Thank you for the opportunity to join you here in Yerevan for this thematic conference. And congratulations to the World Psychiatric Association (WPA) for your great work in strengthening mental health care for the people of the world. The World Organization of Family Doctors (WONCA) and the WPA have a strong history of working together to promote and support universal access to mental health care, and I intend for our partnership to continue during my three years as WONCA president.

We have the capacity to successfully treat mental health disorders, Yet in many parts of the world only a small minority of people with mental health illnesses has access to effective treatment.

In this presentation I will focus on the integration of mental health into primary care, and I will argue that integrating mental health into primary care is the most viable way to close the treatment gap and ensure that people get access to the mental health care they need. I will draw on the work that the World Health Organization (WHO) and the World Organization of Family Doctors (WONCA) have been engaged in around the world over recent years, and will draw out some of the key issues and challenges for Eurasia.

I am a family doctor. In Australia, I am called a general practitioner which, as in the United Kingdom, indicates that I have undertaken formal postgraduate training and attained qualifications in the recognized specialty of general practice.

The words we use to describe ourselves as doctors working in the community can be confusing. Whether we call ourselves a general practitioner, a GP, or a family physician, or a primary care doctor. In this talk I will use the term family doctor. The language we use to describe who we are doesn’t matter. What matters is the common work that we do, the vision that we share, the outcomes that we achieve.
clinics in different parts of the world. Yesterday I met with Dr Armine Tadevosyan, who works in the rural village of Agarak, in the north of Armenia. This is Dr Armine in her clinic with her small team of family medicine nurses and midwives, who together provide primary care services to over 3,500 children and adults in their village and the surrounding region.

I wish to start by telling you a little about WONCA. WONCA was started over 40 years ago with a small group of family medicine colleges and academies, that banded together to create a world body that shared an ideal of training and education for family medicine and high standards for clinical care in all nations of the world.

WONCA now has Member Organizations representing over 500,000 family doctors in over 130 countries and territories around the world. Each year, the 500,000 family doctors represented by WONCA have over 2 billion consultations with our patients. Two billion. That’s the scope of our current work and our influence.

But we need to do more. We need to work to ensure that every family doctor, every GP, every primary care doctor, joins us in our commitment to deliver high quality primary care to our patients and communities. We need to expand our commitment to the education and training of family doctors and quality care and primary care research to the 80 nations of the world where WONCA does not yet have a presence. And we need to ensure that the care we provide includes mental health, as well as addressing physical health concerns.

So let’s talk about mental health and primary care. There are a number of ways that I know, as a family doctor, that I have had a good day working in my clinic. Here is one of them:

«I haven’t had a good day as a family doctor unless at least one person has cried in my consulting room».

This might sound mean, but you need to understand the context.

In my practice, I see many people with chronic disease, especially with HIV/AIDS. I know that many of my patients are at risk of depression as a comorbid condition. I also know that, as a family doctor, I need to be vigilant in seeking to detect patients with undiagnosed depression. I know that many people who commit suicide in my country have presented to a health care setting seeking help in the days before they kill themselves. So detecting undiagnosed depression among my patients is a medical emergency.

I also know that many of my patients don’t come in saying «I’m depressed». They may come in with physical symptoms like headache or backache and stomach ache, or wanting to talk about trouble at home or at work or with their children, or complain of difficulty sleeping, or excessive worrying, or loss of weight, or poor concentration, or just not feeling right. It is only when I pick up on the cues, and ask the right questions, that the tears start to flow. And I can work towards making a diagnosis. And work towards assisting my patients on the pathway towards managing their depression.

Family doctors, like psychiatrists, appreciate the link between the physical health and well being of our patients and their mental health and well being.

The beauty of family medicine, like psychiatry, is that we put our patient in the centre of care and have a focus on the whole person, rather than on individual diseases.

In the words of the Canadian family medicine academic Ian McWhinney, one of the giants of our profession who passed away last year, «The family doctor is committed to the person rather than to a particular body of knowledge, group of diseases, or special technique». This is our generalist ideal.

Ian McWhinney also advised us that, «ideally, family doctors should share the same habitat as their patients». This allows us to best understand the social context of our patients’ lives.

Mental health problems constitute a substantial part of the burden of illness of patients in the community and are a regular reason for contact with a family doctor. In fact, mental health problems are part of patients’ and families’ daily life experience, which is why it is vital that family doctors address such problems.

You and I know that people are more than a collection of disconnected parts. The woman with a history of myocardial infarction may be depressed that she can no longer care for her aged mother – and her depression may put her at risk for another heart attack. The man who uses alcohol to control his chronic anxiety symptoms and develops pancreatitis – may then worry obsessively that he will be doomed to a life of chronic pain, which further compounds his anxiety.

We are aware of the consequences of physical ill health on the mental health of many of our patients. Depression, in particular, is a common co-morbidity for many people with chronic health conditions, such as cancer, heart disease, diabetes, HIV and tuberculosis. We are also aware of how mental ill health can impact on the physical well being of our patients. This especially affects our patients with intellectual disabil-
ity and chronic mental health conditions.

