INTIGRATING MENTAL HEALTH IN PRIMARY HEALTH CARE

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Mental Health in Primary Health Care Setting

Mental disorders are associated with significant physical and social disability and increased mortality. A WHO analysis of the global disease burden shows mental health disorders make up five of ten leading causes of disability worldwide, and that the proportion of the global disease burden attributable to mental disorder is likely to increase by 50 percent between now and 2020 (Ustun, Sartorius, 1995). Mental Health is an important component of Primary care and approximately 20% of the population experiences a mental health disorder at any time. About 90% of people with a mild to moderate mental illness such as depression, anxiety, and addiction are treated in primary care setting.

- A study of the frequency and diagnosis of mental disorders was done in four developing countries: 1624 patients who were attending primary health facilities in 4 developing countries were examined to determine how many were suffering from mental disorders. Using stringent criteria to establish the presence of psychiatric morbidity, 225 cases were found, indicating an overall frequency of 13.9%. The great majority of cases was suffering from neurotic illness and for most of the presenting complaints was of a physical symptom, such as headache, abdominal pain, cough or weakness. The health workers following their normal procedure correctly detected one third of the psychiatric cases (Cambridge journal 2009).

The promotion of Mental Health (MH) is listed among the essential elements of primary health care (PHC) in the report of Alma Ata Conference, but found no place in the text of the Alma Ata Declaration, it has been accepted by acclimation, the WHO representative in the secretariat of the conference proposed to include the MH in the conference report without changing the text of declaration that had just been adopted.

The simple interpretation of MH promotion: equals the reduction of numbers of people with mental illness in a community.

The Comprehensive interpretation of MH

Promotion: is the prevention and treatment of MH illness as well as the enhancement of the coping capacity of individuals and community, as well as the elevation of MH on the scale of values of individuals and communities. With such definition of the promotion of MH care the shift of MH activities from tertiary care facilities to the periphery was successful in a relatively small no. of countries – for example in Iran which has trained large no. of PHC workers to recognize and deal with the mental disorders they encounter in their work (Sartorius N. Psychiatry in Developing countries, 2001).

- The treatment of MH illness was not a worthy task in their eyes nor in the eye of the majority of decision makers in the field of health because they did not consider M. Disorders as a major public health problem of major public health importance (Definition of **Major Public Health Problem**: The criteria for the designation of a disease as a major PH problem are high prevalence, severe consequences if left untreated and the tendency to remain stable in the future unless prevented or reduced by healthcare interventions).

Integrating MH into Primary Health Care

- In 1990 the WHO stated: Providing MH services in PHC involves diagnosing and treating people with mental disorders and ensuring that PHC worker are able to apply key psychosocial and behavioral service skills, for example interviewing, counseling and interpersonal skills, in their day to day work in order to improve overall health outcomes in PHC (WHO 1990).
- Complementary with tertiary and secondary levels. Gen. hospital services (acute cases, short stay, consultations)but provide no solution for chronic cases who end up in admission(revolving door syndrome) unless backed up by PHC services.

Reasons for Integrating MH into PHC

1. Mental Disorders Burden: prevalent in all societies, burden on families and society as a whole, produce significant economic and social hardships
2. Mental and physical health problems are interwoven: Integration ensures holistic manner treatment meeting physical and mental peoples 'needs and vise versa; better outcome; PHC provide better care than the psychiatric hospitals.

3. Treatment gap for M. disorders is enormous:

   Between the prevalence and no. of people receiving treatment and care. MH in PHC close the gap, improve prevention, detection of M. disorders by workers and health professionals as they are in the frontline.

4. Enhances access: easier access, closer to their home, keeping families together, maintaining daily activities. Better outcome in Comorbidity (cancer, TB, HIV) by well MH trained workers meeting the physical and mental needs of patients.

5. Human Rights promotion : Minimizing stigma and discrimination, removing the risk of human rights violations in psychiatric hospitals. Treatment close to their homes will Reduce chronicity, better social integration with the family and society, no disruption to normal daily life and employment.
6. Affordable and cost effective : less expensive services than hospitals; patient and family avoid indirect cost seeking distant location specialists' care. Treatment of common M. disorders is cost effective and investment by the government can bring important benefits.
7. Generates good health outcomes : Particularly when linked to network of services at secondary level and in the community.

8. Improve human resources capacity for MH :

Integrating MH to PHC services can be an important solution addressing to human resources shortage to deliver MH intervention.

