Integrating mental health in primary health care – executive summary

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WHO Library Cataloguing in Publication Data

Names: World Health Organization. Regional Office for the Eastern Mediterranean

Title: Integrating mental health in primary health care: executive summary / World Health Organization. Regional Office for the Eastern Mediterranean

Description: Cairo: World Health Organization. Regional Office for the Eastern Mediterranean, 2023

Identifier: ISBN 978-92-9274-161-7 (pbk.) | ISBN 978-92-9274-162-4 (online)

Subjects: Mental Health Services | Primary Health Care | Delivery of Health Care, Integrated - organization & administration | Emergency Services, Psychiatric | World Health Organization | Eastern Mediterranean Region

Classification: NLM WM 30

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Background and rationale

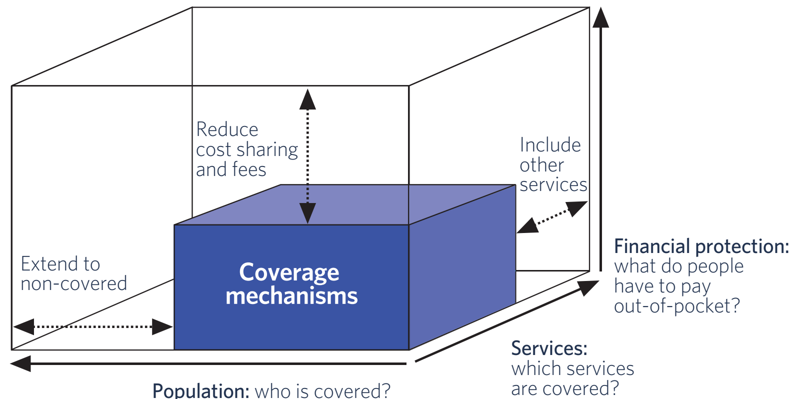
Overview

Mental, neurological and substance use (MNS) disorders are common: one in 10 people suffer from a mental disorder, directly affecting 1 in 4 families. The public health burden they generate has grown by 41% in the last 20 years. Mental disorders contribute 4.7% of the total disability-adjusted life-years (DALYs) in the Eastern Mediterranean Region of the World Health Organization (WHO), with depressive disorders and anxiety disorders being the third and ninth leading causes of non-fatal burden *(1)*. Mental disorders have become a pressing concern for most countries of the Region, given that a number of countries in the Region face humanitarian crises, which generate a surge in psychosocial need and disrupt existing health systems.

The advantages of decentralized, integrated mental health care have been known for many years *(2,3)*. It produces good health outcomes for the majority of people with mental disorders and facilitates holistic management of comorbid physical and mental health problems. It helps to close the huge treatment gap and improves access to effective care for persons with mental health needs, providing care closer to their homes and families without disrupting their daily activities. It facilitates community outreach and the promotion of mental health, and long-term monitoring and management of affected individuals. It reduces stigma and discrimination, promotes respect of human rights and reduces the risk of human rights violations. It is cost–effective and affordable, and is a less expensive model than concentrating mental health care in psychiatric hospitals.

Despite the availability of cost–effective and affordable pharmacological and psychological interventions for MNS disorders *(4)* and effective mental health promotion strategies, there is a vast treatment gap between those people who require care, and those who actually receive it. Recently published data from the World Mental Health Survey showed that in high-income countries, 1 in 5 people with a depressive disorder receive minimally adequate treatment, and this falls to 1 in 27 in low- and lower middle-income countries *(5)*.

In order to bridge the treatment gap, countries need to not only increase the resource for mental health care but, more importantly, utilize the available human and material resources efficiently, taking advantage of the paradigm shift articulated by the WHO comprehensive mental health action plan 2013–2030 (see Box 1) from institutional to an integrated community-based model of mental health care. The WHO Mental Health Gap Action Programme (mhGAP) *(6)* aims to scale-up services for MNS disorders in countries, especially 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 (see mhGAP intervention guide, version 2, mhGAP humanitarian intervention guide, mhGAP training manuals, mhGAP Evidence Resource Centre, mhGAP operations manual).



■ **FIG. 1.** The UHC cube showing the three dimensions of universal health coverage

Source: The world health report: health systems financing: the path to universal coverage. Geneva: World Health Organization; 2010.

