

WORLD MENTAL HEALTH DAY

October 10, 2009



MENTAL HEALTH IN PRIMARY CARE: ENHANCING TREATMENT AND PROMOTING MENTAL HEALTH



World Mental Health Day is a registered service mark of the World Federation for Mental Health

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FOREWORD

WORLD MENTAL HEALTH DAY 2009 MENTAL HEALTH IN PRIMARY CARE: ENHANCING TREATMENT AND PROMOTING MENTAL HEALTH

This global awareness campaign addresses the continuing need to “make mental health issues a global priority.” Mental illnesses do not discriminate according to culture or age, and an individual’s mental health is an integral aspect of overall health and wellbeing. There is a growing body of knowledge on the benefits of integrating mental health into primary care settings. This integration would align the diagnosis, treatment, and care of mental illnesses with the mainstream healthcare system, alleviating the problems associated with the current separation of physical health and mental health care.

The theme of this year’s campaign is intended to draw worldwide attention to the growing body of knowledge on integration which emphasizes the benefits of enhancing overall health and promoting mental health by integrating healthcare services. World Mental Health Day 2009 aims to provide consumers, families, and advocacy associations around the world with accessible information on this topic. Involving consumers at a grassroots level in the process of healthcare integration will strengthen the message that mental health is integral to good overall health and it is imperative that appropriate services are provided for everyone who needs them, regardless of where they receive those services. During this time of healthcare reform it is critical that advocates are well informed on these important integration issues. We can be influential in ensuring that people living with mental illnesses receive the same level of priority within the general and primary health care system.

The release in September 2008, of *“Integrating Mental Health into Primary Care: A Global Perspective”* by the World Health Organization (WHO) and the World Organization of Family Doctors (Wonca) signaled a major step in fostering a global effort to integrate mental health into primary care. In the publication’s introductory message, WHO Director General Dr. Margaret Chan and Wonca President Professor Chris van Weel state the case for such an effort:

“Primary care starts with people. And, integrating mental health services into primary care is the most viable way of ensuring that people have access to the mental health care they need. People can

access mental health services closer to their homes, thus keeping families together and maintaining their daily activities. In addition, they avoid indirect costs associated with seeking specialist care in distant locations. Mental health care delivered in primary care minimize stigma and discrimination, and remove the risk of human rights violations that occur in psychiatric hospitals. And, as this report will show, integrating mental health services into primary care generates good health outcomes at reasonable costs. Nonetheless, general primary care systems must be strengthened before mental health integration can be reasonably expected to flourish.” (*Integrating mental health into primary care: A global perspective*; © World Health Organization and World Organization of Family Doctors (Wonca), 2008, page vii)

World Mental Health Day 2009, will highlight the opportunities and challenges that integrating mental health services into the primary health care delivery system will present not only to people living with poor mental health, their families and caregivers, but also to healthcare professionals and providers. As always, the campaign will focus on the critical role that mental health advocacy organizations, along with patient/service user groups, need to play in shaping this major general health and mental health reform movement. Such informed proactive and sustained advocacy will be necessary if the movement toward integration is to result in improved access to affordable services that are of adequate quality for people experiencing mental illnesses and emotional health problems the world over.

The global mental health community has learned from previous reform attempts that achieving parity in the delivery of mental health services around the world is a struggle. The effective integration of mental health into primary care at a level of priority appropriate to the documented burden of disease for mental illnesses will be a major undertaking in a time of global economic and social difficulty. However, it is well past time for the world to listen to and act on this call to improve mental health services.

Thomas H. Bornemann, Ed.D.
Director, the Carter Center Mental Health Program

INTRODUCTION

Mental health disorders continue to be a serious and expensive global health issue, affecting people of all ages and from all cultures and socio-economic status. Major depression ranks fourth in terms of disability adjusted life years and will soon be the second leading cause of disability worldwide. Out of the estimated 450 million people globally who have a mental health disorder, fewer than half receive the help they need. Many low-income countries have one or two psychiatrists for the entire population. Many developed countries have “carved out” mental health services from primary care health systems – giving mental health and illness less attention, less money, reduced options and services and little or no connection to the individual’s total healthcare needs.

The Hogg Foundation for Mental Health in the United States notes that “...*mental and medical conditions are highly interconnected. Therefore, improving care for individuals with mental disorders requires close attention to the interface of mental health and general medical care.*”

The topics of integrated care and collaborative care have been areas of discussion by policy makers and healthcare service organizations for many years. Considerable research has been done; trial programs have been implemented. From the landmark US Surgeon General’s 2001 Mental Health Report to the recently published report from the World Health Organization and the World Organization of Family Doctors (Wonca), the rationale and justification for a holistic approach to mental and physical healthcare has been championed.

It is now time to review, discuss and confront the barriers that continue to impede progress to healthcare integration and effective service delivery, and to better define and advocate for a system that works for every country’s health system. The goal of effective citizen advocacy should be the establishment of an appropriate, affordable, and accessible healthcare system that brings all necessary components together to promote an integrated collaborative approach to wellness for all. That there “can be no health without mental health” has been confirmed by the advances in research and practice over the past 50 years. The World Federation for Mental Health believes that the time has come for governments and healthcare service systems to place the highest priority on creating an integrated approach to healthcare

that will enhance wellness by including all aspects of illness and wellness into one system of treatment.

The goal of the 2009 World Mental Health Day global awareness campaign is to promote the critical need to bring mental health care to a higher level of importance. We want you to envision a system of care that supports any ailment you have, where all doctors and specialists work together to give you the best in patient-centered care. How can we be patient-centered unless we are working together to treat all aspects of health and wellness? The hundreds of World Mental Health Day advocacy, awareness, and education events and activities that will be launched and conducted by grassroots mental health organizations throughout the world on October 10 can certainly bring these issues to the forefront of public attention and will hopefully direct new energy and effort at improving treatment and services for those living with mental health problems and their related physical health consequences.

We greatly appreciate your continued support of World Mental Health Day and for all the work you do to advocate for better mental health in your communities.

On behalf of the WFMH Board and Staff we thank you,



L. Patt Franciosi, PhD
Chair, World Mental Health Day



Professor John Copeland
President, World Federation for Mental Health

SECTION I

PRIMARY CARE AND MENTAL HEALTH

WHO, back in 1948, defined “health” as ‘A state of complete physical, mental and social well-being, and not merely the absence of disease or infirmity’.

Why is the topic of “Mental Health in Primary Care” of great enough importance to be selected as the theme for World Mental Health Day 2009? How does advocacy for integrating mental health care improve the possibility for better diagnostic, treatment and prevention of mental illnesses and mental health problems, and how would such integration serve to promote the improved mental and emotional wellness of people worldwide over the next 20 years?

Dr. Margaret Chan, Director General of the World Health Organization, in her message launching WHO’s 2008 World Health Day, “*Primary Health Care: Now More Than Ever*”, stated that WHO’s focus on primary health care grows both from her personal conviction, and from an increased demand from Member States. Dr. Chan noted that “such a demand displays a growing appetite among policymakers for knowledge related to how health systems can become more equitable, inclusive and fair. It also reflects, more fundamentally, a shift towards the need for more comprehensive thinking about the performance of health systems as a whole.” (WHO *The World Health Report 2008 Introduction and Overview*, p. 2)

The concept that health systems might become more “equitable, inclusive and fair” is in itself solid rationale for inserting the needs of people living with mental health problems and disorders into the discussion of improving integrated primary health care. For centuries, mental health treatment, mental health promotion and prevention of disorders have not received the needed level of attention from governments, from the medical profession, and from the general public.

For centuries, the illnesses of the mind have been treated as a social issue – separate from any physical health issue. Now, though, most will agree that mental health disorders do not happen in isolation – in fact, they frequently occur

in relation to or alongside other medical issues – such as heart disease, diabetes, cancer, neurological disorders and in response to many life situations. An individual’s medical issues and life circumstances do not affect just one area of the body – but the body as a whole, each having an affect on the other. It would seem obvious that treating an individual’s health in a holistic and integrated manner would achieve more positive outcomes and increased potential for recovery and productivity.

Primary care is the long-term relationship between a person and their doctor. The general doctor provides care for most of their health needs and coordinates additional health care services beyond the doctor’s area of expertise. *The United States Institute of Medicine gave this definition for primary care in 1996: “Primary care is the provision of integrated, accessible health care services by clinicians who are accountable for addressing a large majority of personal health-care needs, developing a sustained partnership with patients, and practicing in the context of family and community.” The following definition is derived from the 1960s-era: Primary care may also be thought of as a level of care in the larger health-care system, to be distinguished from secondary care (care provided by community-based specialists and local community hospitals) and tertiary care (care provided by specialists at regional or academic health centers). In non-industrialized nations with limited health resources, primary care may be provided by village health workers, nurse-auxiliaries, promotoras, community health advisors, barefoot-doctors, etc. ([www.msm.edu/Centers_and_Institutes/National_Center_for_Primary_Care_\(NCPC\)/What_is_Primary_Care.htm](http://www.msm.edu/Centers_and_Institutes/National_Center_for_Primary_Care_(NCPC)/What_is_Primary_Care.htm))*

Mental health care has usually been seen as a separate field, or a specialty along side the general healthcare system. It is the treatment of disorders of the mind. Neurological disorders starting in the brain were once seen as a separate matter, not needing any physical monitoring – but in recent years there has been greater recognition of the very important link between good mental health and good overall health. Mental disorders can have an effect on physical health and many physical ailments can induce more mental health issues. Also, it has been determined that those with severe and persistent mental illnesses are often twice as

likely to have multiple physical health issues. Yet, even with this recognition of the inseparable relationship between mind and body and of the significant co-morbidity of mental and physical disorders, insufficient attention across the medical field continues to be given to healthcare systems that would, as Dr. Chan says “identify major avenues for health systems to narrow the intolerable gaps between aspiration and implementation” (*The World Health Report 2008, p.3*).

To improve diagnosis, treatment and outcomes, health care providers must find new ways to build partnerships that create a more effective and collaborative practice that focuses on patient-centered, whole body care. It is imperative that mental health and mental disorders are included in plans and policies intended to promote the concept of “Primary Health Care: now more than ever” if the desired reform movement is to achieve the goal of improved health for all of the world’s citizens and to create and sustain a truly comprehensive and integrated health care delivery system.

The 2009 World Mental Health Day global awareness campaign theme “***Mental Health in Primary Care: Enhancing Treatment and Promoting Mental Health***” is intended to address the continuing need to “make mental health a global priority,” and stresses the all too-often neglected fact that mental health is an integral element of every individual’s overall health and well-being. The campaign theme is intended to draw worldwide attention to the growing body of information and knowledge focusing on the integration of mental health into primary healthcare. This is a significant trend in shifting mental health diagnosis, treatment and care from the traditional separate but unequal mental health services delivery system into mainstream healthcare.

The engagement of the “end users” of mental health services, their families who carry much of the responsibility for helping people living with mental illnesses, and the advocates who attempt to influence mental health policies, is critical during this time of change, reform, and limited resources. The principal goals for the 2009 World Mental Health Day campaign are to inform and equip the grass-

roots mental health community to enable it to advocate for making mental health and mental illnesses integral to planning for appropriate health services. One of the primary advocacy concerns that must be addressed is the danger that adequate and effective diagnosis, treatment and recovery of people living with mental illnesses will not receive a parity level priority within the general and primary healthcare system. It is the job of the global mental health advocacy movement to assure that this is not an unintended result of healthcare reform.

WMHDAY 2009 highlights the opportunities and the challenges that integrating mental health services into the primary health care delivery system will present to people living with mental disorders and poor mental health, to their families and caregivers — and to healthcare professionals. As always, the campaign will focus on the critical role that mental health advocacy, patient/service user, and family/caregiver organizations need to play in shaping this major general health and mental health reform movement. Such informed proactive and sustained advocacy will be necessary if the movement towards integration is to result in improved access to quality, adequate and affordable services for people experiencing mental illnesses and emotional health problems the world over.

Advocates, families, professionals and policymakers across the global mental health sector must remember that this current movement to improve the way in which mental health services are delivered is not the first such reform effort. Lessons learned from the past tell us that achieving equality in how mental health services are addressed in countries around the world is not an easy struggle. The effective integration of mental health into primary care at a level of priority appropriate to the documented burden of care of mental illnesses will be a major undertaking in a time of global economic and social difficulty. Certainly, it is well past time for the world to listen and to act to improve mental health services and ready access to services by those experiencing serious mental health problems and disorders such as schizophrenia, anxiety disorders, bipolar disorder, and depression.