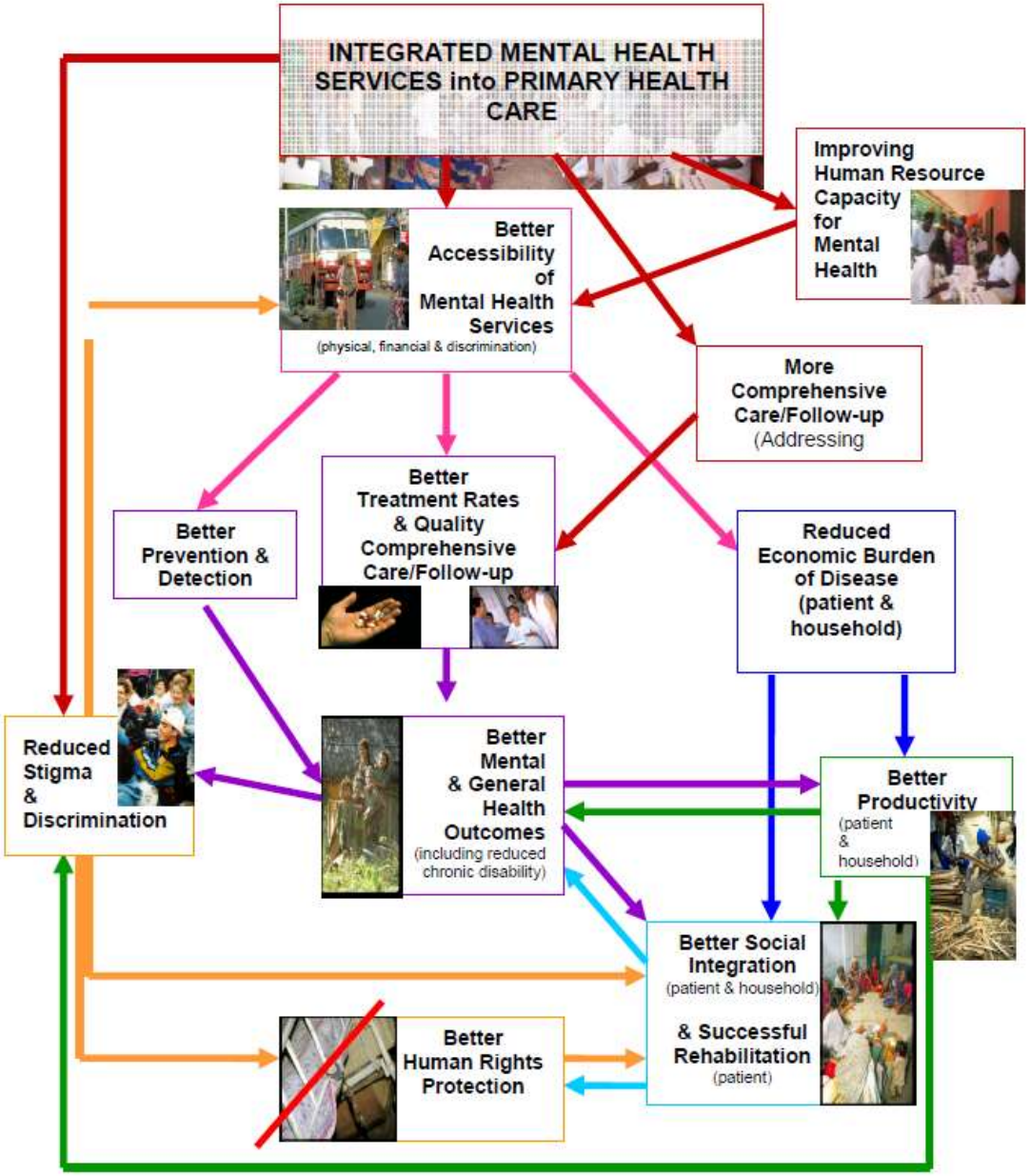

Figure 1: Rationale for Integrating Mental Health Services into Primary Health Care

Steps for Successful Integration

1. Preliminary situational analysis : Careful analysis of the current functions, status and strength of 3 levels within the country's existing Health system and the community context as well. Commitment from the government and a formal policy and legislation that concretize this commitment.
2. Funding and financial support : shift of funds from tertiary to the primary and secondary care, or new funds must be available. Although MH in PHC is cost effective, financial support is required to establish and maintain the service, training costs, and MH specialist employed who provide support and supervision.

3. Clear Delineation of M. Disorders : of few targeted M. disorders to be treated at PHC level is desirable. It simplifies both the requirement of limited types of medicine, and for the trained PC workers to be more skilled and proficient in using few selected drugs. Range of M. disorders can then be increased in stepped manner according to capacity and need. Basic essential psychotropic medicines must be available with sufficient allocated government funds and legislations to allow PC workers to dispense it particularly where MH specialists are scarce.

4. Human resource training competencies : Training the staff in identification and treatment of M. disorder should occur in pre and in-service settings,

which involves programs in diagnosis, management, follow up consultations, human rights and family intervention.

However workers must practice skills and receive specialist supervision over time (ongoing training and support). MH professionals should be available to discuss difficulties in management and provide advice on intervention to be carried out by the PC staff.

5. Effective referral system and coordination of collaborative network : Effective referral system between primary, secondary and tertiary levels need to be in place, its recommended to develop and coordinate a collaborative network in order to provide appropriate MH services.

6. Intersectoral approach and links with community services :

Formal services: M. disorders require psychosocial solutions. The link between MH service and various community agencies (education, social welfare, justice, employment/labor..etc)at the local level so that appropriate housing, income support, disability benefit, employment...etc can be more effectively implemented.

Informal services: also fundamental, through NGO's, religious leaders and other systems of support, it will definitely lead to a better outcome and rationalization of resources.

7. A MH service coordinator is crucial : Integration is a ***process*** not an event, involves series of developments. Besides, the idea of integration has gained great acceptance, health workers need training and additional staff to be employed, agreement for budget allocation will be required . Unexpected problems can sometimes threaten the program outcome or even its survival, thus MH service coordinators are crucial in steering programs around these challenges and driving forward the integration process.

8. Recording system for evaluation and monitoring : Recording system need to be setup to allow for continuous monitoring, evaluation and updating of MH activities. MH data need to be routinely recorded in patient's file and integrated in the overall general

health information system in PHC level in order to be used for monitoring, evaluation, planning and service improvement.

Summary

- The MH effort at all levels of care and particularly at the PC level should be wider and include not only the treatment of M. disorders but also an involvement in dealing with the ***psychosocial aspects of Health care*** in general; the ***prevention of M. illness*** and the ***promotion of MH***(understood as an effort to give greater value to M. life and functioning).
- Defined in this way the MH component of PHC would make a much more significant contribution to health care than it can do if it remain restricted to the treatment of small no. of (frequently seen) Mental disorders – no matter how useful this contribution is by itself.

Thank You