The Regional framework to scale up action on mental health in the Eastern Mediterranean Region operationalizes the objectives of the mental health action plan into concrete measurable activities by scaling up action on mental health, strengthening the health system and advancing towards the Sustainable Development Goal of universal health coverage (Fig. 1). One of the strategic interventions identified in the regional framework is the integration of cost–effective, feasible and affordable evidence-based interventions for mental conditions in primary health care (PHC) and other priority health programmes. This also reaffirms the commitments of the Alma-Ata Declaration (1978) *(7),* which stresses the importance of PHC in the protection and promotion of the health of all people.

Universal health coverage is the overarching target identified as the health goal of the United Nations (UN) 2030 Agenda for Sustainable Development, which for the first time includes specific indicators related to mental well-being and substance use disorders. In response to the Sustainable Development Goals, the Lancet Commission on global mental health and sustainable development (2018) expands the mental health agenda to improving the mental health of whole populations and advocates that mental health should be fully integrated in routine PHC. The WHO Special Initiative for Mental Health (2019–2023) aims to integrate mental health into universal health coverage and achieve the highest standards of mental health and well-being by scaling up interventions and services across community-based, general health and specialist settings.

The WHO Regional Office for the Eastern Mediterranean has developed this guidance to support countries in their efforts to integrate the management of MNS disorders into PHC, focusing on the priority disorders identified in the mhGAP programme. It aims to provide a "one-stop-shop" for information, guidance and resources on the "what" and the "how" of implementing integration of mental health in PHC in the Region. The target audiences for this guidance are country-level policy-makers and health managers, and many components will be useful for interested nongovernmental organizations and clinical staff at PHC and specialist mental health service levels.

BOX 1. Vision of the Mental health action plan 2013–2020

A world in which mental health is valued, promoted and protected, mental disorders are prevented and people 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, all in order to attain the highest possible level of health and participate fully in society and at work free from stigmatization and discrimination.

Extending population coverage through integration of mental health in primary health care

The WHO has proposed a service organization pyramid for the optimal mix of services for mental health (see Fig. 2).

Components of a mental health system

- Limited long-stay facilities
- Specialist mental health services in general hospitals
- Community mental health services providing outreach and support to PHC
- Mental health services integrated into PHC, with PHC staff able to identify and treat priority disorders
- Informal community mental health services through schools and community leaders
- People with mental disorders and their families having the knowledge of how best to take care of themselves

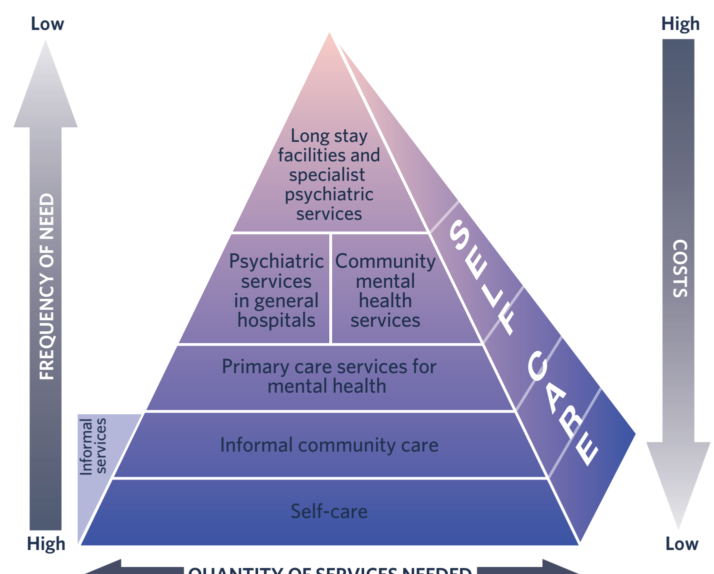


FIG. 2. WHO service organization pyramid for the optimal mix of services for mental health

Source: adapted from: Integrating mental health into primary care: a global perspective. Geneva: World Health Organization and World Organization of Family Doctors, 2008.

A critical organizational challenge is to develop a holistic approach to strengthening the whole mental health system, with the appropriate use of different health care platforms and delivery channels *(8)* providing for a balance of community and hospital services *(9,10,11)*. This recognizes that there are hugely different levels of resources available to different countries, and therefore countries will require differently balanced care models (see Fig. 3). The fundamental component relevant to all countries in all three models, irrespective of resources, is the integration of mental health into PHC with specialist back-up. In countries with more resources available, the additional components are the provision of increasingly comprehensive and differentiated specialist mental health services.