It was probably always the case, but we do live in worrying times. At a time of rapid change and social unrest and conflict in many parts of our world, family medicine provides some comfort to our patients, our communities and our nations.

We can provide comfort because we are used to dealing with complexity and uncertainty.

We provide comfort at a time when uncertainty is increasing for our patients who are faced with a barrage of choices and options and a wealth of misinformation thanks to the Internet.

We provide comfort to our nations, which are facing uncertainty about their capacity to provide health care to all people and know that they should be keeping people out of expensive hospitals, but are not sure how to do this.

At this time of uncertainty about the future of health care, the role of the family doctor continues to grow. And this need for comfort moves our global organization into an increasingly strategic role with the World Health Organization and other global health organizations, like the World Psychiatric Association.

Integrating mental health into primary care is an essential part of this work, and together WONCA and the World Health Organization have been working to strengthen the provision of mental healthcare through primary care. This led to our 2008 joint publication on Integrating Mental Health into Primary Care, which some of you also contributed to. With this publication, the WHO has made a powerful statement that mental healthcare is a core component of family medicine and primary care.

Specific skills and competencies are required to effectively assess, diagnose, treat, support and refer people with mental disorders; it is essential that primary care workers are adequately prepared and supported in their mental health work.

All medical students need education about mental health; all trainees in family medicine need training in mental health; all qualified family doctors need continuing professional development in mental health. Access to appropriate therapies, medications, and referral services is essential. Research must be conducted on rates of mental health problems in communities and the diagnosis and management of mental health problems in primary care.

It has been excellent this month to see the new WHO World Health Report, which focuses on the research needed for universal health coverage. It has important messages for family medicine and psychiatry.

Dr Margaret Chan, Director-General of the World Health Organization has said that «Mental health is essential for achieving person-centered and holistic primary health care».

Dr Chan is right. We need to create awareness and change the public perception of mental health. We need to sensitize the public on the issues of mental health, and I am going to share with you some ways we can do this.

I am a board member of an organization in Australia, called beyondblue, which is funded by the Australian Government, and which is committed to raising awareness among health professionals and the general public about mental health, tackling stigma and discrimination about mental health, and supporting the people of our nation to seek the support they need. This is an example of one of our public education campaigns – this ad runs on national TV and in movie cinemas.

In each country, we need to highlight the role of clinical leaders among primary and specialty care doctors who will advocate for the need to manage both the physical and mental health care needs of each of our patients.

We need to reinforce the need for active government and corporate support, including funding reform, to ensure that the care of mental health concerns is integrated with the care of physical health concerns for people attending both primary and specialty medical care settings.

For too long, mental health disorders have been largely overlooked as part of strengthening primary care. Mental health is central to the values and principles of the Alma Ata Declaration; holistic care will never be achieved until mental health is integrated fully into primary care.

Common misunderstandings about the nature of mental health disorders and their treatment have contributed to their neglect. For example, many people think that mental disorders affect only a small subgroup of the population, but in fact large numbers of people attending primary care clinics may have a diagnosable mental disorder. Others think that mental health disorders cannot be treated, but we know that effective treatments exist and can be successfully delivered through primary care. Some believe that people with mental health disorders are violent or unstable, and therefore should be locked away, when we all know that the vast majority of affected individuals are non-violent and capable of living productively within their communities.

People need to be able to access mental health...
services closer to their homes, thus keeping their families together and maintaining their daily activities. In addition, they avoid indirect costs associated with seeking specialist care in distant locations.

Mental health services delivered in primary care have the potential to minimize stigma and discrimination, and remove the risk of human rights violations that sometimes occur in hospitals and institutions in some parts of the world. And, as our report shows, integrating mental health services into primary care generates good health outcomes at reasonable costs. Nonetheless, primary care systems must be strengthened before mental health integration can be reasonably expected to flourish.

Our common humanity compels us to respect people’s universal aspiration for a better life, and to support their attainment of a state of complete physical, mental and social well-being, and not merely the absence of disease or infirmity. With integrated primary care, the substantial global burden of untreated mental disorders can be reduced, thereby improving the quality of life for potentially hundreds of millions of people and their families. This is all part of universal health coverage.

The 2013 World Health Report examines the research base for universal health coverage. Universal health coverage has been part of the charter of the United Nations since 1948. And universal coverage does not mean meeting the needs of 80% of the population – it means ensuring that health care is available to everybody.

In the aftermath of Alma-Ata we had «Health for All by the Year 2000». Clearly this was not attained and, as a consequence, in 2000, the United Nations agreed to the Millennium Development Goals, the MDGs, 8 goals with targets to be reached by 2015, 8 goals «to free people from extreme poverty and multiple deprivations».

Sadly progress in the health related MDGs, numbers 4, 5 and 6, is not as significant as we would like to see although we have seen millions of lives saved through reductions in preventable deaths.