FACT SHEET

CONNECTING BODY AND MIND: A RESOURCE GUIDE TO INTEGRATED HEALTH CARE IN TEXAS AND THE UNITED STATES

Hogg Foundation for Mental Health (2008, Dec) pp 5, 11, 13, 20, 23, 31

KEY POINTS

- Medically ill populations are at increased risk for behavioral health problems, just as individuals with behavioral health problems are at higher risk for medical co-morbidities. Failing to treat medical or psychiatric co-morbidities decreases an individual's chances for successful recovery and overall health.
- Screening for behavioral health problems in primary care or medical problems in behavioral health settings is crucial for detection of health concerns, but is not sufficient to improve the outcomes of individuals with co-morbid conditions.
- Many primary care providers need training on identifying and treating behavioral health disorders, but this training is most effective when delivered through on-going communication and collaboration with behavioral health providers.
- Although several models for integrated care exist, the most effective models impact the treatment system in comprehensive, multi-faceted ways.
- The cost benefit of providing integrated care for depression, and probably other common mental health disorders, is similar to the benefit achieved in managing other chronic health conditions.
- Successful integration efforts require dynamic, committed leadership.
- A growing number of resources such as clinical and implementation manuals, screening and assessment tools, patient registries and training programs have been developed and will greatly improve a health or behavioral health care system's ability to achieve outcomes seen in research studies.
- Financial incentives are needed that support evidence-based, integrated models of care, rather than specialty referral and limited or no follow-up.
- Outcome or performance measurement systems that focus on the holistic health of consumers/patients will help encourage collaboration across primary care and behavioral health systems.
- Technology can be an important tool in facilitating integration, including identifying and screening patients, tracking patient progress, encouraging adherence to clinical protocols, facilitating communication between providers and evaluating the impact of integrated programs.

LESSONS LEARNED

Why integrate behavioral health into primary care settings?

- Most people seek help for behavioral health problems in primary care settings.
- Behavioral health problems often go undetected and untreated in primary care.
- People with common medical disorders like diabetes have higher rates of behavioral health problems.
- When psychiatric disorders are not addressed in people with chronic medical illnesses, they have worse psychiatric and medical outcomes.
- Populations of color, children and adolescents, older adults, and uninsured or low-income patients seen in the public sector are especially unlikely to receive appropriate care for psychiatric disorders.
- Treating behavioral health problems in the primary care presents an important opportunity to intervene early and prevent more disabling disorders, and also to reach people who cannot or will not access specialty behavioral health care.

Why integrate physical health care into behavioral health settings?

- Adults receiving treatment in behavioral health settings often have common physical health conditions as well, such as cardiovascular disease, diabetes and hypertension.

- Although most people served in behavioral health settings have medical conditions, more than half of those conditions go unrecognized.
- Individuals with severe mental illnesses typically have less access to primary medical care than the general population.
- People with severe mental disorders die of physical ailments an average of 25 years earlier than the rest of the population.
- Community mental health centers recognize the importance of medical care for their clients, but often are limited in their capacity to provide.

How can we improve behavioral health treatment in primary care settings?

- Screening for psychiatric disorders leads to improved patient outcomes only when appropriate care follows detection.
- Without additional supports, physician education results in minimal or short-lived changes in providers' practices and in patient outcomes.
- Enhancing referrals to specialty behavioral health providers with additional supports may lead to improved follow-through and outcomes, but more research is needed.
- Placing a behavioral health specialist in a primary care practice is unlikely to improve patients' outcomes unless their care is coordinated and based in evidence-based approaches.
- Research shows that collaborative care is an effective approach and improves outcomes for a wide range of primary care patients with psychiatric disorders.
- The primary care behavioral health model is likely beneficial, but has not been systematically evaluated.

How can we improve physical health care in behavioral health settings?

- Screening for physical health conditions is likely necessary but insufficient unless it is followed by quality health care.
- Health promotion programs show promise in reducing rates of chronic physical illness in people with severe mental illnesses.
- It is unknown whether training psychiatrists in primary care leads to improved physical health outcomes for consumers.
- Co-locating primary care providers in behavioral health care settings may improve consumers' physical health outcomes.
- Enhancing referrals with additional supports may lead to improved follow-through and outcomes, but more research is needed.

What barriers interfere with integrating care?

- Clinical barriers include differences in primary care and behavioral health cultures, providers' lack of training, providers' lack of interest and stigma.
- Organizational barriers include difficulties with communication and consultation across physical and behavioral health providers, the physical separation of different provider types, and primary care's orientation to treating acute problems.
- Policy barriers include legal obstacles to sharing information across provider systems and regulations that limit the services organizations can provide.
- Financial barriers are complex and include issues related to the alignment of incentives in.

We highly recommend that you view this entire document and all the wonderful information it contains.

You can find it at:

http://www.hogg.utexas.edu/PDF/IHC_Resource_Guide.pdf

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FACT SHEET

SEVEN GOOD REASONS FOR INTEGRATING MENTAL HEALTH INTO PRIMARY CARE

Integrating Mental Health into Primary Care: A Global Perspective. WHO/Wonca, 2008, pp 21-46.

1. **The burden of mental disorders is great.** Mental disorders are prevalent in all societies. They create a substantial personal burden for affected individuals and their families, and they produce significant economic and social hardships that affect society as a whole.
2. **Mental and physical health problems are interwoven.** Many people suffer from both physical and mental health problems. Integrated primary care services help ensure that people are treated in a holistic manner, meeting the mental health needs of people with physical disorders, as well as the physical health needs of people with mental disorders.
3. **The treatment gap for mental disorders is enormous.** In all countries, there is a significant gap between the prevalence of mental disorders, on one hand, and the number of people receiving treatment and care, on the other hand. Primary care for mental health helps close this gap.
4. **Primary care for mental health enhances access.** When mental health is integrated into primary care, people can access mental health services closer to their homes, thus keeping their families together and maintaining their daily activities. Primary care for mental health also facilitates community outreach and mental health promotion, as well as long-term monitoring and management of affected individuals.
5. **Primary care for mental health promotes respect of human rights.** Mental health services delivered in primary care minimize stigma and discrimination. They also remove the risk of human rights violations that can occur in psychiatric hospitals.
6. **Primary care for mental health is affordable and cost effective.** Primary care services for mental health are less expensive than psychiatric hospitals, for patients, communities and governments alike. In addition, patients and families avoid indirect costs associated with seeking specialist care in distant locations. Treatment of common mental disorders is cost effective, and investments by governments can bring important benefits.
7. **Primary care for mental health generates good health outcomes.** The majority of people with mental disorders treated in primary care have good outcomes, particularly when linked to a network of services at secondary level and in the community.

To view the entire section, please go to:

<http://www.globalfamilydoctor.com/index.asp?PageID=9063&ContType=IntegratingMentalHealthIntoPrimaryCare>

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SECTION II

PRIMARY CARE AND MENTAL HEALTH SERVICES IN PRACTICE

Although to some the idea of integrating mental health with primary care might seem like a new idea but the concept is not a new one and is, in fact, being studied and used around the world. Health care, including mental health care, is organized and viewed differently in almost every country of the world. It is important to find an approach to integrating mental health and primary care that will be both comprehensive and effective within the structure and resource capacity of each country. This section provides some examples of programs and policies for integrating mental health and primary care that are currently being implemented around the world. They are discussed here in summary; please view the full material for further and more detailed information.

DETECTING MENTAL DISORDERS IN PRIMARY CARE

Vimal Kumar Sharma MD, PhD, FRCPsych,¹

John R M Copeland MD, ScD, FRCPsych,²

Mental health problems are one of the leading causes of disability in the world. A large proportion of people with mental disorders around the world fail to receive appropriate help in spite of developments in new treatments for mental illnesses (psychological, social as well as medicinal), and as a consequence suffer in silence. In the developed countries this may be due to the stigma attached to mental illness leading to reluctance to ask for help for any kind of mental health problem. Another important reason could be primary care health services providing inadequate training and poor skills for detecting and treating people with mental health problems. Research studies have highlighted the lack of time and training available to general practitioners and primary care workers for assessing the mental health of their patients.

A poor provision of mental health care in low and middle income countries is often blamed on a lack of resources. It

takes about six years to train a doctor and further three years to train as a psychiatrist. These countries therefore have few doctors and fewer psychiatrists, because of the high cost of medical education. A high proportion of them immigrate to high income countries. In a number of African countries there are no psychiatrists and in some only one or two. There is no foreseeable answer to this problem. As a result many thousands of mentally ill people remain untreated, unable to work and in poverty or in mental institutions.

Early and accurate detection of mental health problems followed by an appropriate treatment and management plan directed towards recovery and return to work would help to reduce the global burden on health and social care systems caused by mental disorders. Work in the field of psychotic disorders has clearly shown that early intervention not only helps towards quick and full recovery, but also leads the person to better reintegration into the society. Our emphasis should therefore be to establish systems in every corner of the world to help identify people with mental health problems at the earliest opportunity and provide appropriate interventions. One way to approach this problem is to take advantage of modern technology such as computer assisted methods to scale up human resources available in the area of health and social well being, particularly in low and middle income countries.

We have developed with primary care workers a computer assisted package, the Global Mental Health Assessment Tool (GMHAT/PC) that has already been translated into a number of languages (Spanish, Dutch, German, Hindi, Chinese and Arabic with French and Portuguese versions in preparation). The package is an innovative way to address this problem. Firstly, this method aims to improve the recognition of mental illness in primary care and the initiation of appropriate treatments by empowering primary care workers. Secondly, by developing a more comprehensive mental health assessment with computer assisted differential psychiatric diagnosis consistent with ICD 10 criteria, pathways of care, quality of life, needs and risk assessment aimed at

secondary care. These methods have been developed by primary care physicians and psychiatrists and have proved to be effective so far in the UK, India and Abu Dhabi. The use of computers could be a restriction to general use, but we are developing the program to be installed on a touch screen PDA, making it easy to use anywhere and where the results could be communicated by mobile phone. These methods which have so far taken seven years to adapt and develop are based on many years of developing and using computer assisted research diagnostic tools. A brief description of the GMHAT/PC is as follows:

THE GLOBAL MENTAL HEALTH ASSESSMENT TOOL (GMHAT/PC)

The GMHAT/PC is a computerized clinical assessment tool developed to assess and identify mental health problems in primary and general health care. The assessment program starts with basic instructions giving details of how to use the tool and rate the symptoms. The following screens consist of a series of questions leading to a comprehensive yet quick mental state assessment focusing sequentially on the following symptoms or problems: worries; anxiety and panic attacks; concentration; depressed mood, including suicidal risk; sleep; appetite; eating disorders; hypochondriasis; obsessions and compulsions; phobia; mania/hypomania; thought disorder; psychotic symptoms (delusions and hallucinations); disorientation; memory impairment; alcohol misuse; drug misuse; personality problems and stressors. One question at a time appears from these respective subsections. The questions proceed in clinical order along a tree-branch structure. For each of the major clinical disor-

ders there are key screening questions. When the patient has no symptoms based on the key items of a subsection, the interview moves on to the next subsection. At the end of the interview the screen asks for the interviewer's details and his/her clinical diagnosis if available. The screen then proceeds to a summary report of symptoms and their scores and presents the GMHAT/PC diagnosis. The main computer diagnosis is derived using a hierarchical model and designed around ICD-10. The diagnostic program takes account of severity of symptoms (moderate to severe). It also generates alternative diagnoses and co-morbid states based on the presence of symptoms of other disorders. In addition, it includes an assessment of risk of self-harm. The program also contains management guidelines for these disorders.

For services where there is no adequate psychiatric secondary care service available, the secondary care model, GMHAT/FULL, using the new ALL-AGECAT differential diagnostic program is now undergoing validity trials.

Those interested in trying out GMHAT/PC, translating it and/or introducing it into their clinical service, should contact us. No charge is made for this program.

¹ Consultant Psychiatrist and Acting Medical Director, Cheshire and Wirral Partnership NHS Foundation Trust and Honorary Senior Lecturer, Liverpool University

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INTEGRATING MENTAL HEALTH AND PRIMARY CARE - Primary Care for Mental Health in Practice

(WHO/Wonca, *Integrating Mental Health into Primary Care – A Global Perspective*, 2008, pg. 49)

The following best practice examples demonstrate that integrating mental health into primary care is possible across a range of circumstances; and in difficult economic and political circumstances. The represented countries have vastly different socioeconomic situations and health care resources. Consequently, their specific models for integrating mental health into primary care vary greatly. While details differ, success has been achieved through leadership, commitment, and local application of the 10 principles outlined in the next section. Clear policies and plans, combined with adequate resources and close stewardship, training and ongoing support of primary care workers, availability of psychotropic medicines, and strong linkages to higher levels of care and community resources result in the best outcomes.

To see the full list of countries and obtain further information, we suggest you view the full document at:

http://www.globalfamilydoctor.com/PDFs/IntegratingMentalHealthIntoPrimaryCare.pdf?nav_id=339.

ARGENTINA

In Neuquén Province, primary care physicians lead the diagnosis, treatment and rehabilitation of patients with severe mental disorders. Psychiatrists and other mental health specialists are available to review and advise on complex cases. A community-based rehabilitation centre, the Austral, provides complementary clinical care in close coordination with primary care centres. It also serves as a training site for general medicine residents and practising primary care physicians. The model for mental health care is based on four key elements.

1. *Primary care physicians.* Diagnosis, treatment and rehabilitative services for severe mental disorders are provided by a team of health service providers, under the leadership of a primary care physician who is trained for that responsibility. In addition, primary care physicians frequently address life stressors and family conflicts, which they manage with brief, problem-oriented psychotherapy.

2. *Outpatients.* People with mental disorders receive outpatient treatment in their communities, where they enjoy the support of family, friends, familiar surroundings, and community services.
3. *Holistic care.* Patients receive holistic care, which is responsive to both mental and physical ailments.
4. *Specialist support.* Psychiatrists are available to review and advise on complex cases. They also train primary care physicians and nurses. Because psychiatrists are used sparingly and institutional care is avoided, costs are lower and access to needed services is improved.