LOW RESOURCE SETTINGS

1. Primary care mental health	2. Limited specialist mental health staff
- Case findings and assessment - Talking and psycho-social treatments - Pharmacological treatments	*Limited specialist staff provision of:* - training and supervision of primary care staff; - consultation-liaison for complex cases; - out-patient and in-patient assessment - treatment for cases which cannot be managed in primary care

MEDIUM RESOURCE SETTINGS

1. Primary care mental health	2. General adult mental health services
- Case findings and assessment - Talking and psycho-social treatments - Pharmacological treatments	- Out-patient/ambulatory clinics - Community mental health teams - Accute in-patient care - Long-term community-base residential care - Work and occupation

HIGH RESOURCE SETTINGS

1. Primary care mental health	2. General adult mental health services	3. Specialised adult mental health services
- Case findings and assessment - Talking and psycho-social treatments - Pharmacological treatments	- Out-patient/ambulatory clinics - Community mental health teams - Accute in-patient care - Long-term community-base residential care - Work and occupation	- Out-patient/ambulatory clinics - Community mental health teams - Accute in-patient care - Long-term community-base residential care - Work and occupation

■ **FIG. 3.** Mental health service components relevant for countries and regions with low, medium and high levels of resources*

**Country income groups based on gross national income per capita in 2013 calculated using the World Bank Atlas method: low income ≤ US$ 1 045, middle income (lower-middle and upper-middle combined) US$ 1 045–12 746, and high income ≥ US$ 12 746.*

Source: Thornicroft G, Deb T, Henderson C, 2016 *(11)*. *© 2016 World Psychiatric Association.*

Choosing which mental health services are best covered through primary health care

During the last decade, the broad description of the components of mental health care that can be delivered through PHC has been refined and operationalized to a set of care packages that can be scaled-up and delivered, even in settings where specialists are scarce. The evidence for these has been brought together, leading to the following conclusions *(3,6,12)*.

- Nonspecialist health workers in PHC can deliver effective treatments for some MNS disorders. The effectiveness and sustainability of nonspecialist mental health care requires close collaboration with specialist mental health providers to offer support through training, consultation, supervision, quality assurance and referral.
- There are effective pharmacological and psychosocial treatments for MNS disorders. These are best provided as stepped care models, where treatments are tailored to the needs of each individual.
- Self-care is important at all levels of health care and promotes recovery and better mental health. Families provide many practical aspects and emotional support.
- Detection and diagnosis of common MNS disorders can be reliably carried out using brief screening in PHC.
- Community case finding of less-common MNS disorders, such as psychosis and dementia, is followed by diagnostic assessment by an appropriately trained health worker.

- The best outcomes are achieved with continuing care and support to maintain regular use of medication for extended periods.

Evidence-based interventions that can be delivered through PHC are summarized in Table 1. These correspond closely with the cost–effective, feasible and affordable evidence-based interventions ("best buys") for the prevention and management of mental disorders identified for the Eastern Mediterranean Region in the development of the regional framework.

