Integrating Mental Health Into Primary Health Care: A Global Perspective

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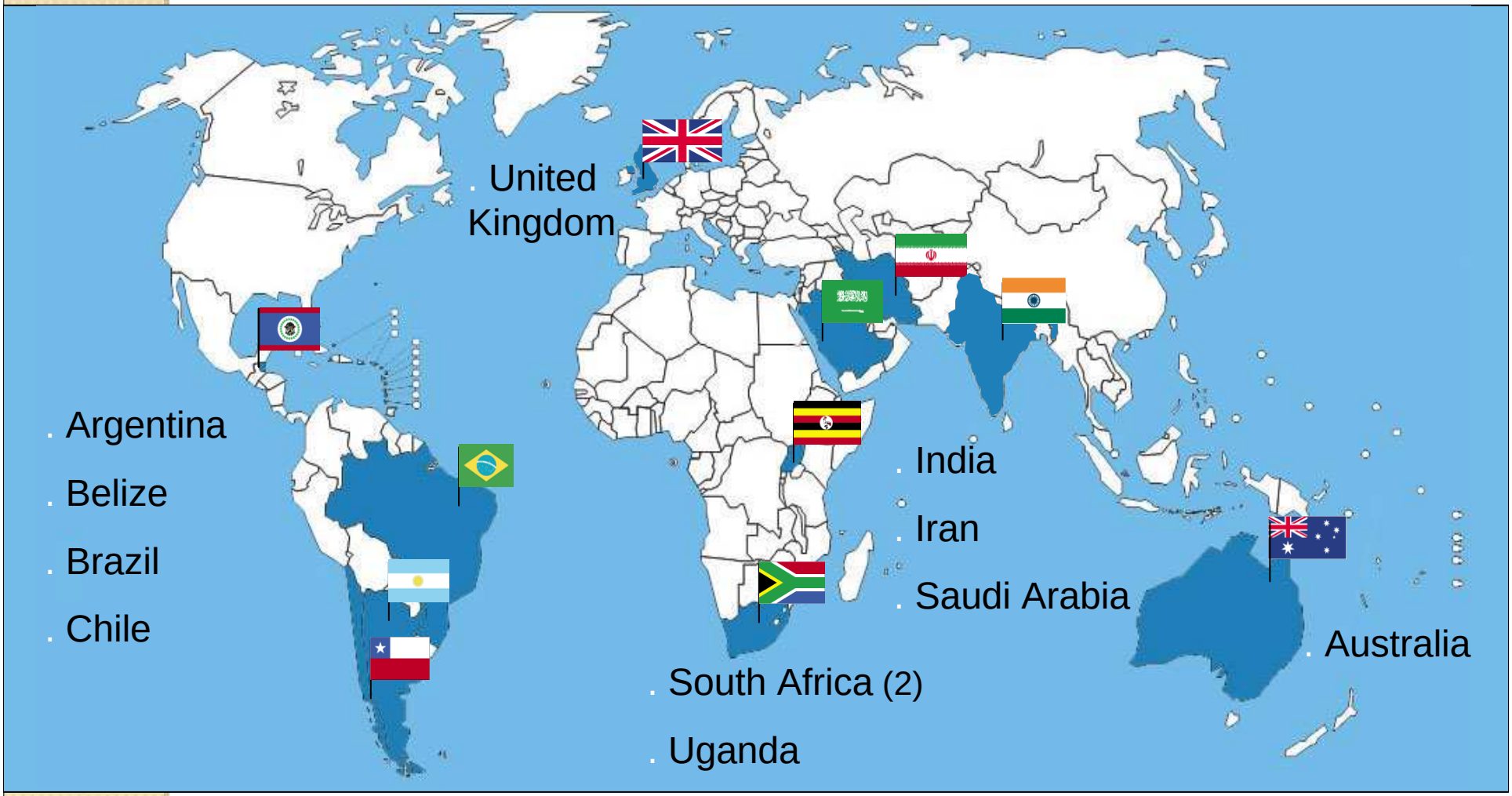
12 best practices

on 5 continents

Analysis of 12 best practices



Best practices: Argentina

- Physician-led primary care for mental health in Neuquén province, Patagonia region

