

Integrating Mental Health into Primary Care

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For many years, the World Health Organization (WHO) has stated that "mind and body are linked" and that "there is no health without mental health" [1-3]. One of the recommendations in the World Health Reports of 2001 and 2008 was to integrate mental health into primary care in the community [1,3]. Mental health disorders represent a large proportion of the world's disease and disability burden [1-3]. In Europe, the 12 month prevalence of neuropsychiatric disorders was recently estimated at 38.2% of the population [3]. The most frequent disorders are anxiety disorders (14%), major depression (6.9%), somatoform disorders (6.3%), alcohol and drug dependence (> 4%), and attention deficit hyperactivity disorder (ADHD) (5%). Disorders of the brain and mental disorders in particular are the largest contributor to all the causes of morbidity burden, contributing 26.6% to the disability burden. However, less than one-third of people suffering from mental disorders in Europe receive any treatment, suggesting a considerable level of unmet needs [4].

People with mental problems, especially anxiety disorders and depression, are characterized by a high utilization of general medical services, presenting with somatic and pain symptoms. Among those not seeking care for their psychiatric symptoms, two-thirds seek care from their general practitioner (GP) for the somatic symptoms that accompany depression

and anxiety, highlighting the need for GPs to recognize mental health problems in patients who present with physical symptoms [5]. More than 70% of mental health patients in the OECD-Europe usually seek help from the GP, much more often than from psychiatrists or psychologists [6]. Fifty percent are treated only by primary care. Likewise, in the United States and Canada [7], primary care physicians are the most contacted provider of mental health care, providing up to 60% of psychiatric care, while 80% of antidepressants are prescribed not by psychiatrists. Studies from different countries have shown that up to 40% of primary care visits are related to mental disorders [8]. A recent Israeli study [9] found a high rate (46.3%) of current mental disorders in primary care clinics, with rates of current depressive episode, general anxiety disorder, somatization disorder and neurasthenia being relatively high as compared to rates of other countries, while in the community the rates were mid-range compared with other countries. These findings point to a relatively higher use of primary care service by patients with mental disorders in Israel. Furthermore, mental health disorders are very often co-morbid with physical disorders like obesity, hypertension, diabetes, cardiovascular disorders, tobacco use and sexual dysfunction, emphasizing the central role of the primary care physician in the treatment of patients with common psychiatric disorders.

An important step toward integration of mental health into general health in Israel was initiated on 1 July 2015 within the framework of the Israeli Mental Health Reform. Prior to this reform, general health and mental health were almost two separated systems. Whereas general health

care was provided by the four health maintenance organizations (HMOs), mental health care was not included in the 1994 Health Insurance Law and was provided mostly by the government. With this reform, psychiatric care was transferred from the state to the four HMOs with an appropriate budget. As a consequence, the health providers have started a process of reorganizing the treatment of mental disorders, including the collaboration between primary care and psychiatrists.

In this issue of *IMAJ*, Avny and colleagues [10] review the evidence, from both randomized controlled trials and descriptive studies, that various collaboration models between psychiatrists and primary care physicians in the community may improve the psychiatric care of patients suffering from depression, anxiety and somatization disorders. The studies reviewed demonstrate that collaboration models increase accessibility and patient compliance, decrease stigmatization, and increase remission rates of depressive disorders. An additional consequence is augmentation of primary staff skills and knowledge in the field of psychiatry while fostering a humanistic atmosphere in the primary clinic.

There are four main patterns of collaboration between primary care and mental health services. The first is a single point of referral from primary care to a psychiatric consultation. The patient is seen in the psychiatric clinic, not in the clinic of the family physician (FP), with a follow-up letter to the FP. The second is the "shifted outpatient model," shifting the venue of specialist care from outpatient clinics to primary care facilities. The third is psychiatric consultations in the primary care practice, in the presence of the FP. The psychiatrist advises

the FP and the patient through ongoing correspondence. Finally, the "consultation-liaison" model has the psychiatrist discussing difficult cases with members of the FP and primary care team, and sometimes sees patients with them, but the patient remains with the primary care team.

A meta-analysis of 3408 patients managed by the FP utilizing these various models of psychiatric consultation has shown that all the consultation models were superior to regular psychiatric care in patients with somatization and depressive disorders [11]. The outcome variables included general functioning, psychological symptoms, medical symptoms, and health care utilization. The decrease in health care utilization was more prominent in patients with somatic complaints. This point should be of note, since some FPs are concerned about the extra burden of treating psychiatric disorders. The consultation models may reduce the burden of dealing with frequent visits and unnecessary lab tests that characterize the management of these "somatoform" patients. FPs usually express a high level of satisfaction with the collaboration services they receive from a mental health team in primary care [12].

There is now almost universal recognition that primary care is the place where most mentally distressed people first seek help, and also the acceptance that even in physical disorders the proper psychological management of distress is an important component of treatment. GPs can play a leading role in diagnosing and treating patients suffering from mild to moderate illnesses provided there is an accessible

psychiatric consultation. There is no single best practice model that can be followed by all. The collaboration model should be adjusted to the local capacities of the primary care and mental health systems.

Most medical schools around the world do not provide adequate instruction to future physicians in the management of common mental disorders, preferring to emphasize the much rarer major mental disorders. A long-term intervention to increase the GP's expertise in mental health disorders should focus on training and education in medical schools and residency education programs where, currently, psychiatric disorders are not given sufficient weight. As such, the current residency syllabus in family practice in Israel contains only an elective period of 2 months in psychiatry.

In summary, integrating mental health 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 home while maintaining their daily activities. Collaboration between psychiatrists and primary care physicians, as well as education programs, are essential to increase the skills and confidence of the GPs to effectively assess, diagnose, treat and refer people with mental disorders. Mental health care delivered in primary care minimizes stigma and in the long run may save time for the GPs and financial resources for the health providers.

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