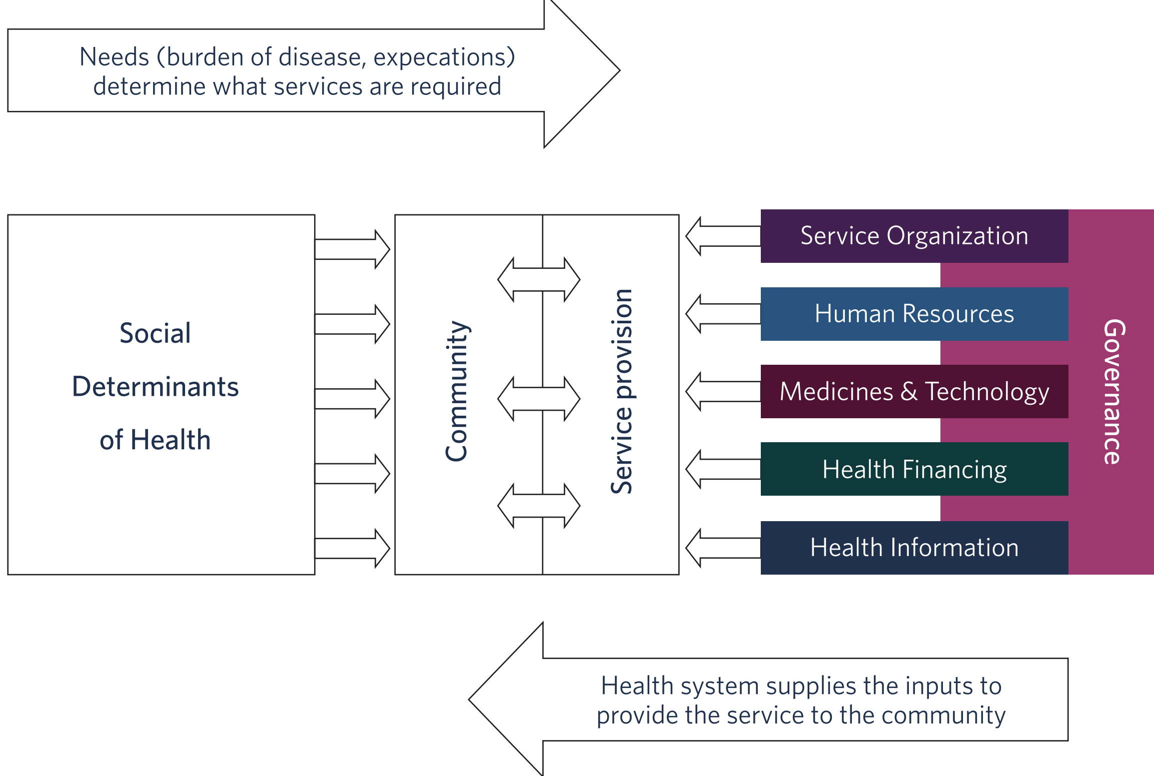
TABLE 1. Intervention priorities for mental, neurological and substance use disorders delivered by primary health care

Adult mental disorders	▪ Screening and proactive case finding of psychosis, depression and anxiety disorders ▪ Diagnosis and management of depression (including maternal) and anxiety disorders ▪ Continuing care of schizophrenia and bipolar disorder ▪ Management of depression and anxiety disorders in people with HIV or who have other (noncommunicable) diseases
Child mental and developmental disorders	▪ Screening for developmental disorders in children ▪ Maternal mental health interventions ▪ Parent skills training for developmental disorders ▪ Psychological treatment for mood, anxiety, ADHD and disruptive behaviour disorders ▪ Improving the quality of antenatal and perinatal care to reduce risk factors associated with intellectual disability
Neurological disorders	▪ Diagnosis and management of epilepsy and headaches ▪ Screening for detection of dementia ▪ Interventions to support caregivers of patients with dementia ▪ Management of prolonged seizures or status epilepticus
Alcohol and illicit drug use disorders	▪ Screening and brief interventions for alcohol use disorders ▪ Opioid substitution therapy (e.g. methadone and buprenorphine) for opioid dependence
Suicide and self-harm	▪ PHC packages for underlying MNS disorders ▪ Planned follow-up and monitoring of suicide attempters ▪ Emergency management of poisoning

Source: adapted from Patel et al. *(13)*.

How this guidance tackles the issues of integration of mental health in primary health care

This guidance uses a whole health systems approach with an emphasis on service delivery to translate the evidence of effective and efficient treatments into feasible and affordable health care provision and the system supporting it. Health management systems have been described as comprising six interrelated components or building blocks (see Fig. 4).



■ **FIG. 4.** The health systems framework

Part 1. The context for integration of mental health services in primary health care

Part 1 presents the background and literature informing the impetus to integrate mental health in PHC and its relevance to the Eastern Mediterranean Region (as summarized above). It informs the practical steps of how to do it that are covered in Parts 2–4 of the guidance (see Fig . 5).

