

# Integrating Mental Health In To Primary Health Care

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**Abstract:** *Mental health problems represent 5 of the 10 leading cause of disability worldwide, accounting 12% of the global disease burden. One in every four people will experience mental health problem during their life-time. More than 450 million people suffer from mental illness. In the world mental health problems are the leading disabling health conditions, due to common mental illness like depression, anxiety, alcohol dependency and drug abuse are mostly leads to chronic medical problems. these mental illness can impair the self-care and social functioning of an individual which directly effects on families The effective treatment are existing but only few of them are access the care because most of the mental health care institutes are located in the cities and town which are far from rural area, the people who are living in the rural areas are not able to access mental health services and they are not aware about the mental health care and they are not ready to seek help for such illness which has social stigma. They are having difficulties in accessibility, affordability for mental health treatments, so for such situation there is need of integration of mental health into primary care. Integration of mental health into primary health care helps to improve access to mental health by avoiding fragmentation of health services by providing both physical and mental health services in primary setting and addressing mental health issues in the primary care are often more attractive for patient and families who are concern about stigma. By using WHO reports, government documents and research studies the present short review will be more focusing on the global mental health burden and history of the mental health in Indian health system and why integration is important in the mental health field and what to integrate and the reasons for integrating mental health into primary health care. Then this review also explains how to build an integration model in primary health care by introducing community mental health model like Bellary Model (District Mental Health Program) SANGHAT and Banyan organization which are working on community mental health, as case study.*

**Keywords:** Mental Health, Integration, Primary health care

## 1. Introduction

World health organization (WHO) defines Health as a state of complete physical, mental and social wellbeing of individual and not merely absence of disease or infirmity. Health includes wellbeing of both physical and mental health. The World Health Organization(WHO2011) defines mental health as “state of well being in which the individual realizes his/her own abilities, can cope with the normal stress of life, can work productively and fruitfully and is able to make a contribution to his/her community”. It should be noted the definition does not refer exclusively to the absence of “mental illness”, but also addresses the concept of “mental wellness”. According to World Health Organization, “There is no health without mental health” hence it becomes important to focus on mental health too along with the physical health.

The WHO Report 2001 draws attention to the fact that nearly 450 million persons are estimated to be suffering from mental and behavioral problems across the globe. The global prevalence of mental and behavioral disorders are estimated to be 10% in adults mental health problems contributes to four of the ten leading causes for disability. One in four families will face burden due to mental illness in their lifetimes. It is estimated that by 2020, 15% of the Disability-Adjusted Life-Years lost would be due to mental and behavioral disorders. More than 90% of the peoples who kill themselves have diagnosable mental disorders. Suicide is third leading cause of death among the age group of 15-44years. According to World Health Organization depression will be the second highest leading cause of disease burden by 2030 in middle income

countries and third highest cause of diseases burden in low-income countries.

Vikram Patel, a leading mental health advocate states that even in developed countries roughly 50% of the people don't receive appropriate care for mental health problems. Where as in developing countries the treatment gap is much higher an estimated 90% of people don't receive a proper treatment and care for mental health problems.

## 2. The Situation in Indian

India too has a large burden of mental illness. 2% have severe mental illness (schizophrenia, bipolar and major depression). About half of them remain without treatment, due to lack of awareness about mental health problems, and problems of accessibility and affordability (SEARO WHO 2005). Neki (1987) study stated that there is a 27% psychiatric disorder among hospitalized elderly with depression. The prevalence rate in the community for depression is also very high as high as 40% or more according to some studies. (Venkoba 1984, Sen and Williams 1987). The suicide rate amongst males in India is 12.2 per 100,000 population and in females it is 9.1 per 100,000 population and neuropsychiatric disorders of India are estimated to contribute about 12.% to global burden of mental disease.

India is facing lack of human resource in the field of mental health care we have 1Psychiatrist for 3 lakh population .And in rural area we have 1 Psychiatrist for 10 lakh population.