- Primary care physicians lead the diagnosis, treatment and rehabilitation of patients with severe mental disorders
- Specialists advise on complex cases
- Community-based rehabilitation centre provides training and complementary clinical care in close coordination with PHC: the 'Austral'

➡ Improved social inclusion for people with mental disorders

➡ Lower cost for effective community-based mental health services

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Best practices: Australia

- Integrated mental health care for older people in general practices in inner-city

- General practitioner physicians provide primary care for mental health to patients
- Community psychogeriatric nurses, psychologists, and geriatric psychiatrists give advice and support
- Supported, collaborative, and shared model of care

➡ Greater autonomy and responsibility of primary care providers for older people's mental health care

➡ Less 'revolving door' patients due to better continuity of care

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National and Health contexts

- Predominance of European settlers/immigrants (90%)
- Indigenous population (2.2%) belongs to the most disadvantaged group
- Mixed high income economy whose main sector of employment and revenue is services.
- 14% under the national poverty line

- Life expectancy at birth: 79 years ♂ - 84 years ♀
- Total expenditure on health (2004): 3123 Int $ per capita, 9.6% of GDP
- Health care provided and funded through a mix of federal, state and private contributions.
- Most primary care is provided by general practitioners

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Mental health in Australia

1992: New mental health policy passed in Australia

- Change in the approach of mental health care from an institutional to a community-oriented service.
- Framework for the protection of the rights and civil liberties of people with mental disorders
- Mental health expected to be part of the mainstream health system, including primary care.

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Primary care and integration of mental health

- General practice now regarded as a medical speciality, with emphasis on continuity of care
- Primary care is funded mainly through Medicare, a government-funded health financing system
- Implementation plan for the National mental health plan 2003-2008 included
  - Ongoing support for existing programmes for primary mental health care
  - Development of primary care programmes for shared mental health care
  - Strengthening linkages between general practitioners and mental health specialists
- All general practitioners undertake mental health training at both undergraduate and postgraduate levels

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Description of Model

- GP has primary responsibility in
  - Initial identification of older people's mental disorders
  - Arranging investigations, prescribing medications, monitoring progress
  - Identifying need for alterations to the management plan/specialist advice/referral
- Various options for specialist support
  - Contact older adult mental health specialist for advice
  - Referral to the older adult mental health community team (practical assistance)
  - Request for further specialist assessment by an old age psychiatrist
- Enhanced continuity of care through
  - Intensive communication between primary care, community and specialist services and liaison role of psychogeriatric nurses

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Historical evolution

- Planning the older adult mental health service
  - Engagement of central stakeholders
  - Establishment of an area committee (develop a strategic plan)
  - GPs contacted and informed
- Implementing the service
  - Took almost 5 years
  - Following appointment of the psychiatrist, a new series of meeting and the development and circulation of a strategic plan
- GP training for integrated older people's mental health care in primary care
  - Most training through verbal and written advice and informal supervision
  - Joint monthly meeting with GPs and older adult mental health specialists

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Evaluation & Outcomes

- General practitioners and other primary care workers have developed skills in the assessment and management of older adults with mental health problems
- Better continuity of care
- Substantial reduction in “revolving door” patients witnessed by older age mental health specialists

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Lessons Learnt

- Holistic care that is highly accessible to older people is "better care" than specialized care.
- Importance of close communication and collaboration between primary care, community and specialist services/professionals
- Establishment of an integrated mental health service can be highly time-consuming but patience and perseverance are rewarded
- Ongoing informal interaction 'on the job' with specialists is as much a valuable training as formal courses can be

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Best practices: Belize

- **Nationwide district-based mental health**

- Training of psychiatric nurse practitioners and their integration into community-based care
- Psychiatric nurse practitioners conduct home visits and train primary care workers (as a first stage of integration)
- Two stage approach