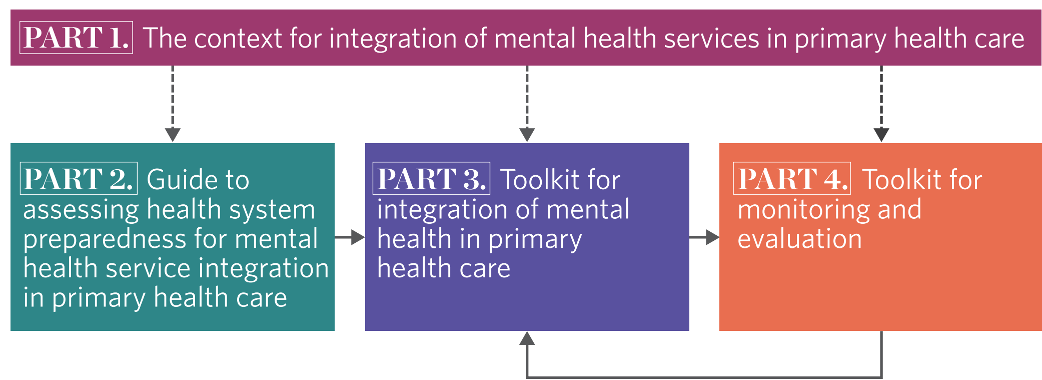


FIG. 5. The four parts of the guidance on integration of mental health in primary health care

Part 2. Guide to assessing health system preparedness for mental health integration in primary health care

Focal points or working groups should be identified to be responsible for conducting the preparedness analysis at system and local levels, and this should involve stakeholders from the outset. The guidance includes a checklist on collecting essential information to assess preparedness (see the Preparedness checklist, available on the Integrating mental health in primary health care package webpage under related links).

If additional information is required, there are existing tools, including tools assessing preparedness for humanitarian emergencies, combined with interviews with key informants, document review, focus groups and direct observation to collect the relevant data.

WHO mhGAP operations manual: 1.2 conduct a situation analysis

WHO Assessment Instrument for Mental Health Systems – WHO-AIMS

WHO Mental health atlas, 2017

WHO Service availability and readiness assessment (SARA)

Additional indicators developed for the Regional framework to scale up action on mental health in the Eastern Mediterranean Region (see Annex)

Emerald questionnaire for cross country comparison of HMIS

PRIME (PRogramme for Improving Mental health carE) Situation Analysis Tool

PRIME Qualitative topic guide for formative study – key informants on district mental health care plans

WHO and UNHCR: Assessing mental health and psychosocial needs and resources: toolkit for humanitarian settings, 2012

IASC Reference Group mental health and psychosocial support assessment guide, 2013

IMC toolkit for the integration of mental health into general health care in humanitarian settings.

A comprehensive plan for a preparedness analysis report structured around the health system building blocks is included in the guidance. The report should discuss the strengths, weaknesses, barriers and opportunities that have been identified, and based on these it should offer recommendations for solutions to identified barriers.

Part 3. Toolkit for delivery of mental health services in primary health care

Part 3 provides detailed information on how to reform services to provide integrated mental health care in PHC. Each of the system strengthening actions summarized in Table 4 are addressed in detail, with specific recommendations to countries with different levels of resources, and there are links to relevant published reports, case studies, instruments and tools.

TABLE 4. Overview of system strengthening actions

Building block	System strengthening actions
Governance	▪ Leadership to manage the integration of mental health care in PHC ▪ Strategic vision for integration of mental health in PHC articulated in the mental health care policy and plan and in the disaster/emergency preparedness plan ▪ Mental health plans include specific goals, budgets and timelines ▪ Accountable resources allocation consistent with plans (e.g. specific mental health allocation allocated by territory, level or programme) ▪ A whole-of-government approach ▪ Effective system for coordination and participation of associations of persons with mental disorders and their families and other stakeholders in mental health policy, legislation and advocacy ▪ Updated mental health legislation, consistent with internationally agreed standards of human rights, supported by standardized documentation and procedures, good practice guidelines, and standards and training requirements for the health professionals who implement the legislation ▪ National external quality and rights review body ▪ Monitoring of effectiveness and efficiency ▪ Collaborative plan of action ▪ Effective advocacy activities
Service organization	▪ Balanced model of mental health services mapped to meet needs ▪ Agreed mental health interventions to be provided through PHC, complementing those to be delivered through other delivery channels ▪ A public health approach, providing person-centred, coordinated care across diseases and settings ▪ Designated specialist services (hospital and community mental health teams) to take referrals, with an efficient referral and back-referral system with good coordination, documentation and communication, and to provide support and supervision ▪ Secure individual health records system ▪ Community engagement and empowerment