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The current Human Resource for Mental Health is as follows

Professionals	Health professional working in the mental health sector rate per 100,000	Training of health profession in educational institutions rate per 100,000
Psychiatrists	0.301	0.0364
Medical doctors, not specialized in psychiatry	Unknown	2.893
Nurses	0.166	0.166
Psychologists	0.047	0.010
Social workers	0.033	0.003
Occupational therapists	Unknown	Unknown
Other health workers	Unknown	Unknown

**Source:** Mental health Atlas-2011, department of mental health and substance abuse-WHO

To address this issue Government of India has generated human resources development scheme under National Mental Health Program. Under the scheme there is a proposal for setting up 11 centers of excellence in mental health (psychiatric institutions), 120 PG centers with mental health specialties. Upgrade gradation of psychiatric wings of medical colleges. Modernization of state run hospitals will also supported. The expected manpower scheme out is 104 psychiatrists, 416 clinical psychologists, 416 psychiatric social workers and 820 psychiatric nurses per year, but not observable growth in human resource development in this field.

#### Historical over view of Integrating Mental Health System in Indian public Health System:

**1946-1975 Creating an Indian System of Mental Health:** The evolution of asylum to mental health institution began in 1920s. Significant developments in psychotropic drug and medicine in international level and in India general hospitals with psychiatric units, and more specialists initiated in Post-independence this trend continued. It is important to note that the Bhole committee recommended primary health care centers and integrating mental health in the primary health setting.

**1975-1982 Piloting Models for Expanding Mental Health Services:** subsequent to the World Health Organization's "Health for All" declaration, WHO's supported strategies for expanding mental health services began by piloting. In northern India Raipur a small community mental health model was developed in Karnataka which is also called as Bellary model through National Institute of Mental Health and Neurosciences (NIMHANS) which is largest mental health institution in India. After that due to the active involvement of other national institutes planning and implementation of new models came up in many areas.

**1982-1990 the National Mental Health Program** This first steps had been taken in the early 1980s NIMHANS identified that the models which operated at the PHC level were too resource intensive, too difficult to scale up. Therefore it piloted district level initiative in Bellary district of Karnataka state. Simultaneously the NMHP asked each state to implement in the districts of state. The Bellary model was taken up by the government as a national model and has remained the model for primary mental health care delivery ever since.

**1990-1996 Rise of NGOs** Government had reduced the budget and this affected on mental health care services. NGOs grew in order to address the gap of mental health care provisions. Though this was not a solution, it led to development of new innovative models, including for rehabilitation and advocacy, using an array of non-specialist health worker such as social workers.

**1996-2002 Human Rights Agenda and District Mental Health Program:** During this time the violation of human rights in psychiatric institutions and religious institutes were exposed by media on 6<sup>th</sup> August 2001, as a result of Erwadi tragedy in Tamil Nadu, where 28 chained mentally ill persons were burnt to death due to some an accidental fire. The Supreme Court and human rights lawyers and activists condemned the poor mental health institution conditions and criticized institution care as approach. Due to this the DMHP got more support. The DMHP strongly advocated community care as a part of the comprehensive integration of tertiary, secondary and primary care.

**2002-2007 10<sup>th</sup> Five Year Plan:** as we know 9<sup>th</sup> five year plan, under National mental health Program more focused on district mental health programs. In the 10<sup>th</sup> five year plane this was re-strategized as the NMHP to strengthen and modernize state level administrations, and mental health institution and medical colleges and made improvements in DMHP. Government budgets for this program increased to seven-folds even though these budgets were subsequently under-spent. A large private mental health sector grew and flourished because of continuing poor government provision.

**2007-2011 the 11<sup>th</sup> Five Year Plan:** the NMHP was reinvigorated by making some changes through evaluating the NMHP/DMHP. New elements are introduced into mental health both school health programs and suicide prevention programs. Training programs for general medical practitioners become a priority.

**2012-2015** both the 12<sup>th</sup> five year plan and draft of National Health Policy 2015 call for an integration of mental health into primary health care.

#### The Rational of IMHPHC:

One in every four people will experience mental illness during their life time, yet more than 40% of the countries in the worldwide are not having a mental health policy. In the world we can see that leading disabling health conditions are due to depression, anxiety, alcohol, and drug abuse and these patients are likely to get other

chronic medical problems. Mental illness (schizophrenia, depression, mania, epilepsy, anxiety, etc) can impair the self-care and social functioning of the individual and decrease the productivity.

Though effective treatments for many mental health problems are now available only a few people can access and afford it. What about the poor, rural people, marginalized, vulnerable people those who are living in the remote area? For them it is very difficult to access the services. In the low-middle income countries this has become a challenge. One source states that number of psychiatrists serving in the entire continent of Africa with a population of almost 1 billion, is less than the practicing in the US state Massachusetts with a population of less than 7 million. But even in the developed countries there is a shortage and they draw away psychiatrists from developing nations. Clearly there is need to build an approach that does not depend so heavily on specialists.