Neuquén's *sanitarios* and *curanderos* are often the first point of contact for people with mental disorders. In some cases, patients go from *curanderos* to formal primary care. However in rural areas, self-care and informal care are used most frequently and the family's supportive role is seen as fundamental.

Psychologists are distributed among health centres around the city and consult where needed. They are not affiliated to any particular clinic, but rather serve a number of health care settings. Psychologists address psychosocial complaints in addition to severe mental disorders. Patients with mental disorders are sent to the provincial hospital if required. The limited number of public sector psychiatric beds in the province (10) sometimes complicates the treatment of acutely ill patients. Severely ill, violent, or suicidal patients requiring long-term care are sent to the psychiatric hospital in Buenos Aires.

INDIA

Mental health services are integrated with general primary care mainly in primary care centres, community health centres, and Taluk hospitals (which provide outpatient care). People with mental disorders are identified and directed to these facilities by:

- *anganwadi* workers;
- primary care centre staff – junior public health nurses and accredited social health assistants;
- mental hospitals and private clinics;
- nongovernmental organizations and rehabilitation centres;
- community-based social workers and volunteers;
- *panchayath* members;
- district mental health programme team members;
- schoolteachers.

New referrals are seen by the medical officer/physician at the primary or community health centre. If medical officers have been trained as part of the District Mental Health Programme, they make a diagnosis and prescribe the next course of action, e.g. medication or referral. Alternatively, if medical officers have not been trained, or if the problem is beyond their level of expertise, they instruct the patient to return on the day when the district mental health team will be present next. People with mental disorders undergo the same procedures and wait in the same queues as other patients who are attending the centre for other reasons. On a normal work day, about 300 to 400 people are seen at a primary or community health centre, and among them roughly 10% have identified mental disorders. On mental health clinic days, the district mental health team receives patients in a designated area of the primary or community health centre. They are separated from the centre's main activities, mainly to avoid crowds. New referrals queue, in order of arrival, together with follow-up patients. Returning patients bring their patient books, which contain relevant records and medical information. The patient and (often) a family member or caregiver are seen by the psychiatrist in a designated room or, if not available, in a corner of a large hall with privacy from others. A diagnosis and prescription, where needed, are entered by the psychiatrist into the patient book and handed to the nurse, who then dispenses medication if indicated. The medications are usually brought to the facility by the team, and left behind for use between their mental health clinics. Normally, only trained medical officers prescribe psychotropic medicines and actively follow-up with patients between mental health clinics. Untrained medical officers limit themselves to prescribing medications that have already been selected by the team psychiatrist.

All new patients receive psychoeducation at their first visit, including information about their mental disorder, its origin, prevention, treatment, monitoring and management. This involves them in the process and motivates them to continue treatment. The social worker meets those in need of counselling and follow-up services. The social worker conducts periodic group therapy sessions and arranges admission into rehabilitation centres and contacts with other government services. In certain cases, the social worker makes home visits to assess the family situation and assist with ensuring continuous treatment. If required, individual counselling is conducted by the clinical psychologist and psychiatrist. Thus the services offered during mental health clinics are:

- diagnosis and treatment planning for newly-identified patients;
- review and follow-up for established patients;
- counselling by the clinical psychologist or psychiatrist;
- psycho-education;
- referrals as needed.

The majority of patients are seen for depression, bipolar disorder, schizophrenia or epilepsy (see evaluation/outcomes).

SOUTH AFRICA

The model for integrating mental health into primary care in Ehlanzeni varies somewhat from clinic to clinic. Differences depend on multiple factors such as the clinic's size and location, the training and qualifications of its nurses, and the willingness of health workers to participate in the integrated model. Two models predominate (see below).

Model 1. The first model is characterized by the presence of a skilled professional nurse, who sees all patients with mental health issues. The nurse's primary functions are to conduct routine assessments of people with mental disorders, dispense psychotropic medication or recommend medication changes to the medical officer, provide basic counselling, and identify social issues for amelioration. Patients are referred to complementary services if available, although in many cases community-based social services are sparse. The nurse schedules a specific time each week for mental health consultations and patients know to attend the clinic at this time. These patients do not queue with patients who are attending the clinic for other reasons. General health workers are trained to detect mental disorders, but refer patients either to the designated psychiatric nurse, or to the mental health district coordinator (see below).

Model 2. In the second model, mental disorders are managed as any other health problems. People with mental disorders wait in the same queues and are seen by the primary care practitioner who happens to be available when they reach the front of the queue. Nurses are trained to assess and treat both mental and physical health problems, and patients with comorbid problems are treated holistically. Referrals to secondary care or community-based services are made as needed.

In both models, nurses are responsible for detecting mental health problems, managing chronic mental disorders including dispensing psychotropic medication or recommending

medication changes, counselling, making referrals, and intervening in crisis situations. A district mental health coordinator (trained as a psychiatric nurse) and a medical officer offer support when needed. Functions of the district coordinator include:

- supervising and supporting general health staff with the management of people with mental disorders;
- assessing patients referred from primary care;
- stabilizing patients where required;
- recommending initiation or change of medications to the medical officer;
- assisting in psychosocial rehabilitation;
- counselling;
- making home visits;
- checking the availability of medication in clinics;
- keeping mental health statistics;
- writing sub-district reports.

The main priorities for primary mental health care in the district are the management of schizophrenia and related disorders, bipolar disorder, and major depression. Epilepsy is managed under the rubric of general chronic diseases. Some basic counselling is offered, however because of time constraints, this service is limited. In most cases, counselling referrals are not possible due to the lack of skilled counsellors and psychologists in the area.

UNITED KINGDOM

In Waltham Forest PCT, two practices have been contracted to provide an integrated primary health care service to vulnerable groups such as asylum seekers, refugees, and homeless people. They provide similar services; however the practice based in Walthamstow is presented in this example to illustrate the programme. The Walthamstow practice has 10 general practitioners (of whom two are trainees) and four practice nurses.

The overall service provides treatment and care to people with mild- to moderate- mental disorders, as well as to those with more complex mental and psychosocial needs. In particular, the service seeks to reach people not normally in contact with health services and people from minority ethnic groups.

This service offers a four-step approach to deliver holistic integrated services in primary care (see below).

During step I, general practices provide 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. Patients are also directed to local libraries with collections of written and video materials related to mental health issues. Further assistance, guidance and support are provided by an individual, usually a mental health service user, who has the specific responsibility of promoting self-help and social inclusion among patients.

During step II, the primary care practices undertake mental health and psychosocial assessments of their patients, sometimes using standardized screening and assessment instruments. Depending on the complexity of the problem, patients are either managed in the practice or are referred to appropriate secondary-level and community-based services within the PCT. Psychological therapies, including cognitive-behavioural therapy, are provided within the general practice by a counsellor; however depending on the degree to which long-term counselling is required, patients are sometimes referred to more specialized services outside the practice.

In relation to step III, patients are referred to organizations or institutions that can assist them with economic and social problems. This support is crucial in ensuring that people are able to manage employment, housing, and family issues, thus preventing further isolation and possible deterioration of their mental health. Step IV relates to people who previously have been acutely ill, but are now stable. These patients are meant to receive holistic mental and physical health care within the primary care setting, while at the same time reducing the load on secondary level services. However to date, this step has not been well-implemented in this practice.

In addition to treatment and support of people with mental disorders, the practice also attempts to promote good mental health through its approach to health care in general. For example, the practice communicates carefully with migrants and people who do not speak English, and offers telephone interpretation services to all in need. Similarly, practitioners strive to remain non-judgmental and to assist all vulnerable groups, including homeless people. They also attend to the cultural background of each patient and interact in an appropriate and acceptable manner. The practice hence not only specializes in managing people with mental disorders, but also promotes the mental health of all its patients.

INTEGRATED BEHAVIORAL HEALTH PROJECT - Levels of Integrated Behavioral Health Care

Integrated behavioral care isn't an all-or-nothing proposition. Rather, it is practiced on a continuum, based on level of collaboration between health care and behavioral health care professionals. The following excellent description of collaboration levels, is put forth by William J. Doherty, Ph.D. Susan H. McDaniel, Ph.D. and Macaran A. Baird, M.D., and summarized in Behavioral Healthcare Tomorrow, October, 1996, 25-28:

Level One: Minimal Collaboration

Mental health and other health care professionals work in separate facilities, have separate systems, and rarely communicate about cases.

Level Two: Basic Collaboration at a Distance

Providers have separate systems at separate sites, but engage in periodic communication about shared patients, mostly through telephone and letters. All communication is driven by specific patient issues. Mental health and other health professionals view each other as resources, but they operate in their own worlds, have little sharing of responsibility and little understanding of each other's cultures, and there is little sharing of power and responsibility.

Level Three: Basic Collaboration On-Site

Mental health and other health care professionals have separate systems but share the same facility. They engage in regular communication about shared patients, mostly through phone or letters, but occasionally meet face to face because of their close proximity. They appreciate the importance of each other's roles, may have a sense of being part of a larger, though somewhat ill-defined team, but do not share a common language or an in-depth understanding of each other's worlds. As in Levels One and Two, medical physicians have considerably more power and influence over case management decisions than the other professionals, who may resent this.

Level Four: Close Collaboration in a Partly Integrated System

Mental health and other health care professionals share the same sites and have some systems in common, such as scheduling or charting. There are regular face-to-face interactions about patients, mutual consultation, coordinated treatment plans for difficult cases, and a basic understanding and appreciation for each other's roles and cultures. There is a shared allegiance to a biopsychosocial/systems paradigm. However, the pragmatics are still sometimes difficult, team-building meetings are held only occasionally, and there may be operational discrepancies such as co-pays for mental health but not for medical services. There are likely to be unresolved but manageable tensions over medical physicians' greater power and influence on the collaborative team.

Level Five: Close Collaboration in a Fully Integrated System

Mental health and other health care professionals share the same sites, the same vision, and the same systems in a seamless web of biopsychosocial services. Both the providers and the patients have the same expectation of a team offering prevention and treatment. All professionals are committed to a biopsychosocial/systems paradigm and have developed an in-depth understanding of each other's roles and cultures. Regular collaborative team meetings are held to discuss both patient issues and team collaboration issues. There are conscious efforts to balance power and influence among the professionals according to their roles and areas of expertise.

For Further Information:

www.ibhp.org/index.php?section=pages&cid=85

CANADIAN COLLABORATIVE MENTAL HEALTH INITIATIVE - Collaborative Mental Health Care Framework

Collaborative mental health care describes a range of models of practice in which consumers, their families and caregivers, together with health care providers from a variety of primary health care and mental health settings—each with different experience, training, knowledge and expertise—work together to promote mental health and provide more coordinated and effective services for individuals with mental health needs. A conceptual Framework was developed based on previous research and an analysis of existing collaborative mental health care initiatives to:

- introduce key components of collaborative mental health care
- guide the discussion in the CCMHI
- research papers
- identify the need for future research

FUNDAMENTAL

Policies, Legislation, Funding Regulations and Funds

Policies, legislation and funding regulations need to be congruent with the principles of collaborative mental health care, and sufficient funds need to be made available to facilitate the implementation of collaborative initiatives. Support for the concept of collaborative mental health care, as it is reflected in policies, legislation and funding allocations, has increased since 2000. However, there are policy—related barriers to collaborative mental health care. These barriers can be grouped into two broad categories. The first category involves current efforts to reform the primary health and mental health care systems; challenges emerge when reform strategies are not coordinated. The second category encompasses legislation and policies as they relate to health human resources; in particular, issues related to remuneration, scope of practice and liability schemes.

Research and Community

Collaborative mental health care initiatives should also emerge from evidence-based research through the identification and implementation of best practices and should be based on the needs and resources of individual communities.

KEY ELEMENTS

There are four key elements that help define collaborative mental health care: accessibility, collaborative structures, and richness of collaboration and consumer centeredness.

Accessibility

The goals of collaborative mental health care are met by increasing *accessibility* to mental health services. This includes mental health promotion, illness prevention, detection, and treatment in primary health care settings, or “bringing the services closer to home”. Collaborative mental health care takes place in a range of settings including community health centres, the offices of health care providers, an individual’s home, schools, correctional facilities, or community locations such as shelters. Settings vary according to the needs and references of the individual, and the knowledge, training and skills of the providers. Collaboration may involve joint assessment or care delivery with several providers present with the consumer, families and caregivers, when appropriate, or it may take place through telephone or written communication. In other words, effective collaboration does not require that the health care providers be situated in the same physical location.

Providing mental health services in primary health care settings can be accomplished through various means, for example:

- providing direct mental health care in primary health care settings, or
- providing indirect mental health support to primary health care providers in primary health care settings

In the first instance, mental health care is provided by a mental health specialist;¹ in the second, mental health care is delivered by a primary health care provider who is supported by or consults with a mental health specialist. Strategies developed by various collaborative mental health care initiatives to provide mental health services in primary health care settings include the following:

- mental health specialist offers direct mental health care in primary health care setting;
- scheduled visits in primary health care settings
- co-location of mental health and primary health care services
- mental health specialist offers indirect mental health care in primary health care setting by supporting primary
- health care provider either formally or informally

Collaborative Structures

Successful collaborative mental health care initiatives recognize the need for systems and structures to support collaboration.