Building block	System strengthening actions
Human resources for mental health	▪ Provision of mental health services by nonspecialist health workers through task sharing · Professional licensing and job descriptions · Endorsed competency-based training (pre-service and in-service) · Provision of training and supervision for PHC staff, e.g. by transition of mental health specialists' role to include training and supervision · Recognition of new knowledge, skills, and responsibilities through appraisal, performance review and staff promotion ▪ Long-term costed human resources plan for integrating mental health into PHC ▪ Adequately staffed PHC services with good conditions of service to attract and retain PHC staff (reduce the external brain drain to other countries, and the internal brain drain from the public health sector to international nongovernmental organizations) ▪ Team organization within PHC facilities ▪ Systems for PHC workload demand management ▪ Equitable distribution of PHC staff across different parts of the country, matched to population need ▪ Updated national human resources for mental health database
Medicines and technology	▪ Essential drugs list for mental health services in PHC ▪ Mental health medicines included in effective national systems of pharmaceuticals regulation and quality assurance ▪ Reliable supply system to ensure essential medicines are available in all parts of the country – with a pharmaceutical information system to monitor availability ▪ Approved guidelines on prescribing practices for psychotropic medications ▪ Information provided for patients and families on proper use of medication ▪ Essential equipment and investigations (urgent and routine) available to all PHC facilities
Mental health financing	▪ Specified national budget for mental health care with mental health service delivery targets costed, financed and monitored at a national level and at each level of the health and other relevant sectors ▪ Government and prepayment resources adequately covering selected priority mental disorders, and so limiting out-of-pocket expenses ▪ Financing for pharmaceuticals
Mental health information	▪ National focal point for mental health information ▪ Updated mental health information system, integrated into all levels of the system, aiming towards parity with data collected for physical health conditions. ▪ Minimum mental health data set and mandatory recording and reporting of suicides ▪ Regulated procedures for collection, storage, processing, compilation and dissemination of information ▪ Annual national report with commentary, supported by data sets available at all levels, with analytical reporting down to district level – to be used in planning, monitoring and resource allocation

Integrating mental health in primary health care in humanitarian emergencies

The number and scale of complex emergencies in the Eastern Mediterranean Region is high. More than 62 million people in the Region are affected by emergencies, including 5 million refugees who remain in the Region and more than 21 million internally displaced persons. After an acute emergency, 15–20% of people suffer a mild to moderate mental disorder and 3–4% experience mental disorder of a severity that impairs their ability to function and survive in the emergency environment. People with pre-existing health conditions are particularly vulnerable if their care and treatment is interrupted. Health systems themselves are disrupted by staff shortages, interruption in the supply of medication and loss of infrastructure (transport, power and water).

The internationally recognized set of principles and universal minimum standards are laid out in the Sphere Handbook, Humanitarian Charter and minimum standards in humanitarian response. The IASC guidelines on mental health and psychosocial support in humanitarian emergencies identifies core principles that should underpin mental health and psychosocial support (MHPSS) in emergency settings. It includes 25 action sheets that describe the background, key actions, key resources, sample process indicators and case examples (action sheets 6.1 to 6.5 and 9.1. are most relevant to the integration of mental health in PHC). Based on IASC guidelines, the booklet Mental health and psychosocial support in humanitarian emergencies: what should humanitarian health actors know? provides an overview of what humanitarian health actors should know about MHPSS in humanitarian emergencies. Health managers should make sure that health staff are oriented on relevant parts of this booklet.

The International Medical Corps have developed a toolkit for the integration of mental health into general health care in humanitarian settings, which provides a framework and resources for the steps and components to support understanding and implementation of integrated mental health programmes in humanitarian settings.

Emergency planning and preparation

National emergency preparedness plans, costed and with an agreed, specified budgetary allocation, should include MHPSS, and should strengthen the capacity of the PHC workforce to deliver evidence-based interventions in MHPSS during an emergency. The development, revision and ongoing support of emergency preparedness requires ministerial, provincial and district level discussions in collaboration with national and international stakeholders. Ideally one local health staff member should be appointed a lead mental health coordinator.