➡ Reduced number of inappropriate psychiatric hospitalizations

➡ Increased access to outpatient and community-based mental health services

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National and Health contexts

- Small population (270,000) and size (22,965 km²)
- Cultural and ethnic diversity
- Upper middle income economy, depending on agriculture and tourism
- Rather high poverty level, stable at 34% (1996-2002)
- Recent significant progress on social indicators

- Life expectancy at birth: 67 years ♂ -74 years ♀
- Total expenditure on health (2004): 339 Int $ per capita, 5.1% of GDP
- Growing prevalence of chronic NCD
- Health Sector Reform Project (1998)
- Growth of private health sector but still large predominance of public health services (minimal fees)
- Increased number of health workers (Cuba, Nigeria) largely deployed in rural remote areas

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Mental health in Belize

- Paucity of epidemiological data in international literature
- Harmful use of alcohol, particularly among men, is regarded as problematic for the country.
- Family violence
- National mental health programme: creation of networks for guaranteeing care within the community
- Future development planned:
  - Department of Mental Health
  - Acute mental health units
  - Support systems at regional hospitals

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Primary care and integration of mental health

- Belize primary care infrastructure:
  - 3 polyclinics,
  - 37 health centres and 43 public rural health posts.
- Services available at the centres:
  - Ambulatory services, pre- and postnatal care, immunization services, and general health education
  - Outreach services (mobile clinics)
  - Some specialist services in selected centres

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Description of Model

- 7 of 8 district hospitals: 2 psychiatric nurses
  - Outpatient clinic at the hospital
  - Mobile clinics at the health centres, home visits and other community activities
  - Expanding role: e.g. counselling to victims of domestic violence
- 1 psychiatrist visiting district hospitals on a rotating basis
- Other community programmes (e.g. schools, police, training)

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Historical evolution

- Institutional model (Rockview Psychiatric Hospital), highly centralized care, only covering severe mental disorders
- 1992: introduction of a new paradigm of mental health
- Two-stage process:
  - Training of 16 psychiatric nurse practitioners at district level (10 months) in 1992, 13 additional in 2004
  - Ongoing training of general practitioners at primary care level

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Evaluation & Outcomes

- Services available
  - Constant growth of primary care services for mental health (929 outpatient cases in 1993 to 14,000 in 2006)
  - Simultaneous decrease in the number of psychiatric inpatients (from 150 to 180 inpatients to 47 to 50)
  - Good mental health staff retention rate
- Patient/staff satisfaction and skills

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Lessons Learnt

- Appropriateness of the two stage approach in context of very limited trained mental health specialists
- Importance of a fully functional and experienced group of secondary level district-based mental health practitioners
- Impact of accessibility and affordability of services on treatment coverage
- Effectiveness of nurse practitioners in managing the mental health care of the vast majority of patients

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Best practices: Brazil

- **Integrated primary care for mental health in the city of Sobral**

- Collaborative care approach
- A specialist mental health team regularly visit family health centres
- Joint consultations are undertaken between mental health specialists, primary care practitioners and patients.

➡ Good quality mental health care in family health centres

➡ Ongoing training and supervision of primary care workers in the management of patients with mental disorders.

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Best practices: Chile

- **Integrated primary care for mental health in the Macul district of Santiago**

- Following Chile's national mental health plans
- General physicians diagnose mental disorders and provide medications; psychologists provide individual, family and group therapy
- A mental health community centre provides ongoing support and supervision

➡ Increased identification and treatment rates for people with mental disorders at the family centre

➡ Improvement in user satisfaction

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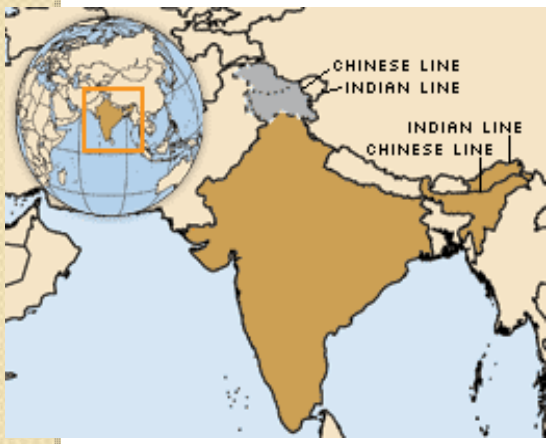
Best practices: India