First, providers will either create or be part of an organizational **structure** that will define the ways in which people have agreed to work together. This structure can be:

- formal (e.g., service agreements, coordinating centres, collaborative networks)
- informal (e.g., verbal agreements between providers).

Second, providers will organize or create systems that will define how they agree to accomplish certain key functions of collaborative mental health care, for example:

- referral strategies (e.g., forms, referral networks)
- information technology (e.g., electronic client records, Web-based information exchange, teleconferencing,
- videoconferencing, e-mail, list serve)
- evaluations (e.g., developing evaluation instruments and agreeing to adopt certain evaluation instruments,
- methodologies and software in common)

Richness of Collaboration

A central feature of effective collaborative mental health care is the **richness of collaboration** among health care partners, including: primary and mental health care providers, consumers and caregivers. Characteristics of **richness of collaboration** include:

- knowledge transfer among health care partners through various educational initiatives, for example:
 - courses, lectures, tutorials, seminars, rounds, rotations, case discussions, internships, workshops, symposia;
 - educational materials, such as: research papers, studies, books, guides, manuals
- the involvement of health care partners from a wider range of disciplines (e.g., nurses, social workers, dietitians, family physicians, psychologists, psychiatrists, pharmacists, occupational therapists, peer support workers)
- communication among all health care partners.

Consumer Centeredness

The needs of consumers are at the core of collaborative mental health care. **Consumer centeredness** calls for consumers to be involved in all aspects of their care, from treatment choices to program evaluation, and for initiatives to be designed to address the needs of specific groups; in particular, those that are often underserved or has a great need for both primary and mental health care. A growing number of collaborative mental health care initiatives emphasize the role of the consumer by allocating time and resources to consumer and/or caregiver:

- education (e.g., educational materials, sessions or information centres)
- peer support
- participation in the development of collaborative mental health care initiatives (e.g., focus groups, committees) and in the development and implementation of program evaluations (e.g., instrument design, roles as interviewers or respondents)
- participation in adapting mental health promotion and treatment interventions to individual

CONCLUSION

Collaborative mental health care is ultimately influenced by these fundamentals: **policies, legislation, funding, research, and community needs and resources**. There are four key elements that define collaborative mental health care: **accessibility, collaborative structures, richness of collaboration and consumer centeredness**. In our upcoming series of papers on the current state of collaborative mental health care, the discussion will be framed according to these key elements and fundamentals. The series of forthcoming implementation Toolkits and the collaborative mental health care Charter will also be based on this Framework.

For Further Information:

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HOGG FOUNDATION FOR MENTAL HEALTH - Integrated Health Care

What is collaborative care?

Collaborative care is an integrated health care model in which physical health and mental health providers partner to manage the treatment of mild to moderate psychiatric disorders and stable severe psychiatric disorders in the primary care setting.

How can the collaborative care model be adapted to fit an organization's unique needs?

There is a great deal of flexibility in the collaborative care model, even in the implementation of its required elements. Organizations can create and implement a collaborative care system that reflects their organizational resources and their patients' needs.

Diagnostic groups

The bulk of research on collaborative care models has focused on the treatment of depression. However, emerging research has found the collaborative care approach to be useful with other diagnoses, and collaborative care experts agree that it can be useful in treating many types of mild to moderate psychiatric disorders or stable severe psychiatric disorders in the primary care setting.

Patient identification

Patients with mental health needs can be identified in different ways. Some providers choose to use a standardized screening instrument to systematically screen primary care patients for mental health problems. Other providers rely on informal means to identify patients with suspected mental health needs. Both approaches have their costs and benefits. Screening protocols improve the detection of mental health problems, but can be costly and time-consuming. Informal detection imposes less of a burden on primary care staff, but can lead to low rates of detection of mental health problems. The best approach depends on the resources of the organization.

Assessment tools

Any instrument that covers the psychiatric diagnoses to be treated in the primary care setting is appropriate, as long as it has adequate psychometric properties (i.e., adequate reliability and validity with the target population). Patients

complete the assessment tool regularly, so the clinical care manager can monitor their response to treatment.

The assessment tool is different from a screening instrument. A positive result on a screening instrument signals the physician that the patient is likely experiencing difficulties. An assessment tool is then used to establish that the patient is indeed experiencing difficulties and the nature of the problem. The physician supplements the assessment tool results with additional questions to confirm the diagnosis.

Interventions

Psychotropic medication is the most common intervention used to treat mental health problems in the primary care setting. The primary care physician or other qualified staff (e.g., nurse practitioner) prescribes an antidepressant or other appropriate medication, and the care manager monitors the patient's response and adherence to the medication.

When pharmacotherapy is the intervention employed, the organization may require its providers to use a medication algorithm to guide the choice and dosage of medications. There are multiple algorithms available for organizations interested in adopting one.

Collaborative care models can also include brief evidence-based psychotherapy as an intervention. There are several brief evidence-based psychotherapies that have been used in the primary care setting, including cognitive-behavioral therapy, interpersonal therapy, and problem solving therapy. Behavior management and related evidence-based treatments are also options for treating children. These therapies can be conducted by clinical care managers with the appropriate credentials or by a collocated mental health professional.

Psychotherapy and behavior management approaches are particularly important options for children. Depending on the diagnosis, pharmacotherapy may not be the first-line remedy for children, given concerns about the safety and effectiveness of using psychotropic medications with children.

Clinical care manager

A variety of professionals and paraprofessionals can be trained to be effective care managers. Many of the research studies on collaborative care have used licensed professionals in that role, including nurses, nurse practitioners, masters-level social workers or psychologists, and doctoral level

psychologists. These professionals are effective in providing brief psychotherapy, too, if that is offered by the clinic.

Paraprofessionals can be trained to serve in the clinical care manager role when their responsibilities are limited to monitoring treatment adherence and response and providing education to patients. Paraprofessionals are bachelor-level staff with some clinical experience, such as a licensed practical nurse.

Treatment monitoring

When face-to-face contacts are impractical or impossible, clinical care managers can work with patients through other means, including the telephone and televideo links. Consultation with the psychiatrist can also be done through these means.

Patient registry

The patient registry used to track those with identified mental health needs can be accomplished in several ways. It can be incorporated into the existing clinical database, as long as the necessary data are included and care managers are able to retrieve the information they need.

The registry can also be kept separate from the database in a simple Excel or Access spreadsheet. Collaborative care researchers have free patient registry templates available in Excel and Access.

The registry can also be created in a secure web-based application. Although expensive, this option can be especially useful to organizations in which the care manager, primary care physician, and psychiatrist are geographically separated. With a web-based registry, each member of the team can

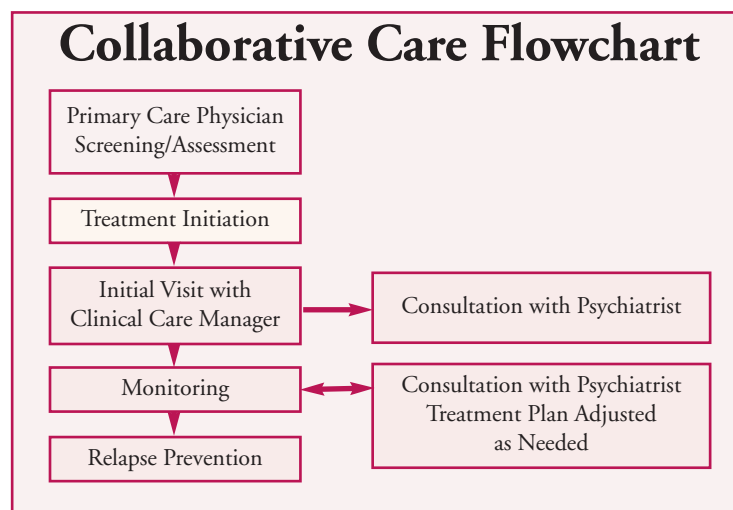
log on to the web site from any computer with Internet access to enter information or view the patients' progress, facilitating communication.

Specialty mental health providers

Weekly supervision of the clinical care manager by a psychiatrist is critical when the patient intervention involves psychotropic medication. In some collaborative care models, psychiatrists are also available to the primary care physician for direct consultation on difficult patients.

The collaborative care model can also be set up such that mental health providers in the primary care setting work directly with collaborative care patients. Psychiatrists may provide medication management. Psychologists, social workers, and other qualified staff may provide counseling or brief evidence-based psychotherapy. When the patient intervention involves brief evidence-based psychotherapy, supervision by an experienced clinician (e.g., Ph.D. psychologist) can also be useful.

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FACT SHEET

10 PRINCIPLES FOR INTEGRATION

(Integrating Mental Health into Primary Care – A Global Perspective (2008) WHO/Wonca. pp 49-55)

As a result of analyzing and synthesizing these best practices, WHO and Wonca identified 10 common principles that can be applied to all mental health integration efforts. Across the full spectrum of political and economic contexts, and levels of the health system, these ten principles are ‘non-negotiable’ for integrated primary mental health care.

1. Policy and plans need to incorporate primary care for mental health.

Commitment from the government to integrated mental health care, and a formal policy and legislation that concretizes this commitment, are fundamental to success. Integration can be facilitated not only by mental health policy, but also by general health policy that emphasizes mental health services at primary care level. National directives can be fundamental in encouraging and shaping improvements. Conversely, local identification of need can start a process that flourishes and prospers with subsequent government facilitation.

2. Advocacy is required to shift attitudes and behaviour.

Advocacy is an important aspect of mental health integration. Information can be used in deliberate and strategic ways to influence others to create change. Time and effort are required to sensitize national and local political leadership, health authorities, management, and primary care workers about the importance of mental health integration. Estimates of the prevalence of mental disorders, the burden they impose if left untreated, the human rights violations that often occur in psychiatric hospitals, and the existence of effective primary care-based treatments are often important arguments.

3. Adequate training of primary care workers is required.

Pre-service and/or in-service training of primary care workers on mental health issues is an essential prerequisite for mental health integration. However, health workers also must practice skills and receive specialist supervision over time. Collaborative or shared care models, in which joint consultations and interventions are held between primary care workers and mental health specialists, are an especially promising way of providing ongoing training and support.

4. Primary care tasks must be limited and doable.

Typically, primary care workers function best when their mental health tasks are limited and doable. Decisions about specific areas of responsibility must be taken after consultation with different stakeholders in the community, assessment of available human and financial resources, and careful consideration of the strengths and weaknesses of the current health system for addressing mental health. Functions of primary care workers may be expanded as practitioners gain skills and confidence.

5. Specialist mental health professionals and facilities must be available to support primary care.

The integration of mental health services into primary care is essential, but must be accompanied by complementary services, particularly secondary care components to which primary care workers can turn for referrals, support, and supervision. This support can come from community mental health centres, secondary-level hospitals, or skilled practitioners working specifically within the primary care system. Specialists may range from psychiatric nurses to psychiatrists.

6. Patients must have access to essential psychotropic medications in primary care.

Access to essential psychotropic medications is essential for the successful integration of mental health into primary care. This requires countries to directly distribute psychotropic medicines to primary care facilities rather than through psychiatric hospitals. Countries also need to review and update legislation and regulations to allow primary care workers to prescribe and dispense psychotropic medications, particularly where mental health specialists and physicians are scarce.

7. Integration is a process, not an event.

Even where a policy exists, integration takes time and typically involves a series of developments. Meetings with a range of concerned parties are essential and in some cases, considerable skepticism or resistance must be overcome. After the idea of integration has gained general acceptance, there is still much work to be done. Health workers need training and additional staff might need to be employed. Before any of this can occur, budgets typically will require agreement and allocation.

8. A mental health service coordinator is crucial.

Integration of mental health into primary care can be incremental and opportunistic, reversing or changing directions, and unexpected problems can sometimes threaten the programme's outcomes or even its survival. Mental health coordinators are crucial in steering programmes around these challenges and driving forward the integration process.

9. Collaboration with other government non-health sectors, nongovernmental organizations, village and community health workers, and volunteers is required.

Government sectors outside health can work effectively with primary care to help patients with mental disorders access the educational, social and employment initiatives required for their recovery and full integration into the community. Nongovernmental organizations, village and community health workers, and volunteers often play an important role in supporting primary care for mental health. Village and community health workers can be tapped to identify and refer people with mental disorders to primary care facilities; community-based nongovernmental organizations can help patients become more functional and decrease their need for hospitalization.

10. Financial and human resources are needed.

Although primary care for mental health is cost effective, financial resources are required to establish and maintain a service. Training costs need to be covered, and additional primary and community health workers might be needed. Mental health specialists who provide support and supervision must also be employed.

For Further Information:

WHO/Wonca

Integrating Mental Health in Primary Care – A Global Perspective

http://www.globalfamilydoctor.com/PDFs/IntegratingMentalHealthIntoPrimaryCare.pdf?nav_id=339

WORLD MENTAL HEALTH DAY IS A REGISTERED SERVICE MARK OF THE WORLD FEDERATION FOR MENTAL HEALTH

FACT SHEET

WORLD HEALTH ORGANIZATION

*Fact Sheet N*220, September 2007*

MENTAL HEALTH: STRENGTHENING MENTAL HEALTH PROMOTION

There is no health without mental health

- The essential dimension of mental health is clear from the definition of health in the WHO constitution: “Health is a state of complete physical, mental and social well-being and not merely the absence of disease or infirmity.” Mental health is an integral part of this definition.
- The goals and traditions of public health and health promotion can be applied just as usefully in the field of mental health as they have been in the prevention of infectious or of cardio-vascular diseases, for example.