One of the best ways to prepare for an emergency is by establishing a well-integrated balanced model of mental health care that will provide a good organizational structure to respond to an emergency. Map existing resources for MHPSS in emergencies: who and where are the health service and community resources for MHPSS?

Train and supervise health care staff in the management of priority mental health conditions relevant to emergencies using the mhGAP humanitarian intervention guide. Aim to train at least one health care staff member per PHC facility; ideally this can build on their non-emergency training in priority mental disorders. Orient community workers, staff working in general health care, and staff working in protection in psychological first aid and the Save the Children psychological first aid training manual for child practitioners (PFA). Make emergency preparedness plans for people with severe or chronic mental illness residing in institutions and in the community (see Action Sheet 6.3 of the IASC guidelines for mental health and psychosocial support in emergency settings). Prepare emergency stocks of essential medicines and medical devices, including all of the essential psychotropic medicines (e.g. the Interagency emergency health kit 2011 for 10 000 people for 3 months). Put in place supplies of guidelines and supporting tools that will be required to provide MHPSS care in an emergency.

Emergency response phase

During the early phase, two key areas are a good assessment and coordination. Coordination of activities is crucial to getting the most complete assessment in order to distribute resources to meet needs efficiently, and to avoid fragmentation or duplication. An initial analysis needs to be done quickly, but it is an ongoing process that should not stand in the way of providing MHPSS services. Assessing mental health and psychosocial needs and resources: toolkit for humanitarian settings includes two tools relevant for mental health in PHC: Tool 5: Checklist for integrating mental health in PHC in humanitarian settings, and Tool 7: Template to assess mental health system formal resources in humanitarian settings.

In an emergency, PHC staff can provide evidence-based interventions for people with MNS disorders so long as they have been properly trained and have support and supervision by specialist services and a clear referral/back referral system (e.g. using the mhGAP humanitarian intervention guide (mhGAP-HIG)) and psychological interventions such as cognitive behavioural therapy, group inter-personal therapy, and Problem Management Plus (PM+). Staff should also respond to ensure that the basic needs and rights of people with severe mental disorders are met. This includes people living at home, and in some circumstances may need to extend to residential and hospital care since there is a high risk of neglect and abuse during an emergency.

Community health workers, school staff and volunteers can potentially offer psychological first aid for people in acute distress. Ideally, orientation training (0.5–1.0 days) should be provided as part of the preparedness phase but if there are insufficient numbers of psychological first-aiders, orientation training can be provided during a crisis. A triage system should be developed so that trained PHC staff see people needing clinical interventions beyond psychological first aid.

Recovery phase

After the disruption of an emergency there is the need to rebuild, and therefore the opportunity to construct a better model of mental health care than before. Humanitarian emergencies attract attention to stress and psychosocial difficulties, and there may be additional resources and funds available for rebuilding. Five of the 10 case examples described in Building back better: sustainable mental health care after emergencies *(16)* were from countries of the Eastern Mediterranean Region, each demonstrating "that it is possible to make substantial gains in building and strengthening sustainable mental health services during and following emergencies".

Part 4. Toolkit for monitoring and evaluation

Country policies and plans

Each country has its own unique policies and plans and will need to plan monitoring and evaluation to measure indicators related to their own goals, targets, processes and timelines as documented in their mental health plans. This guidance includes a core set of reporting forms for collecting information on the core indicators used to monitor the implementation of integration of mental health in PHC.

If additional information is required, the following tools contain most of the indicators needed for system and locality level monitoring and evaluation. Countries should review their own policies and plans to identify which indicators to use, and to determine whether additional indicators need to be developed to monitor strategies, objectives or processes that are not adequately addressed by these indicators.

- WHO mental health policy and service guidance package: monitoring and evaluation of mental health policies and plans
- WHO Assessment Instrument for Mental Health Systems (WHO-AIMS)
- WHO Mental health atlas
- Questions to collect data for 11 additional indicators developed for the Regional framework to scale up action on mental health in the Eastern Mediterranean Region and their metadata
- Patient outcome measures (e.g. WHO-5 Well-Being Index, Health of the Nation Outcome Scales (HoNOS) (14,15), WHO Disability Assessment Schedule 2, and IMC Client Satisfaction Scale
- IASC Common monitoring and evaluation framework for mental health and psychosocial support programmes in emergency settings, 2021.

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