- **Integrated primary care for mental health in the Thiruvananthapuram District, Kerala**



- Outreach clinical services and in-service training and support of primary care workers provided by a multidisciplinary district mental health team.
- Trained primary care officers diagnose.
- Free and ready availability of psychotropic medications in the clinics

➡ After 3 years only, autonomy of primary care centres

➡ Comprehensive mental health care available in 22 locations in the district

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Best practices: Iran

- Nationwide integration of mental health into primary care

- Community health workers (*behvarzes*) responsible for active case finding and referral
- General practitioners have mental health care as part of their general health responsibilities
- Specialists based in district or provincial health centre for complex cases
- Traditionally, strong ties between medical education and health sectors

➡ A significant proportion of the population is covered by accessible, affordable and acceptable mental health care

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National and Health contexts

- Populous country, young
- Refugees
- Natural resources - OPEC's second largest oil-producing member
- Relatively high levels of inequality and income poverty
- High unemployment, and low labour force participation by women
- Advanced health and education

- Life expectancy at birth: 68 years ♂ -73 years ♀
- Total expenditure on health (2004): 604 Int $ per capita, 6.6% of GDP
- Health networks for primary care
- Disparities in access to care
- Demographic and epidemiological transition: ageing, rise in chronic non-communicable diseases
- Prioritizing health sector reform
- Control over pharmaceutical products

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Mental health in Iran

- Point prevalence of mental disorders estimated 22.4%
- Drug abuse (injected opioid++) is a major issue:
  - more than 3.7 million (i.e. 5% of the population)
  - 2.5 million suffer serious social and health problems
  - at least 1.1 million are dependant
- National Mental Health Programme (1988)
- Lack of comprehensive and coherent mental health legislation

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Primary care and integration of mental health

- Primary care structure
  - Basic unit: the **health house** - staffed with *behvarzes*, serving 1,000 to 1,5000 people (2 to 3 villages), <1 hour walk
  - **Health centres** - staffed by up to 3 GPs, 2 technicians +/- 1 nurse; rapid staff turnover
  - **District health centres** - smallest autonomous health unit
  - **Provincial health centres**
- Nationwide expansion of primary care in the 80s
- Integration of mental health in 1989

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Description of Model

- In health centres, general practitioners
  - diagnose mental disorders and provide treatment as needed
  - accept referrals from *behvarzes*
  - provide training to health workers at lower levels of the health system (e.g. disease control technicians, behvarzes)
- At district level, one mental health specialist and 5 to 10 inpatient psychiatric beds in a general hospital
- At village level, behvarzes have responsibility for
  - community education, active case-finding and referral, follow-up, and maintenance of patient registries.

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Historical evolution

- 1970s - Community-based mental services in Iran
- 1980s – 2 key events
  - Establishment of a primary care network with effective referral system, nationwide
  - Creation of the Ministry of Health and Medical Education (MOHME)
- 1985 – Iranian national mental health programme (Integration)
- 1986 – Pilot project
- Upgrading at national scale
  - Training of general practitioners and *behvarzes* in mental health
  - Equal funding for sustainability
  - Health information system: 5 mental health indicators integrated