Mental health is more than the absence of mental disorders

- Mental health can be conceptualized as a state of well-being in which the individual realizes his or her own abilities, can cope with the normal stresses of life, can work productively and fruitfully, and is able to make a contribution to his or her community.
- In this positive sense, mental health is the foundation for well-being and effective functioning for an individual and for a community. This core concept of mental health is consistent with its wide and varied interpretation across cultures.
- Mental health promotion covers a variety of strategies, all aimed at having a positive impact on mental health. Like all health promotion, mental health promotion involves actions that create living conditions and environments to support mental health and allow people to adopt and maintain healthy lifestyles. This includes a range of actions that increase the chances of more people experiencing better mental health.

Mental health is determined by socio-economic and environmental factors

- Mental health and mental health disorders are determined by multiple and interacting social, psychological, and biological factors, just as health and illness in general.
- The clearest evidence is associated with indicators of poverty, including low levels of education, and in some studies with poor housing and poor income. Increasing and persisting socio-economic disadvantages for individuals and for communities are recognized risks to mental health.
- The greater vulnerability of disadvantaged people in each community to mental health disorders may be explained by such factors as the experience of insecurity and hopelessness, rapid social change, and the risks of violence and physical ill-health.
- A climate that respects and protects basic civil, political, socio-economic and cultural rights is also fundamental to mental health promotion. Without the security and freedom provided by these rights, it is very difficult to maintain a high level of mental health.

Mental health is linked to behaviour

- Mental, social, and behavioural health problems may interact to intensify their effects on behaviour and well-being.
- Substance abuse, violence, and abuse of women and children on the one hand, and health problems such as HIV/AIDS, depression, and anxiety on the other, are more prevalent and more difficult to cope with in conditions of high unemployment.

ment, low income, limited education, stressful work conditions, gender discrimination, social exclusion, unhealthy lifestyle, and human rights violations.

Enhancing the value and visibility of mental health promotion

- National mental health policies should not be solely concerned with mental health disorders, but also recognize and address the broader issues which promote mental health. These would include the socio-economic and environmental factors, described above, as well as behaviour. This requires mainstreaming mental health promotion into policies and programmes in government and business sectors including education, labour, justice, transport, environment, housing, and welfare, as well as the health sector. Particularly important are the decision-makers in governments at local and national levels, whose actions affect mental health in ways that they may not realize.

Cost-effective interventions exist to promote mental health, even in poor populations

Low cost, high impact evidence-based interventions to promote mental health include:

- Early childhood interventions (e.g. home visiting for pregnant women, pre-school psycho-social interventions, combined nutritional and psycho-social interventions in disadvantaged populations).
- Support to children (e.g. skills building programmes, child and youth development programmes)
- Socio-economic empowerment of women (e.g. improving access to education, microcredit schemes)
- Social support to old age populations (e.g. befriending initiatives, community and day centres for the aged);
- Programmes targeted at vulnerable groups, including minorities, indigenous people, migrants and people affected by conflicts and disasters (e.g. psycho-social interventions after disasters);
- Mental health promotion activities in schools (e.g. programmes supporting ecological changes in schools, child-friendly schools)
- Mental health interventions at work (e.g. stress prevention programmes)
- Housing policies (e.g. housing improvement)
- Violence prevention programmes (e.g. community policing initiatives); and
- Community development programmes (e.g. 'Communities That Care' initiatives, integrated rural development)

WHO is working with governments to promote mental health

- To implement these effective interventions, governments need to adopt a mental health framework as used to advance other areas of health and socio-economic development, and thereby engage all relevant sectors to support and evaluate activities designed to promote mental health.
- WHO supports governments by providing technical material and advice to implement policies, plans and programmes aimed at promoting mental health?

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WORLD MENTAL HEALTH DAY IS A REGISTERED SERVICE MARK OF THE WORLD FEDERATION FOR MENTAL HEALTH

SECTION III

BENEFITS AND BARRIERS TO INTEGRATING MENTAL HEALTH INTO PRIMARY CARE

As shown in prior sections, the reasons for integrating mental health with primary care services seem obvious and critical to all patient-centered forms of healthcare. Mental and physical health are interdependent; mental health services are lacking or non-existent in some countries and communities; integration can keep healthcare costs down and access to treatment up; and treating all health care issues together can create a better continuity of care – creating more positive and successful outcomes.

While there appear to be many models and examples of integrated mental health and primary healthcare, we know that the concept also has many barriers to success. Countries and individual communities have varying health systems, numbers of doctors, financial issues, cultures, language issues, and numerous other obstacles to adopting this model of care.

The Hogg Foundation for Mental Health, in the United States, states in their newly released *Resource Guide to Integrated Health Care – Connecting Body and Mind* (http://www.hogg.utexas.edu/PDF/IHC_Resource_Guide.pdf) some barriers to integration –

- Clinical barriers include differences in primary care and behavioral health cultures, providers' lack of training, providers' lack of interest and stigma.
- Organizational barriers include difficulties with communication and consultation across physical and be-

havioral health providers, the physical separation of different provider types, and primary care's orientation to treating acute problems.

- Policy barriers include legal obstacles to sharing information across provider systems and regulations that limit the services organizations can provide.
- Financial barriers are complex and include issues related to the alignment of incentives in health care funding, as well as the inability to bill for key integrated services.

In order to overcome the barriers and make the benefits work – we must work together and remove the obstacles. It is important to know what barriers are keeping your community from integrating mental health into primary care and begin to change them. Consumers, practitioners, health care organizations, etc all need to come together to form a team – communication, compromise and a willingness to work together can overcome many obstacles.

To expand our information base, we asked some professionals in mental health to tell us what they see as the benefits and barriers to integration in their regions of the world. We have received contributions from the Middle East Region, the Western Pacific and South East Asian Region, and the Central and South American Regions. We hope this will give you more information on the topic in relation to your area of the world.

PSYCHIATRIC TRAINING OF THE PRIMARY CARE PHYSICIAN IN THE GENERAL HOSPITAL

South America

Rodolfo Fahrer, MD, PhD

Psychiatry, as a specialty of Medicine, has extended its field of action to the entire medical practice spectrum, be it institutional, private or community. Therefore, it covers health care, teaching and research of the bio-psychosocial, psychodynamic, psychopathological and psychotherapeutic aspects of patients within the framework of general medical practice; it also deals with the relationship of the physician and other professionals of the health care team with the patient, the family, the General Hospital, the Psychiatric Hospital and the community.

The World Health Organization defines health as a state of complete physical, mental and social wellbeing. To achieve that goal it is essential that the provision of health care be based on a global vision of the individual and the community. For this reason, mental health must be a component included in primary care.

By Primary Health Care we understand the essential health care based on practical methods and technologies, with scientific foundation and socially acceptable, at the disposal of all individuals and families of the community by means of their full participation and at a cost that the community and the country can support in all and each of the stages of its development with a spirit of self-responsibility and self-determination. It represents the first level of contact between the individuals, the family and the community with the health care system; it is based in taking health care as close as possible to the place where people live and work: it constitutes the first element in a permanent and progressive process of health assistance.

To achieve maximum efficacy, Primary Health Care will have to employ the means that the community accepts and understands, and which the health team is in conditions of applying. To this end, they have to receive an adequate psychosocial and technical training according to the health needs of the community.

Care of mental health by the Primary Health Physician acquires even greater relevance because, due to its position, he is the agent of change in the projects of health promotion

for the community. The Primary Care Physician has the possibility of a more continuous and permanent contact with the patient.

Obviously, this reflects the need to train the general physician for the comprehension and management of mental health problems in areas of Primary, Secondary and Tertiary Prevention.

In all countries, under the auspices of the WPA, there has been an attempt to standardize undergraduate psychiatric training and improve its quality. However, the teaching of psychiatry varies considerably across the world and even between medical schools in developed countries. There is now recognition that many patients in the community, especially those seen in general practice and in general practice settings will have some degree of psychological distress.

Training opportunities vary, but specific psychiatric training essentially takes place in three main settings: During an attachment in psychiatry as part of a vocational training scheme; during trainee appointment, and over CME Programs.

For a successful model of therapeutic strategy it is necessary for the Primary Care Physician to be trained in the initial psychopharmacological and psychotherapeutic treatment of the principal psychosocial and psychiatric problems of patients.

In our experience, the training of the Primary Care Physician to improve his psychiatric knowledge is a goal that will not be achieved by just including lectures on the subject in undergraduate or postgraduate medical training.

In our Department of Mental Health at the University Hospital, Buenos Aires, for years we have been working close together with Primary Health Physicians in Psychiatric Training Programs. These Programs have a special modality of integrating theory with clinical practice.

The trend has been towards active teaching processes and this seems to be the right direction. "Doing is better than watching". Experience is always necessary (many times is better than a few). Close supervision and careful, constant feedback are essential.

The general integrated "working together" programs can only be effective if the Psychiatrist involved is sufficiently motivated as a leader who knows the problems, has a clear medical attitude and is able to transmit his enthusiasm for

something which he certainly finds both interesting and stimulating.

We also developed several specific Teaching programs with the modality of “working together”, in clinical or research programs with different Departments of the Teaching Hospital: Primary Care, Surgery, Internal Medicine, and Pediatrics. This teaching modality is only possible if the Psychiatrist works in the General Hospital in an integrated way.

This job of training and re-training is the responsibility of the Psychiatrist. The latter must have sound training in clinical psychiatry, psychotherapy, psychopharmacology and social dynamics, experience in the scientific method and teaching skills; he should be capable of proper integration with multidisciplinary teams and have a high “common sense” level.

During the year 2007, we conducted a Survey Study of Psychiatrists whose objective was to evaluate the psychiatrists’ opinion about Primary Care Physicians involved in the care of psychiatric patients.

In addition, this Survey elicited information on their opinions about working with Primary Care Physicians in the care of psychiatric patients.

Forty-four general hospital psychiatrists completed this Survey. Mean age of the survey sample was 37 and 53% of them were men.

Results obtained from the Survey show that more than half of the Psychiatrists work in private practice; some of them consult with Primary Care Physicians (10/30% of their

work time); but there were few Psychiatrists consulting with Primary Care Physicians (51-70% of their work time).

Most of the interviewed Psychiatrists agreed that the Primary Care Physicians should be directly involved in the care of psychiatric patients. And they also agreed that Psychiatrists should be available for consultation in Primary Care Physician’s offices.

Almost all the surveyed Psychiatrists reported that the most effective way to treat patients with psychopathology is teamwork between the Primary Care Physician and the Psychiatrist. All of them agreed that the training of the Primary Care Physician should include a psychiatric clerkship.

These results confirm our work for so many years in the Department of Mental Health, University Hospital, training the Psychiatrist to become the Primary Care Physician’s trainer with the modality of “working together”.

This methodology implies that the teaching and learning process must take place within the framework of daily medical practice.

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BENEFITS AND BARRIERS TO INTEGRATION IN THE MIDDLE EAST

Professor Omer El Rufaie

BENEFITS

1. Established evidence of significantly high missed psychiatric morbidity among primary care patients (predominantly anxiety and mood disorders) and consequently:
 - Unnecessary investigations, which may be hazardous and expensive
 - Unnecessary medications
 - Inappropriate referral to specialist facilities
 - Unnecessary repeated visits to medical facilities
 - Continuity of suffering and negative impact on functioning in various domains
2. How to address the problem of missed psychiatric morbidity among primary care patients?
 - Appropriate training programs for the GPs, using training models especially tailored for each group of GPs, depending on careful assessment of their weaknesses and strengths.
 - Utilizing psychiatry primary care clinics for 'hands-on' training of GPs, relevant nursing and other paramedical staff.
3. Psychiatry Clinics in primary health care settings for:
 - Educating and training GPs in detecting psychiatric morbidity among their patients and embarking on appropriate management.
 - Manage within the PHC setting: GP alone or in collaboration with the centre's psychiatrist
 - Refer to a specialist psychiatrist i.e. outpatient psychiatry clinic.
 - Refer to emergency department, in case of emergencies e.g. homicidality, suicidality etc.
 - Offering psychiatric services for patients referred by the GPs.
 - Training programs for nursing and relevant paramedical staff.

TARGETED GOALS

- Significantly reducing psychiatric missed morbidity and therefore significantly cost-effective health services. In our UAE experience we used the same consulting rooms, clerical and nursing staff, in addition to the same filing system i.e. no extra costs were spent for having the psychiatry clinic operating in the PHC centre.
- Implementing concept of 'wholeness' i.e. managing patients' physical and mental health simultaneously.
- Managing psychiatric patients in relaxed non-stigmatizing surroundings, away from psychiatric hospitals, with all attached stigma, which should be spared for the severely ill.