### The Reason for Integration of Mental Health:

The closest, easiest form of care is available in the locality that is primary health care service and this is the first level of contact for individuals, family in the community level with the national health system.

Primary health care helps to maintain the family support and care for the patient, the community also accepts and allow him to work, contribute to household productivity and allow participating in the social activities without any discrimination. It is more accessible, affordable and acceptable for the population. Providing mental health services in the primary health care helps to treat the person as a whole or more patient centered will be more effective. (Lane M, Olfson M 1993).

It ensures that the whole population is covered and has access to mental health care that they need in the early in the course of disorder and without disruption. And in the other hand when the people receive treatment at primary healthcare the likelihood of better health outcomes, fast recovery and social integration will increase.

**Reduced Stigma:** To address patient mental health needs in the context of general health care settings are often more attractive to patients and family members who are concerned about the stigma. Treating both physical and mental disorders in a single setting helps to reduce stigma and discrimination among the people. The stigma associated with mental illness will be reduced due to equal treatment of the people with mental and physical illness in primary care within the community setting the acceptance will be more in the community they will also treat the person as he/she is. The primary care for mental health removes the risk of human rights violations to psychiatric hospitals. The stigma and discrimination will also be reduced because the people in the primary care that in the community setting treated in the same way as people with other conditions there will be equal treatment. And they will be receiving same appointments and same health workers to look after them. This is essential for bringing change in people perception of their disorder.

### Advantages of IMHPHC

**Better treatment of Co-morbidity:** mental health is often co-morbid with many physical problems such as cancer, HIV/AIDS, Diabetes and tuberculosis among patients. The presence of substantial co-morbidity has serious implications for the identification, treatment and rehabilitation of the affected individuals. If the primary health care workers received any mental health trainings they can attend the physical health needs of the people those who are suffering from any mental health issues and the individual who are suffering from any infectious and chronic illness and in need of mental health support.

In the integration of approach to addressing mental health in the context of care for HIV/AIDS, Maternal mental health and Non-communicable disease is rooted in the conviction and growing evidence of its efficacy, effectiveness and cost saving (Sweeney S, Dayo Obure et al 2011).

**Improved Prevention and detection of mental disorder:** primary health care workers are the frontline formal health professional, they are the first level of contact for the individual, families and the community with the national health system Alma Ata declaration 1978 equipping these workers with mental health skills promotes a more holistic approach to patient care and ensure both improved detection and prevention of mental disorders.

**Treatment and Follow-up of Mental Disorders:** by providing mental health care services the person who is affected by the mental illness will easily access the care and people who are diagnosed with a mental disorder are often unable to access any treatment for their health problems. By providing the mental health services through primary health care service people will be able to receive the mental health care, because they need better financial accessibility and better acceptability.

**Physical and financial accessibility:** by providing mental health services in the primary level will be the best nearest and easiest way to utilize/access the services. Primary health care is the first and primary level of contact of individuals, families and community to the national health system. When consulting the health center the indirect expenditure like transportation, loss of productivity related to the time spent in accompanying the patient to hospital. Add to the cost of consultation and medications. If the mental health care is integrated in the primary care the cost and care are greatly minimal.

**Reduced Chronicity and improved Social Integration:** when people treated in hospitals which are far from their houses the disruption in their daily life, employment and family life it removes individuals from their normal supports, essential for recovery, and it imposes more burden on families and care givers. Providing services in the primary health care the burden on individuals, families and community will be reduced. Household productivity and social integration will be maintained, resulting in better chances of recovery.

**Improving Human Resources Capacity for Mental Health in PHC's:** Integrating mental health services into primary health can be an important solution to address human resource shortages to deliver mental health interventions. In the clinical outcomes it has been found that for most common mental disorders, primary health care can deliver good care and certainly better care than that provided in psychiatric hospitals.

**Primary Care for Mental Health Promotes Human Rights:** we can see many of the cases, and live examples where the human rights violation took place in psychiatric hospitals and in asylums where the people are tied with chains, treated like animals. Integration of mental health into primary care will reduce the stigma and discrimination when the mental health treatment is available in the primary care and the violation of human rights will be less. In psychiatric hospitals many patients face human rights abuse including degrading living conditions. They can be routinely overmedicated or shackled to beds. In some mental hospitals adult women's and children's are subjected to physical violence and rape.