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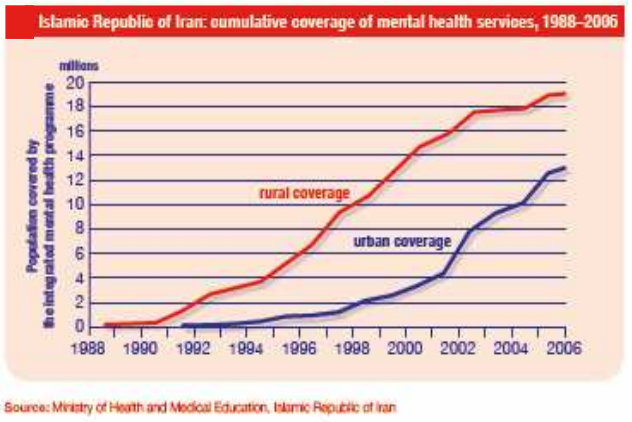
Evaluation & Outcomes



- By 2006, 82% of the rural population and 29% of the urban population covered
- Changed community attitudes;
- Changes in mental health care seeking patterns, from traditional healers to primary care
- Evidence-based interventions for psychosis, mental retardation, and epilepsy

Lessons Learnt

- Importance of having a pre-existing strong primary care network for integration
- Securing support at all levels:
  - Needed support of dedicated professionals in the medical universities and within the Ministry of Health and Medical Education
  - Pivotal role of multipurpose health workers in rural areas (*behvarzes*)
- Need for strong support (quality and costs)

Best practices: Saudi Arabia

- **Integrated primary care for mental health in the Eastern province of Ash-Sharqiyah**

- All primary care physicians provide basic mental health services
- Selected primary care physicians serve as referral sources for complex cases
- A community mental health clinic provides complementary services

➡ Increased identification rate (more than 3 times) in primary care

➡ Increased rate of people with mental disorders treated within the community, with a broader range of treatment options

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Best practices: South Africa 1

- **Integrated primary care services in the Ehlanzeni District, Mpumalanga Province**

- 2 different service models in the same district
- Model 1 based on a skilled professional nurse
- Model 2 involving all primary care workers

➡ From none to 83% of primary care clinics providing mental health services after 10 years of integration

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Best practices: South Africa 2

- **A partnership for primary mental health care in the Moorreesburg District, Western Cape Province**

- Mental health services provided in the primary care clinic by:
  - Primary care nurses, full time
  - A psychologist, part time (8 hours per week)
  - Specialist mental health nurses visiting monthly
  - A regional psychiatrist visiting every 3 months
- Physical health care of people with mental disorders provided by a medical officer (daily)

➡ A partnership model, mainly based on nursing resources

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Best practices: Uganda

- **Integrated mental health in the Sembabule district**

- Following the inclusion of mental health in the Uganda Minimum Health Care Package
- Primary care workers identify, manage emergencies and treat patients with uncomplicated or stable mental disorders
- Village health teams formed to help identify, refer and follow-up people with mental disorders

➡ Creation of a consumer association

➡ Better outcomes with minimized disruption to patient's lives

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Best practices: United Kingdom

- **Primary care for mental health for disadvantaged communities in London**

- Following the introduction of a new contract that increased GP's accountability
- Close links developed with
  - Secondary level health and community services
  - Employment, housing and legal organizations and services

➡ Improved holistic (physical and mental) care

➡ Improved early identification of illness and comorbidity

➡ Reduced stigma and improved social inclusion

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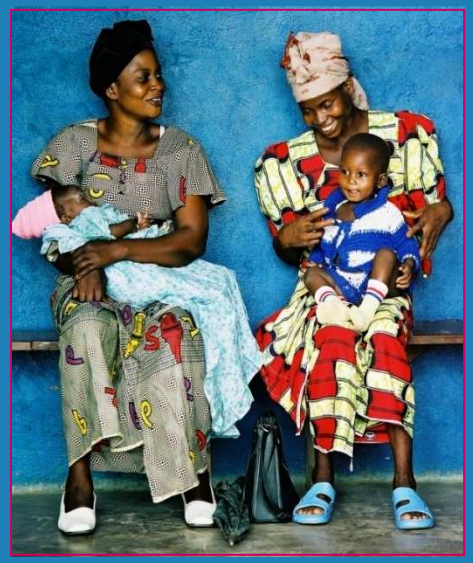

Thank you!