BARRIERS

- Attitude of health services strategic planners and decision makers who always put emphasis on hospital based services, rather than primary care. Also the attitude towards psychiatry in general is still not that positive.
- Psychiatry factual knowledge and clinical skills among many GPs are inadequate. This is related, in many situations, to their basic medical school training. This is worsened by lack or inadequate CME programs.
- Negative or ambivalent attitude of many GPs towards psychiatry.
- Presentation of many psychiatric illnesses by physical symptoms; constitutes a challenge for detecting psychiatric diagnoses, whether primary or co-morbid.
- What constitutes a psychiatric case among primary care population is an issue of controversy and further work needs to be done. The important point is how to categorize transient self limiting disorders, following physical illness, overwork, over wary i.e. stress. This is a common problem among PHC patients. Is this issue satisfactorily addressed by ICDS-10? Related to this, GPs and psychiatrists working in PHC should avoid medicalizing of social problems.

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CHILD MENTAL HEALTH SERVICES: CHALLENGES AND OPPORTUNITIES IN THE MIDDLE EAST

Professor Valsamma Eapen

In the first decade of this new millennium, health professionals are faced with a rapidly increasing need for child mental health services and changing models of service provision. This gives us a unique opportunity to make provision for services where it has not been available before, or to improve upon the existing services.

BARRIERS

1. Lack of recognition of child mental morbidity at the primary care level.

Mental health problems are highly prevalent in young people but despite possibilities for effective treatment, only about one-third of young people with mental health problems receive professional help. In a study of the help seeking preference for mental health problems in children in the UAE, Eapen et al (2004) found that only 37% preferred to consult a mental health specialist.

Common barriers to seeking professional help include:

- Social stigma of accessing mental health services.
- Reluctance of the family to acknowledge that their children have a mental health problem.
- Negative perceptions of family and friends about mental health treatment.
- Lack of trust and faith in the usefulness of such treatment.
- Many consult traditional healers and alternative medicine avenues before consulting mental health professionals.

Other barriers to seeking professional help include:

- Practical and logistic difficulties in accessing the services
- Cost
- Availability
- Accessibility of mental health services

Given this reality, culturally sensitive assessment and intervention methods and creation of age-appropriate services within the primary care and school health setting should take priority.

2. Methods to improve provision of services at community and primary care level

An efficient and cost effective way of addressing the child mental health needs of the country, regardless of its economic status, would be to implement mental health screening programmes in schools (Eapen 1999). Such a programme would have the following considerations:

- Be implemented utilizing the existing resources and taking into account the local health priorities
- To be complemented with provisions for treatment and care
- To integrate existing and available school and health personnel resources
- To provide training for primary healthcare staff, teachers and other professionals who work with children
- To increase the ability and confidence of school and health workers in the detection of mental health problems
- The detection of mental health needs in children is to be matched up with appropriate referral system, pathways of care, and mental health service provision.

3. How to increase accessibility of child mental health services

Although many children with mental health problems are in contact with primary health care services, few receive appropriate help. A study of children attending primary care facility in the UAE observed that, while around 40% had a mental health problem only 1% was identified by the primary care physician (Eapen et al 2004). The reasons for failure to access mental health services include:

- Lack of parental awareness
- Lack of recognition by the primary care staff
- Lack of resources and opportunities for referral to specialist mental health services

Factors that determine which children access health services are:

- The type and severity of the disorder
- Parental education and awareness
- Age and gender of the child,
- Family and social background factors

With the existing deficiencies and gaps in services and patterns of service use, a greater emphasis on developing resources at population and primary care levels is urgently needed with emphasis on public health education, improved training of primary care staff and increased accessibility of specialist mental health services.

OPPORTUNITIES

- Given the fact that around 50% of adult psychiatric disorders have their origin in childhood and early adolescence, preventive services should focus on this early period of life with surveillance and monitoring of “at risk” children coupled with appropriate early intervention strategies.
- Children’s mental health needs are varied, complex and changing based on the developmental stage and this requires comprehensive and flexible approaches that address the young person’s basic needs, education and family connection as well as advocate for security and protection, and recognize and address the needs of the more vulnerable children.

- The current problem of access to mental health care for children and adolescents could be improved with additional funding and change in perceptions of policy makers.

Health service planning must take into account the developmental differences while providing access to the existing system with a better targeted and integrated care of mental health, substance use, child protection and vocational-rehabilitation services.

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BENEFITS AND BARRIERS TO INTEGRATION IN THE WESTERN PACIFIC REGION

Dr. M Parameshvara Deva, FRCPsych, FRANZCP

INTRODUCTION

Primary care psychiatry, as a concept, is that knowledge and skills can be used to spread basic psychiatric care to vast majority of peoples in the over 1.6 billion people of the Western Pacific region - has been recent in coming. Even the teaching of psychiatry as a subject in medical and nursing schools of the region only took root after the 1950s. The relegation of mental hospitals to out of town mental 'asylums' far from the population, along with its jail-like atmosphere and restrictive practices, did not bode well for the future of mental health as a part of general health. Indeed until the late 1960s Psychiatrists in some Asian countries were known as Alienists being alienated from the mainstream of medical care, although the WHO constitution of 1946 had clearly defined health to include mental and social health. Where available, psychiatry was focusing on the institutionalized mentally ill in mental hospitals, in the form of lecture demonstrations. The importance of addressing common psychological distress in patients in primary care clinics and non psychiatric clinics or wards was minimized and the dichotomy between the mental and physical was all but watertight in both minds and practices of doctors and nurses.

Be that as it may, the WHO's launch of a Primary Care version of the ICD-X (ICD-X PHC) in 1992 was a landmark decision endorsing the importance of the not so severe mental problems that easily formed a quarter of all clients in most primary health care settings. The non-psychotic mental problems such as anxiety and depressive problems or illnesses were equally if not more common within in-patient settings where often referral to a psychiatrist was in the form of psychiatric emergencies. In 1997 the ICD-X PHC Kit was launched by the WHO and at last there was endorsement of the long neglected branch of mental health in primary care and a training kit was now available.

A decade has passed since the official realization that the psychiatric problems in non-psychiatric settings are important and in 2001 the World Health Report once again emphasized the delivery of mental health care in primary care settings, as well as teaching of psychiatry in primary care settings. While the concept is no longer new in 2009, its im-

plementation in the Western Pacific region is by and large unsatisfactory at grassroot levels of the 1.6 billion people.

REALITY OF PRIMARY CARE DELIVERY IN THE WESTERN PACIFIC

A major factor in the slow and, at times, non-existent progress of efforts to improve primary care psychiatry is the practice of primary health care itself in the region. The Western Pacific Region is very diverse with some of the richest and poorest people in this vast region, and the health care systems vary widely. There are few countries with comprehensive health insurance systems and millions pay a fee for service to private doctors when the government services are scarce or difficult to access. This has led to many primary care doctors working up to 14 hours a day for 6 days a week. This leaves little time for any new training. Limited supervision of standards of care by supervisory bodies means that the improvement in detection rates of mental health problems in primary care remains low.

In many countries, for economic and reasons of low budgets for training of doctors, the primary care services are provided by non medical nurses, medical assistants, or nurse practitioners who may have even less training in mental health care. In some of the Pacific Island countries, there are no psychiatric trained doctors or nurses, so that even if the primary care provider is aware of a mental health problem in a client, there is no one he or she can consult or refer to for assistance. When nurses are available and do have some experience in mental health care they are limited in their options for treatment as nurses do not have the right to initiate psychotropic medicines.

Although most doctors and nurses deal with human distress every day of their working lives, few are given even the basic of training in how to counsel persons with emotional distress. The curriculum of nursing schools and medical schools have little emphasis on the way a health care professional should deal with stress and distress in any branch of medicine. Often the referral of distressed patients by doctors to a social worker, if available, is only to find transport, offer money or get consent from relatives.

The reality is that, at undergraduate levels in most of the developing countries of the Western Pacific, the focus on mental health has been minimal or where present has focused on the psychoses and not the anxiety or depression or stress related illnesses that are far more commonly seen than psychotic illnesses. There are also few medical or nursing

schools in the region that teach primary care psychiatry to their future doctors or nurses. The result is that most see psychoses as all there is in psychiatry, and develop few skills in recognizing human distress, in their patients. The psychiatrist, if there is one available nearby, sees few patients with anxiety or depression until the symptoms become severe and the client is officially referred to them. Few psychiatrists in this region have heard of the ICDX PHC or when they do have taught it to Primary care providers. The use of a watered down version of a psychiatry textbook for primary care providers is not the way to train them in detecting common mental health problems in primary care.

THE REALITY OF PSYCHIATRIC CARE IN THE WESTERN PACIFIC REGION

The state-of-art colonial mental hospitals or mental asylums of the 1920s or 30s in many Western Pacific region remained the mainstay of care for the mentally ill well past independence from colonial rule in the 1950s and were not replaced by the newer short stay general hospital psychiatric units that were becoming the norm in many other parts of the world. The result has been the almost unassailable position of large mental hospitals even in the relatively affluent countries of the western Pacific. This has stunted the growth of primary care psychiatry as even doctors see the 'real' psychiatry as one that needs a mental hospital for its practice.

Many countries have a psychiatrist population ratio of 1 per 250,000 populations and most are offered in the large urban centers. Indeed, in a few countries there are no psychiatrists in the rural population centers. Although most of the larger countries have their own training programs in psychiatry and psychiatric nursing, the numbers trained are small in comparison to their needs. There are very few child and adolescent psychiatrists although young people constitute half of the populations in many developing countries. The few psychiatrists we have are often overloaded with not only care of the severely and chronically ill but shoulder a very heavy administrative and bureaucratic load that deprives them of career development and any attempt to train others in primary care psychiatry.

Psychiatry being a low priority in health care plans of many developing countries, suffers from chronic underinvestment in human and material resources. Thus shortages of medicines and absence of the newer medicines plus chronic shortages of trained mental health staff are common features in many low income countries of the western pacific region.

OPPORTUNITIES FOR BETTER INTEGRATION OF MENTAL HEALTH IN PRIMARY HEALTH CARE

Despite the 4 seemingly impossible situations in many developing countries of the Western Pacific there are many opportunities that lay dormant. One of these is the very strong presence of large numbers of fully trained SRNs or 3 year trained nurses in all countries of the region. While doctors are small in numbers and usually hospital based, nurses are distributed throughout the country's rural and urban areas. Many have trained in midwifery and not only curative but also preventive and community work. Many have some skills in dealing with family crises. But sadly their training in mental health, if present, is insufficient and not geared to dealing with day to day problems of anxiety or depression in primary care clients.

Secondly, there are also a variety of 2nd level medical workers such as health extension workers, 'feldshers' with medical training of up to 4 years who work in remote and rural areas as primary care providers, who also are not trained in basic mental health work at primary care level.

Thirdly, there are a variety of short courses to train volunteers, traditional midwives, medical aides, nursing aides who are already functioning at the primary care level but do not have basic skills in providing mental health care. All of these human resources have basic medical training and often are in the frontline of providing health care in developing countries of the region but remain deprived of and unable to include mental health care in their daily work. Detractors of mental health services often basing their limited understanding of mental health in primary health care, argue that the nurses and other health care workers mentioned above are 'already overloaded with work and simply cannot provide this extra service'. Somewhere the 1946 WHO definition of health is conveniently forgotten. Newer diseases such as SARS and HIV-AIDS take priority in the training of nurses but mental health gets left behind.

Training Courses in Primary health care-mental health does not need not a high budget or sophisticated skills or equipment. 3-4 day courses have been conducted in Cambodia, Mongolia, PR China, Malaysia, Philippines, PNG, Solomon Islands, Vanuatu, Fiji and Cook Islands with very limited funds and with lasting effect, in the past 10 years for GPs, nurses and volunteers. But the funds for these are very scarce, and interest very limited at the highest level so that a fair amount of the training is done on voluntary bases and does not cover the health staff of the whole country.

In 2008 the Ministry of Health Mongolia with the help of the WHO Mongolia office and several NGOs, embarked on a 4 day Training of Trainers course in PHC Psychiatry. The participants, for the most part psychiatrists, were trained in a selection of primary care psychiatry topics to be taught at primary care level. The plan is to train others and carry out training of primary care providers in the vast country of Mongolia with the help of the WHO and a number of other agencies.

CONCLUSIONS

1. It is clear that Mental Health can and must be integrated into Primary health care if health services in the region are to truly subscribe to the WHO's definition of Health as defined in the WHO Constitution of 1946 – Para 1 line 2. Be that as it may be, the progress in integration has been very slow and indeed non-existent due to ignorance and prejudice that is pervasive and sometimes institutionalized.
2. And yet the process of bringing about that very badly needed integration is not only inexpensive and easily done, but can start immediately as has been done in some countries on an ad-hoc basis. What is holding it back is largely one of administrative will that is in short supply. Administrators at all levels in the region appear out of touch with the mental health needs of populations in this vast region of 1.6 billion people and 37 countries and territories.
3. Given the will and small outlays in training funds and human resources, this long neglected aspect of health care can improve immediately and provide the missing component that the writers of the WHO definition on health aspired it to be over 60 years ago.

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SECTION IV

CALL TO ACTION:

THE ROLE OF ADVOCACY IN THE INTEGRATION OF MENTAL HEALTH INTO PRIMARY CARE

Gabriel Ivbijaro, Wonca

On the whole, life expectancy worldwide is improving. However, the gains in mental health care have not kept pace, and are patchy. Many people who suffer from mental health problems continue to suffer stigma and discrimination. They have poor access to both general and mental health and their life expectancy is worse.