### 3. Case Studies (Community Mental Health Model)

There have been many approaches to integration of mental health into primary health care. Below I present three case studies each of which is an example of how such integration has been attempted in India. Then we present the learning from these case studies.

#### Case study 1

**District Mental Health Program 1996:** This is district level approach which is seen as the main model to be scaled up under the National Mental Health Program. It was developed by National Institute of Mental Health And Neurosciences, for planning and delivering the mental health services as a part of general health care by using district level administration. **Features** 1) Integrates mental health care in the general health care services: By short term skill based training to general health care staff in identification and treatment of the common mental ailments with supervision and support a mental health team based at head quarters. 2) This is the most important feature of this model no new staff is proposed just existing staff provided with more skill and support. 3) Few essential psychotropic drugs will be available in the primary health care, along with the records that will be maintained. **ICE** (Information communication and education) is an integral part of Bellary model adopted for community mental health program in India. To promote identification of person requiring care and promote mental health. It aims to reduce the myths and stigma which are practicing by the people related to mental illness in the community (in the society). Encourage regular access to treatment at the local level and rehabilitating the patient in the community.

#### Case study 2:

**SANGHAT** is a non-government organization, Started in 1996 in Goa, Sangath developed a vision to provide professional healthcare services for developmental disabilities and mental health problems. Today, it is one of the largest NGOs in the state, with more than 100 service providers, two centers in Goa, projects across India, collaborations with leading institutions in the world, and international recognition for its path-breaking research and intervention programmes in the community. One pioneering strategy has been to use relatively low-cost human resources, by empowering ordinary people and community health workers, to deliver mental healthcare with appropriate training and supervision from experts.

As a result of success in designing effective and low-cost models of care for people with mental health problems, Sangath has been able to contribute to improving the quality of mental health care, not just in Goa, but in other parts of the country, and globally.

**Features:** Primary care is based on community health volunteers who are especially trained for this and those who are dedicated only to address mental health issues. Support to the primary care providers is given by a team of specialist – though in their model medical personal can be trained for this. However experts who are only attending mental health needs are required at the referral level. Sangath is providing community volunteers and through this implementing community mental health programs which is helping volunteers to in identifying, refer and needful care will be given.

#### Case study 3:

**The Banyan** working for the care of people with mental illnesses. The organization was started during the year 1993 Mrs. Vandan and Mrs. Vaishnavi (students of Madras school of social work) founder of this organization. The motive behind of this organization is to provide care for homeless women with mental illness, living on streets for whom there was no option, since 1993 to 2013 there are 1640 women rescued among them, there are 1066 women's rehabilitated to their families The main objective of the Banyan is to increase services in law resource settings such that mental health care is accessible and visible. To enhance the quality of care in institutional settings such as the beggar's home, jails and homeless shelters through adequate treatment, care and rehabilitation facilities .To work with multiple patterns, particularly with user survivors and care givers so the rights based approach is widely adopted. Care with human touch: ensuring effective treatment with a model that combines medication and rehabilitation: psychological therapies, vocational training, occupational therapy and reintegration with communities. Treatments near to home to encourage those with mental illness and their care givers to seek professional help by making the process easy and accessible. Assistance for the whole family to relieve the resource burden of a mentally ill and ensure effective care at home. **Services:** Outpatient services, Disability allowance, Awareness programs. Rescue, Medical and



psychiatric services, Psychological services Occupational therapy and vocational training Rehabilitation, Reunion with family Employment and group home referral to community living After care active follow up services, Home visit, Telephone follow-up, Capacity building program for stake holders community workers, health care workers and social worker Community living and self help group in long term rehabilitation.

#### 4. Conclusion

Integrating mental health care into primary health care is one of the important area to be focused, as the reports and institutes effort we are trying to provide a service to the needy people, but how much it can be done? Because the majority of the NGO's and good private hospitals are settled in cities, and what extent they can provide with low budget. what about the poor rural and community people how they can approach, so it is necessary to look into the people and provide a good health care system which deals both physical and mental health issues in the very nearest and easiest health centers that is primary health care center. For this there strong need research, training human resource, creating awareness and changing people attitude towards accessing mental health treatment which are providing in private mental health setting and government health care. Government and health ministry has to give more focus on this so that citizens of our country get both physical and mental health care services in their doorstep, community without any difficulties. So that they can contribute more in developing our country not become burden on the country.

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