focus on delivery of mental health care in primary care. WHO has developed mental health Gap Action Programme (mhGAP) that has been implemented in more than 100 countries.

The WHO Mental Health Gap Action Programme (mhGAP) aims to scaling up services for MNS disorders especially in low- and middle-income countries. The programme is based on evidence that with proper care, psychosocial assistance and medication, effective treatment can be provided for people with priority MNS conditions even where resources are scarce. The MNS conditions covered in the mhGAP interventions include depression, psychoses, epilepsy, child & adolescent mental and behavioural disorders, dementia, disorders due to substance use, self-harm/suicide, other significant mental health complaints, and conditions related to stress. The mhGAP programme provides the resources to support the front -line services for these priority conditions, which can be delivered through primary care and other non-subspecialist settings (e.g. mhGAP Intervention Guide). Structured training methods and materials have been developed and used for the mhGAP interventions, to train both primary care staff and to train the trainers. A mobile version of mhGAP-IG 2.0 has also been developed.

- **Creating an enabling environment:** A coordinated health and social sector response will require collaboration with other government non-health sectors, nongovernmental organizations, community health workers and volunteers. The non-subspecialist workforce for mental health includes family doctors, doctors who may be specialised in other fields but not mental health, nurses and others. Training of this non-subspecialist workforce in mental health with ongoing support and supervision by mental health specialists will allow for task-sharing. Inclusion of mental health indicators in health information systems will further create an enabling environment for integrated services and continuity of care of people with mental disorders. This involves a minimum mental health data set with regulated procedures for collection, storage, processing, compilation and dissemination of information.

Collaborative Care (CC) is an evidence-based approach to improve the management of mental disorders and comorbid chronic diseases in primary care settings *(12)*. The overall aim of CC is to enhance quality of care and quality of life, consumer satisfaction and system efficiency of patients with complex, long-term problems cutting across multiple services, providers and settings. CC has been used successfully for the management of common mental disorders such as depression, and also for people with multi-morbidities. Key elements of CC include:

- Systematic identification of those in need;
- Multidisciplinary team approach, integrating primary care professionals and those in subspecialist settings;
- Multidisciplinary guidelines, with redesigned systems and care pathways;
- Presence of a care or case manager, similar to disease management models, but with enhanced responsibilities for integration of care across comorbid conditions;
- Regular, systematic caseload reviews and consultation with a mental health specialist regarding patients who do not show clinical improvement;
- Close collaboration and involvement of patients in joint decision-making regarding their care;
- Holistic care plans, covering all conditions, and including medications, psychological interventions, and where appropriate, social care, with a streamlined referral pathway that allows patients to move easily from one service to another;
- Self-management systems;
- Regular and planned monitoring and 'treatment to target' using validated clinical rating scales;
- Integrated electronic health records for information sharing between different teams.

Integration of mental health in primary care will not only enhance service coverage for MNS disorders but also facilitate promotion of mental health and wellbeing, prevent mental disorders and reduce risky behaviours including self-harm. It is estimated that more than half of adult mental health problems begin during childhood and adolescence *(2)*. Poor mental health and inadequate life and emotional regulation skills in adolescence are associated with risk behaviours and self-harm, health and social problems such as school failure, delinquency and substance misuse, and increase the risk of poverty and other adverse outcomes in adulthood. WHO and UNICEF have recently initiated development of an evidence-based adolescent health package – Helping Adolescent Thrive (HAT) - for promotion of mental health, prevention of mental disorders, and reduction of risk behaviours and self-harm.

The rates of MNS conditions increase significantly during and after humanitarian emergencies. While many people recover naturally without treatment, the long-term prevalence rates for a wide range of conditions remain elevated. Psychological distress is also common amongst refugees, who are often exposed to various interrelated stressors including the loss of resources and belongings, death of, or separation from, loved ones as well as direct exposure to armed conflict and violence. Worldwide, the services required are not available, and the treatment gap widens in humanitarian emergencies; this can provide the impetus to better address and promote sustainable treatment and management of MNS conditions during and after emergencies. Integration of mental health in primary care using tools such as *Guidelines for mental health and psychosocial support in emergency settings, mhGAP-IG humanitarian version* and other guidance materials can enhance management of MNS conditions in emergencies *(13)*.

In conclusion, to realize the goal of universal health coverage, it is essential to maximize efforts to scale up care for people with mental disorders and for countries to provide sufficient financial and human resources for mental health care and improve access to care for people with mental disorders and their families. It is to recognize the cross-cutting nature of mental health issues and the need to integrate mental health services into the primary care.

Annexes

Box 1. Case study: The National Depression Treatment Programme, Chile

In Chile, primary care programmes for depression have been tested and shown to be effective. In a first study, a stepped-care programme was compared with usual care in the management of depression among low-income women in Santiago, Chile. Stepped care was a 3-month, multicomponent intervention led by a non-medical health worker. The intervention included a psychoeducational group intervention (consisting of nine weekly sessions), structured and systematic follow-up, and drug treatment for women with severe depression. Despite few resources and marked deprivation, women with major depression responded well to the stepped-care treatment programme. At 6-months' follow-up, 70% of the stepped-care group had recovered, compared with 30% in the usual-care group. The programme is now being introduced across Chile.