There can be no health without mental health, and nobody is immune to mental illness. All of us need to work together to address the gap between reality and aspiration, the gap between the haves and the have nots and to address the stigma and discrimination that continues to dog us, both as professionals and service users with an interest in mental health.

'Primary Health Care - Now More Than Ever' (WHO 2008) supports the need for the resourcing and development of primary care globally. We can no longer afford to neglect primary care or service user needs and perspectives. *'Integrating Mental Health Into Primary Care: A Global Perspective'* (WHO/ Wonca 2008) has enabled us to focus sharply on the problems and suffering that service users are subject to when mental health is not part of primary care. It also celebrates the success and voices of service users when mental health integration is achieved.

All stakeholders must work together to deliver the goals and aspirations of all service users and their families. We call on countries, governments, individuals, human rights groups and other non government organisations (NGO's), Academies and Colleges of Family Medicine, nursing and other health care professionals to come together and be the champions of mental health and, together with mental health service users world-wide, recognise that mental health is essential for achieving person-centred holistic primary care in the following ways:

- By demanding that mental health is an essential part of primary care and family medicine, and that mental health should be included in all primary care services
- By specifying that mental health is a key component of all primary care health services when these are commissioned and procured
- By empowering individuals and mental health service users through the adequate recognition and resourcing of self care and advocacy
- By recognising care in the least restrictive environment and the role of family and community support as the first principle of all mental health interventions and treatment
- By acknowledging that psychological, social and environmental interventions and resources are essential components of mental health for all, and access should be promoted for all
- By ensuring that mental health training is facilitated and made available to all who work within primary care
- By guaranteeing the availability of essential pharmacological therapy for those mental health service users who truly require it
- By demanding an end to mental health stigma and discrimination and monitoring and protecting the human rights of all people at all times
- By facilitating the provision and support of specialist services for those whose needs cannot be met in primary care alone
- By guaranteeing continuity of care for those with mental health difficulties, through primary care

World Mental Health Day 2009 provides us with an opportunity to reaffirm the advantages that primary care mental health integration can provide. This 2009 Call To Action recognises that mental health for all cannot be achieved solely by an individual. By communicating and working together, by adopting the principles of respect, dignity and humanity across all sectors and groups, strength can be found and progress achieved.

Primary care provides the first formal contact with health services in most health systems. Those who work in primary care should see themselves as ambassadors and advocates for service users and act accordingly. Those who commission primary care services must include mental health as a key component of the services they commission and must recognise and fund the important components of self-care and advocacy.

Remember that mental ill health can affect anybody. It could be you or your loved ones. We all deserve the best possible care.

WHAT SHOULD I DO NOW?

World Mental Health Day 2009 provides you with an opportunity to be counted.

Service users, their families, carers and advocates.

Take action and send a copy of this 2009 Call To Action to all those who provide health care in your area including health professionals, politicians, charities and other non-government organisations. Ask them how they intend to deliver this 2009 Call To Action. Demand to participate in how your health care is being designed and delivered as it is your right and entitlement.

Primary health care practitioners and teams. Benchmark yourselves against the principles included in the 2009 Call To Action. Develop practical action plans to address identified gaps.

Professional colleges. Include your members and benchmark yourselves against the principles included in the 2009 Call To Action. Develop practical action plans to address identified gaps.

Those who commission health services. Urgently review your service specifications and ensure that contracts embrace the principles of the 2009 Call To Action.

Governments, politicians and opinion leaders. Demand that those who commission and procure demonstrate to you that they are meeting up with the principles of the 2009 Call to action.

IT IS TIME TO ACT, PLEASE JOIN US.

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SECTION V

COMMENTARY

INTEGRATING MENTAL HEALTH
IN PRIMARY CARE:Task-Shifting to Scale Up Services for
People with Mental Disorders

Professor Vikram Patel

In 2008, the world commemorated the 30th anniversary of the landmark declaration by representatives from 134 countries in Alma-Ata, committing themselves to achieving “health for all by the year 2000” through strengthening primary care. The world is very far from achieving this aspiration, but the declaration was a significant juncture in global health as it emphasized the great importance of health care near people’s homes, the need to integrate promotive and preventive health care interventions alongside with medical care, and specifying mental health as an integral component of health.

The World Health Organization (WHO) and The World Organization of Family Doctors (WONCA) published a report on the global perspective on integrating mental health in primary health care to mark this anniversary. The year before, the Lancet had published a series of articles to focus global attention on the massive treatment gap for people with mental disorders in most parts of the world, but especially so in low and middle income countries.

Primary health care was identified as the most crucial setting for delivery of health care to close this treatment gap. It is in the context of these major global health events that this year’s WMHDay theme is critically relevant.

In this commentary, I consider only the specific considerations of how mental health can be integrated in primary care with the goal of scaling up the delivery of evidence based interventions for mental disorders, the call to action of the Lancet series on Global Mental Health and the goal of the Movement for Global Mental Health launched on World Mental Health Day 2008 (www.globalmentalhealth.org). This call for action speaks directly to the core message of the Alma-Ata declaration’s aspiration for health for all built on the principles of equity and social justice, community partici-

pation, appropriate use of resources and inter-sectoral action.

The WHO/WONCA report has provided an excellent review and summary of the strategies needed to integrate mental health in primary care (Box 1). However, there are two critical challenges which we need to address to achieve a realistic, sustainable, integration.

The first is the tension between strengthening horizontal initiatives (i.e. strengthening health systems) versus vertical programs (for e.g. specific mental health care programs).

The second is the tension between community based care with active involvement of non-professional or less specialized health care workers and facility-based specialist health workers.

Ten strategies for integrating mental health in primary care (*Source: WHO-WONCA report on integrating mental health in primary care*)

- Policy and plans need to incorporate primary care for mental health.
- Advocacy is required to shift attitudes and behaviour.
- Adequate training of primary care workers is required.
- Primary care tasks must be limited and doable.
- Specialist mental health professionals and facilities must be available to support primary care.
- Patients must have access to essential psychotropic medications in primary care.
- Integration is a process, not an event.
- A mental health service coordinator is crucial.
- Collaboration with other government non-health sectors, nongovernmental organizations, village and community health workers, and volunteers is required.
- Financial and human resources are needed.

Although we speak with a collective voice for the need to integrate mental health in primary care, does this mean we advocate for a vertical mental health care program to have a primary care component or for a comprehensive primary care program with a strong mental health care component?

Given the extremely weak primary care systems in many countries, particularly in terms of human resources and poor coverage of most basic health care interventions, the former approach is not likely to achieve success. Historically, mental health care has been viewed by primary health care workers to be alien to their day to day work and a vertical mental health care program will continue to perpetuate this perspective.

On the other hand, not having a vertical program runs the risk that mental health care will simply disappear from the agenda in the face of strong competition for limited resources from other health interventions. On balance, then, the most feasible strategy will be to support a vertical program for resource allocation (especially financial resources), but to emphasize the utilization of these resources through the existing primary health care systems, thereby strengthening the system rather than creating a parallel mental health care system. The WHO/WONCA report provides some excellent examples of case studies of how such integration has been achieved.

The second challenge relates to concerns of specialist mental health professionals about the devolution of mental health care to non-specialists with a focus on community oriented care delivered.

In many parts of the world, this concern is largely irrelevant as there are no specialists or facilities to deliver mental health services in any case. Even where these do exist, they are scarce, inequitably distributed with less access to poor and marginalized groups, often unaffordable, associated with stigma and, in some instances, with profound violations of basic human rights. So, the answer to this challenge is that the front-line delivery of mental health care can only be carried out by non-specialists for reasons of acceptability, feasibility and affordability. But are there models to show how this can be done in a manner which is both effective and safe?

Task shifting, which refers to the strategy of the redistribution of health care tasks among health workforce teams, has become a popular method to address specialist health human resource shortages.

Specific tasks are moved, where appropriate, from highly qualified health workers to health workers with shorter training and fewer qualifications in order to make more efficient use of the available human resources for health. The evidence base for task-shifting in mental health care in developing countries is growing and is consistent in its findings. A series of high quality studies evaluating such delivery mechanisms

form the pivotal base for the new global initiatives mentioned earlier. Thus, we now know that lay people or community health workers can be trained to deliver psychological and psychosocial interventions for people living with depressive and anxiety disorders, schizophrenia and dementia in a diverse range of low and middle income countries.

A critical element of these task-shifting interventions, and a significant departure from earlier efforts to improve primary mental health care, is the role of mental health specialists to extend well beyond the training phase to providing continuing supervision, quality assurance and support to the community health workers.

Integrating mental health in primary care has been a slogan for many decades but there has been only limited success in achieving this aspiration, in some part due to the challenges addressed in this commentary (of course, there are others too, not least of which is the very low political will to address mental health).

We now have a reasonably strong evidence base on how to scale up services for mental disorders through primary care while, simultaneously, contributing to strengthening the primary care system. The role of non-specialists, in particular community and primary health workers, is central to this strategy and specialists must play a larger public health role to make the aspiration of mental health for all a reality.

Recommended Reading

1. World Health Organisation and WONCA. Integrating mental health in primary care: a global perspective. Geneva: WHO, 2008.
2. Lancet Global Mental Health Group. Scaling up services for mental disorders-a call for action. *Lancet* 2007;370:1241-1252.
3. Beaglehole R, Epping-Jordan J, Patel V, et al. Improving the prevention and management of chronic disease in low-income and middle-income countries: a priority for primary health care. *Lancet* 2008;372(9642):940-9.
4. Walley J, Lawn JE, Tinker A, et al. Primary health care: making Alma-Ata a reality. *Lancet* 2008;372(9642):1001-7.

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SECTION VI

COMMUNICATION AND PUBLICITY

The World Federation for Mental Health has put together sample press releases, media releases, an official WMHD Proclamation and a new piece on Marching for Mental Health for your personal use and information.

Please use this material for creating more publicity around your WMHD events. The best way to reduce stigma and discrimination is to reach a large audience with powerful advocacy tools. Articles in local papers, marches through town, and public signings of the Proclamation can make your event one of great importance and lasting effect.

The following section contains:

WMHD Sample Proclamation

Media Release for Signing of Proclamation

General Media Release

Sample Article, Letter to Editor

March for Mental Health

WORLD MENTAL HEALTH DAY 2009 SAMPLE PROCLAMATION

WHEREAS, over 450 million individuals around the world are living with a mental illness that could benefit from early diagnosis and appropriate and adequate treatment and support;

WHEREAS, fewer than one-half of those who could benefit from early diagnosis and treatment for a mental illness receive any treatment or care at all;

WHEREAS, mental illness such as anxiety disorders, major depressive disorder, bipolar disorder, and schizophrenia, when not appropriately diagnosed and treated, are leading causes of poor work performance, family disruption, and contribute greatly to the global burden of disease;

WHEREAS, these startling health statistics and the human toll they represent have traditionally received too little attention and concern by the general public, the general healthcare system, and elected and appointed public policy makers, resulting in inadequate priority being given these disorders;

AND WHEREAS, the World Federation for Mental Health has designated the theme for World Mental Health Day 2009 as *“Mental Health in Primary Care: Enhancing Treatment and Promoting Mental Health,”* and urges increased availability of appropriate and equitable mental health services through primary healthcare services and facilities for those experiencing serious mental health problems and disorders;

THEREFORE, I, _____, _____ (TITLE) _____ OF THE _____ (TOWN/COUNTRY AGENCY, ORGANIZATION, MINISTRY) _____ DO HEREBY PROCLAIM 10 OCTOBER 2009 AS WORLD MENTAL HEALTH DAY IN ___TOWN/CITY/COUNTRY_____ and urge all governmental and non-governmental mental health organizations and agencies to work in concert with elected and appointed public officials to increase public awareness about, and acceptance of, mental illnesses and the people living with these disorders; promote improved public policies to enhance diagnosis, treatment, and support services for those who need them through the primary healthcare system; and to reduce the persistent stigma and discrimination that too often serve as barriers for people seeking services and supports available to them.

I further urge all citizens to join and support the local, state/provincial, and national non-governmental organizations that are working to make mental health a priority in communities throughout our nation.

Together, we will all make a difference and promote mentally healthy communities and citizens!

Signed _____ Title _____

Ministry/Office/Agency _____ Date _____

(SEAL)

SAMPLE MEDIA RELEASE FOR SIGNING

THE WORLD MENTAL HEALTH DAY PROCLAMATION

October 10, 2009

FOR IMMEDIATE RELEASE

_____MAYOR (OR OTHER OFFICIAL) OF _____ (town, city, or country) _____
PROCLAIMS OCTOBER 10 WORLD MENTAL HEALTH DAY IN _____ (locale) _____.

The (official's title/position/office), the Honorable _____ (name) _____, designated October 10 as World Mental Health Day 2009 in _____ (locale) _____ through the signing of a Proclamation issued by (legislative body, office, department).

The Proclamation signing ceremony was organized by _____ (organizing organization or agency) _____, and was attended by (members of the organization, public officials, community leaders, and private citizens, etc.).

The Proclamation urged all non-governmental organizations and governmental agencies to work co-operatively with elected and appointment public policy makers and officials to promote the enhancement of equitable and appropriate mental health services in primary healthcare settings, and to increase ready access to services by those experiencing serious mental health problems and disorders such as schizophrenia, anxiety disorders, bipolar disorder, and depression! It also stressed the need for all members of the community to increase their understanding of mental disorders and to help reduce the stigma and discrimination that persists around mental illnesses and the people who live with these serious health disorders.

The theme for World Mental Health Day 2009 is "*Mental Health in Primary Care: Enhancing Treatment and Promoting Mental Health*" and addresses the significant trend in shifting mental health diagnosis, treatment and care of mental illnesses from the traditional separate but unequal mental health services delivery system into mainstream healthcare.

The World Federation for Mental Health (WFMH) established World Mental Health Day in 1992; it is the only annual global awareness campaign to focus attention on specific aspects of mental health and mental disorders, and is now commemorated in over 100 countries on October 10 through local, regional and national World Mental Health Day commemorative events and programs.

GENERAL MEDIA RELEASE FOR WORLD MENTAL HEALTH DAY 2009

FOR IMMEDIATE RELEASE

(Date)

17th ANNUAL WORLD MENTAL HEALTH DAY GLOBAL AWARENESS CAMPAIGN TO HIGHLIGHT NEED FOR MORE ATTENTION TO MENTAL HEALTH IN PRIMARY CARE

The 2009 World Mental Health Day global awareness campaign will focus on “*Mental Health in Primary Care: Enhancing Treatment and Promoting Mental Health.*” This campaign theme addresses one of the increasingly important trends in the way that mental illnesses are being treated worldwide. The campaign is intended to bring worldwide attention to the growing body of information and knowledge focusing on the integration of mental health in primary healthcare, and to provide this information to grassroots patient/consumer, family member/caregiver, and advocacy and educational mental health associations around the world. This is a significant trend in shifting mental health diagnosis, treatment and care from the traditional separate, but unequal, mental health services delivery system into mainstream healthcare.

The World Federation for Mental Health (WFMH) established World Mental Health Day in 1992; it is the only annual global awareness campaign to focus attention on specific aspects of mental health and mental disorders, and is now commemorated in over 100 countries on October 10 through local, regional and national World Mental Health Day commemorative events and programs.

The release, in September 2008, of “*Integrating Mental Health into Primary Care: A Global Perspective*” by the World Health Organization (WHO) and the World Organization of Family Doctors (Wonca) signaled a major step in fostering a global effort to integrate mental health into primary care. In the publication’s introductory message, WHO Director General Dr. Margaret Chan and Wonca President Professor Chris van Weel state the case for such an effort:

“Primary care starts with people. And, integrating mental health services into primary care is the most viable way of ensuring that people have access to the mental health care they need. People can access mental health services closer to their homes, thus keeping families together and maintaining their daily activities. In addition, they avoid indirect costs associated with seeking specialist care in distant locations. Mental health care delivered in primary care minimize stigma and discrimination, and remove the risk of human rights violations that occur in psychiatric hospitals. And, as this report will show, integrating mental health services into primary care generates good health outcomes at reasonable costs. Nonetheless, general primary care systems must be strengthened before mental health integration can be reasonably expected to flourish.” (*Integrating mental health into primary care: A global perspective*; © World Health Organization and World Organization of Family Doctors (Wonca), 2008, page vii)

WMHDAY 2009 will highlight the opportunities and the challenges that integrating mental health services into the primary health care delivery system will present to people living with mental disorders and poor mental health, to their families and caregivers — and to healthcare professionals.

As always, the 2009 World Mental Health Day campaign will focus on the critical role that mental health advocacy, patient/service user, and family/caregiver organizations need to play in shaping this major general health and mental health reform movement. Such informed proactive and sustained advocacy will be necessary if the movement towards integration is to result in improved access to quality, adequate and affordable services for people experiencing mental illnesses and emotional health problems the world over.

GENERAL WORLD MENTAL HEALTH DAY MEDIA RELEASE – CAN BE ADAPTED FOR LOCALIZED USE BY ADDING ADDITIONAL INFORMATION ABOUT WMDAY EVENTS, QUOTES FROM MENTAL HEALTH LEADERS OR EXPERTS IN THE AREA, ETC.

SAMPLE FEATURE ARTICLE, OPINION EDITORIAL, OR LETTER TO THE EDITOR

2009 WORLD MENTAL HEALTH DAY CAMPAIGN HIGHLIGHTS NEED FOR MORE ATTENTION TO MENTAL HEALTH SERVICES IN PRIMARY HEALTHCARE

The 2009 World Mental Health Day global awareness campaign will focus on “*Mental Health in Primary Care: Enhancing Treatment and Promoting Mental Health.*” This year’s theme will address the continuing need to “make mental health issues a global priority”, and will stress the all too-often neglected fact that mental health is an integral element of every individual’s overall health and well-being. Mental illnesses do not choose their victims; they occur in all cultures and at all stages of the life span. Mental illnesses have a major impact on the physical health of people living with them. The campaign theme is intended to draw worldwide attention to the growing body of information and knowledge focusing on the integration of mental health in primary healthcare, and to provide this information to grassroots patient/consumer, family member/caregiver, and advocacy and educational mental health associations around the world. This is a significant trend in shifting mental health diagnosis, treatment and care from the traditional separate but unequal mental health services delivery system into mainstream healthcare.

The engagement of the “end users” of mental health services, their families who often carry much of the responsibility for helping people living with mental illnesses to manage in the community, and the advocates who attempt to influence mental health policies, is critical during this time of change, reform, and limited resources. Informing and equipping the grassroots mental health community to make certain that mental health and mental illnesses are considered integral to overall good health and appropriate services for those who require them are the principal goals for the 2009 World Mental Health Day campaign. One of the primary advocacy concerns that must be addressed is the danger that adequate and effective diagnosis, treatment and recovery of people living with mental illnesses will not receive a parity level priority within the general and primary healthcare system. It is the job of the global mental health advocacy movement to assure that this is not an unintended result of healthcare reform.

The release, in September 2008, of “*Integrating Mental Health into Primary Care: A Global Perspective*” by the World Health Organization (WHO) and the World Organization of Family Doctors (Wonca) signaled a major step in fostering a global effort to integrate mental health into primary care. In the publication’s introductory message, WHO Director General Dr. Margaret Chan and Wonca President Professor Chris van Weel state the case for such an effort:

“Primary care starts with people. And, integrating mental health services into primary care is the most viable way of ensuring that people have access to the mental health care they need. People can access mental health services closer to their homes, thus keeping families together and maintaining their daily activities. In addition, they avoid indirect costs associated with seeking specialist care in distant locations. Mental health care delivered in primary care minimize stigma and discrimination, and remove the risk of human rights violations that occur in psychiatric hospitals. And, as this report will show, integrating mental health services into primary care generates good health outcomes at reasonable costs. Nonetheless, general primary care systems must be strengthened before mental health integration can be reasonably expected to flourish.” (Integrating mental health into primary care: A global perspective; © World Health Organization and World Organization of Family Doctors (Wonca), 2008, page vii)

WMHDAY 2009 will highlight the opportunities and the challenges that integrating mental health services into the primary health care delivery system will present to people living with mental disorders and poor mental health, to their families and caregivers — and to healthcare professionals. As always, the campaign will focus on the critical role that mental health advocacy, patient/service user, and family/caregiver organizations need to play in shaping this major general health and mental health reform movement. Such informed proactive and sustained advocacy will be necessary if the movement towards integration is to result in improved access to quality, adequate and affordable services for people experiencing mental illnesses and emotional health problems the world over.

Advocates, families, professionals and policymakers across the global mental health sector must remember that this current movement to improve the way in which mental health services are delivered is not the first such reform effort. Lessons learned from the past tell us that achieving parity in how mental health services are addressed in countries around the world is not an easy struggle. The effective integration of mental health into primary care at a level of priority appropriate to the documented burden of care of mental illnesses will be a major undertaking in a time of global economic and social difficulty. Certainly, it is well past time for the world to listen and to act to improve mental health services and ready access to services by those experiencing serious mental health problems and disorders such as schizophrenia, anxiety disorders, bipolar disorder, and depression! That will be the central message of World Mental Health Day 2009!

The World Federation for Mental Health (WFMH) established World Mental Health Day in 1992, and coordinates and promotes its annual commemoration on October 10. It is the only annual global awareness campaign to focus attention on specific aspects of mental health and mental disorders, and is now celebrated in over 100 countries through public awareness and education events, proclamation signings, advocacy campaigns, and other public events organized by governmental agencies and non-governmental mental health organizations.

THIS PIECE CAN BE USED AS A NEWSLETTER ARTICLE, OR SUBMITTED AS A FEATURE ARTICLE, OPINION EDITORIAL, OR LETTER TO THE EDITOR TO LOCAL OR REGIONAL NEWSPAPERS. IT CAN ALSO BE PLACED ON YOUR ORGANIZATIONS' WEBSITE TO HELP IN THE PROMOTION OF YOUR WORLD MENTAL HEALTH DAY CAMPAIGN ACTIVITIES. THE ARTICLE CAN BE ADAPTED TO INCLUDE REFERENCES TO YOUR ORGANIZATION AND TO ITS WORLD MENTAL HEALTH DAY CAMPAIGN EFFORTS.

MARCH FOR MENTAL HEALTH

What better way is there to show your support, unity and desire for change than to gather with your fellow advocates and conduct a march or hold a rally?

Possibly none.

In the spirit of World Mental Health Day and the strength and solidarity of the mental health movement - the WFMH is proposing that we all try to do more for World Mental Health Day this year. We are encouraging our partners to not just hold commemorative events for WMHD, but also hold vigils, marches and/or gatherings in support of mental health reform.

This can be a very powerful tool for making views known to those that hold power and for educating the general public. Marching in the streets, holding demonstrations or candlelight vigils - these are some of the most effective ways of, at one time, showing support for a cause, drawing new people to that cause, and attracting the attention of the community, media and those in positions of power. As the WFMH President, John Copeland, noted in our December 2008 newsletter, "Why is mental illness so invisible to governments? If the disease is invisible then those who care about it must be visible."

Those that are able to legally and peaceably assemble to conduct a March or Vigil – we encourage you to do so. Not only are you bringing much needed attention to the subject of mental illness, you are showing those that are facing discrimination and stigma that there is no reason to be ashamed or afraid. You will put a face to this invisible illness; you will humanize the issue, and show the community and government that your cause has validity.

This may all sound like hard work, but it doesn't have to be. Gather together 10-50 of your friends, family and colleagues, pick your gathering place or starting and ending points, make some clever but peaceful signs and you're ready to march for mental health!

HOW TO ORGANIZE A MARCH OR VIGIL

We have gathered some general information for you to use as you plan your March for Mental Health. Please note that requirements are different in every country and community – please find out the laws and requirements for your particular area and avoid any legal issues that might disrupt or cancel your march. The two types of demonstrations we are highlighting are:

Vigil or Rally- These are gatherings where people stay in one place. They are generally solemn and reflective and intended as a peaceful way of honoring or highlighting a person or group of persons or a subject of great concern.

March- A march is a gathering of people who move from one designated point to an agreed upon destination. Marches are good if you have a large crowd or when you want to cover a large area.

1. Pick a date (10/10 would be great!) and secure a location. Check to see if you need a permit or some type of permission to hold your March or Vigil in public – it will be critical to know your rights regarding any type of public gathering. Pick a heavily populated route or public gathering point.
2. Decide on your cause and the message you want to send to those watching. Make it simple, peaceful and strong. Create banners, signs and handouts to use – be sure all are focused to your message, are strong but peaceful, spelled correctly and big enough for people to see.
3. Schedule speakers to address your crowd. You can schedule speakers to start your event, end your event or both. Keep the speeches short and to the point, remember this is a demonstration not a symposium.
4. Get the word out! Contact your advocates, friends, partners, etc - try to include as many groups as possible to show the strength and solidarity within the community. Creating a unified coalition among different groups (mental health groups and professionals, medical groups, families, patients, doctors, nurses, etc) is essential to forming a broad-based social movement and getting the most attention.

5. Assign tasks and determine roles for all involved. If working with different groups – bring all leaders together to utilize and unify everyone’s abilities, networks, and message.
6. Contact the media and write press releases announcing your plans – include your ‘who, what, when, where’ information to be sure all facts about your demonstration are available.
7. Be sure to take pictures, keep notes of the full event and send all your information to wmhday@wfmh.com when you are done – so we can show the world we are united and we wont keep silent any longer!

This could be the single largest advocacy effort for mental illness across the globe! We hope you will join in and do anything you can to show your support. 5 people or 500 people – we can all make a difference if we just do something!

EFFECTIVE SLOGANS

- Show the importance of an issue
- Show the relevance of an issue
- Put a “face” on the issue
- Address each specific audience
- Reflect an understanding of what would motivate change
- Are culturally relevant and sensitive
- Are memorable

EXAMPLES:

Celebrate World Mental Health Day – Open your Mind!

Nothing about us without us

March for Mental Health Reform!

ALL illnesses deserve the same care and treatment!

“Approximately 450 million people have a mental illness. Look around you — do the math.”

No Health without Mental Health!

Mental Discrimination: Open Your Eyes to Our Reality

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*WORLD MENTAL HEALTH DAY IS A REGISTERED SERVICE MARK OF
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