A similar programme was subsequently tested among low-income mothers in postnatal primary-care clinics in Santiago, Chile. A total of 230 mothers with major depression were recruited to the study and randomly assigned to either a multicomponent intervention or usual care. The multicomponent intervention involved a similar psychoeducational group delivered by non-physicians, treatment adherence support, and pharmacotherapy if needed. Usual care included all services normally available in the clinics; including antidepressant medications, brief psychotherapeutic interventions, medical consultations, or external referral for specialty treatment. At 3-months after randomization, women who received the stepped-care intervention were significantly less depressed than those who received usual care.

The National Depression Treatment Programme, the first of its kind in a low- or middle-income country, introduced a version of these programmes into primary care throughout the country. Depression care is integrated with more traditional primary care programmes for the management of hypertension and diabetes within a network of 520 primary care clinics. The programme is led by psychologists and follows clinical guidelines similar to those tested previously, with additional support from physicians and specialists for people with severe depression. *(12)*

Box 2 Case study: Integration of mental health into primary health care In Islamic Republic of Iran

A national mental health programme in the Islamic Republic of Iran was adopted by the Ministry of Health and Medical Education in 1988. Based on the evaluation of pilot project, the Ministry decided to scale up the model of integrated primary and mental health care services to the whole country.

The scope of practice and clinical priorities are defined for the different levels of health care. At village level, the responsibilities of the behvarz (community health workers manning health houses in the community) was expanded to include mental health. In addition to training on mental health as part of their general curriculum, they attend refresher courses held by general practitioners, psychologists or psychiatrist at the provincial level. They are continually supervised by more senior health workers at the primary care centres.

The primary care centres are responsible for identifying and treating severe mental disorders, common mental disorders, epilepsy and mental retardation. General practitioners, who manage urban and rural primary health centres, receive a 1-2 week training session in mental health, as well as refresher training every 1-3 years. This training is provided by a provincial-level psychiatrist. The general practitioners in turn train the disease control technicians in their catchment area, focusing on diagnosis, management and referral of mental disorders.

The district health centres are responsible for the planning, management, implementation and supervision of activities within their health network of rural and urban health centres and village health houses. They in turn are supervised and supported by the provincial mental health units staffed by a psychiatrist and a psychologist, who are responsible for the technical, organizational and administrative management of the services at the periphery.

The deans of the medical universities in every province are responsible both for medical education and for health services in their catchment area, with full collaboration from the senior provincial health administration, especially the directors of the primary care network. This promotes continuity of care across different tiers of the system.

The Islamic Republic of Iran's strong ties between its medical education and health sectors facilitates the training of health workers throughout the country. As such, the medical universities provide strong scientific support for the programme. Nationwide training of general practitioners and behvarz using specially designed manuals and learning support tools has been completed on a province-by-province basis over the last 2 decades, and continues for new health workers and for those who need retraining and upgrading of their skills. A referral system for thepatient from health houses to specialized university facilities is in place.

Research on treatment pathways indicates that the expansion of mental health care into primary care has reduced assistance sought from traditional practitioners; first contact with a traditional health practitioner for a mental health problem has decreased from 40% in 1990 to 14% in 1998 and 16% in 2000. Integration of mental health in primary health care has also provided the foundation for expanding the scope of service to other areas. For example, a national suicide prevention programme is being implemented through training general practitioners in the treatment of depression (especially in regions where suicide rates are high), referral of suicidal patients, follow-up of people who have attempted suicide and control of potential social contagion. Nevertheless, challenges remain, such as the high mobility of general practitioners, particularly in more remote areas, and the fact that the behvarz who are essential to the programme's success in rural areas do not exist in urban settings where the private health sector is dominant and not well-regulated. Public-private partnerships are weak or nonexistent. Therefore, currently effort are underway to develop community mental health centres with outreach services in the urban areas where 70% of the population is living.

Source *(8)*

Box 3. Primary care for mental health for disadvantaged communities in London, The United Kingdom

In Waltham Forest Primary Care Trusts (PCT), in the UK, two practices were contracted to provide an integrated primary care service to vulnerable groups such as asylum seekers, refugees, and homeless people. In particular, the service sought to reach people not normally in contact with health services and people from minority ethnic groups. This service offered a four-step approach to deliver holistic integrated services in primary care. During step I, general practices provided written and verbal information to patients about mental disorders as well as how to access more specialized mental health care services, housing, employment, and social services. Further assistance, guidance and support was provided by an individual, usually a mental health service user, who had the specific responsibility of promoting self-help and social inclusion among patients. During step II, the primary care practices undertook mental health and psychosocial assessments of their patients, sometimes using standardized screening and assessment instruments. Depending on the complexity of the problem, patients were either managed in the practice or were referred to appropriate secondary-level and community-based services within the PCT. Psychological therapies, including cognitive-behavioural therapy, were provided within the general practice by a counsellor or referred to more specialized services if needed. In relation to step III, patients were referred to organizations or institutions that could assist them with economic and social problems. Step IV relates to people who previously had been acutely ill, but were now stable. These patients received holistic mental and physical health care within the primary care setting, while at the same time reducing the load on secondary level services.

In addition, the practice had established linkages with community mental health teams, hospitals, acute psychiatric services, local pharmacies, social care advisers, legal services, the voluntary sector, service user groups, and community groups.

This project demonstrated that, with appropriate support, disenfranchised population groups can be managed within primary care. Since its establishment, the majority of the programme's patients with a mental disorder were treated in primary care. The number of patients with a severe mental disorder recorded on patient registers had increased, with the suggestion of increased active management of these patients by the general practitioners.
Adapted from *(1)*

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