The MDGs have also come in for some criticism because of what they are missing. They don’t tackle the need to strengthen primary care, or to tackle mental health and chronic disease, or to address the social determinants of health, or to ensure universal coverage for people in both rural and urban areas.

The United Nations is now starting the discussions about its focus following 2015 – the post-MDG era. Above the clamour of thousands of interest groups and self-interested industries, our global organisations need to band together to ensure that a focus on mental health, on behalf of our patients and communities, is heard during these debates, and included in whatever comes out from the UN in 2015.

I would like to focus some of the specific areas that require attention:

Child and adolescent mental health. Many children suffer from a mental health disorder. Disorders regularly seen within primary care include attention-deficit/hyperactivity disorder (ADHD), conduct disorder, delirium, generalized anxiety disorder, depressive disorders, post traumatic stress disorder (PTSD), and separation anxiety disorder. Adolescent depression often continues, unabated, into adulthood, and is a risk of youth suicide.

Mental health in older people. The population of the world is ageing rapidly. Older people are more likely of course to have chronic diseases and need health services. Their mental health is influenced by their access to health services, education, employment, housing, social services and justice, and by freedom from abuse and discrimination.

Pockets of success in the detection and treatment of mental health disorders. In some countries, the treatment of mental disorders in primary care has been increasing steadily. Several factors seem to be accounting for the increase, including community-based education and advocacy; increased consumer demand; better training of primary care health workers; development and implementation of evidence-based guidelines; and more accessible services. This trend though is not yet evident in most parts of the world, especially low- and middle-income countries.

The emerging problem of misuse or overuse of mental health treatments. On occasion, primary care workers recommend mental health treatments for those who do not need them. Though clearly not as frequent as underdetection and undertreatment, overuse wastes scarce resources and can be hazardous to patients. Overuse can be the result of poor diagnostic and treatment skills, often related to inadequate education and training. For example, in some countries primary health care workers increasingly are prescribing antidepressants and anxiolytics for people who are experiencing unhappiness but do not meet the threshold for a mental health disorder. Psychotropic medications are sometimes overused in place of other modes of evidence-based treatment such as psychotherapy. And pharmaceutical industry promotion can be a double-edged sword – with increased awareness of conditions like depression, there may be a tendency to overdiagnose and
The challenge of adherence to long-term treatment is also important. The average adherence rate for long-term medication use in primary care is just over 50% in high-income countries, and is thought to be even lower in low- and middle-income countries. Patients are blamed when prescribed treatment is not followed, in spite of evidence that health workers and health systems can greatly influence patients' adherence. In reality, adherence to long-term medication treatment is a multifaceted challenge that requires consideration and improvement of several factors, including a trusting health worker–patient relationship, a negotiated treatment plan, patient education on the consequences of good or poor adherence, recruitment of family and community support, simplification of the treatment regimen, gauging the patient's ability to pay for treatment, and managing side-effects of the treatment regimen.

One question that is raised is whether family doctors have a role to play in managing mental health conditions in low and middle-income countries. There are those who say that family medicine has no real role to play in low and middle-income countries. Well, we have blown that theory out of the water. The new edition of the WONCA guidebook on the role of family medicine in improving health systems was launched in June this year by Dr Margaret Chan and includes contributions from the WHO showcasing the research into the impact family medicine is having in improving health outcomes in many middle income nations including Brazil, China, Thailand and countries of the Eastern Mediterranean region. And there is a chapter outlining the remarkable work that is underway across Africa to strengthen family medicine, especially involving WONCA member organisations within Africa supporting developments in neighbouring nations.

What these developments demonstrate is the need to strengthen the whole health care workforce, including family doctors, community nurses, community health workers, and traditional birthing assistants, and support working together to deliver appropriate care to all people. People in low income countries still want and deserve access to health care, including mental health care, access to caring clinicians, access to life saving medications.

We also need to embrace the concept of reverse innovation. What can health systems in high-income countries learn from the health systems in lower income countries? It is something that each of who spends time working in another health system in another country learns very quickly.

Dr Margaret Chan has stated that primary care is not cheap and must not be a «B-team» version of health care delivery.

If we are going to provide universal coverage, we need to stem the costs of health care, and can do so through increasing our investment in community-based health services, and reducing the amount spent on hospitals. And at the same time there must be a movement of funding from hospitals to the community, rather than expecting more community-based care to be delivered with no increase in resources.

The digital world also provides a lot of challenges. In our asynchronous world, how do we achieve continuity of care? But it will also bring benefits. We are starting to learn how teleconsultations can allow us to conduct home visits with our patients from a distance, and this has been especially successful in telepsychiatry in many parts of the world with family doctors and consultant psychiatrists working together across vast distances to provide optimal patient care.

So how do we integrate mental health into primary care? Well here are ten ways:

1. Policy and plans need to incorporate primary care for mental health. We need formal commitment from our governments to integrated mental health care. 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.
2. Advocacy is required to shift attitudes and behavior. Time and effort are required to sensitize political leadership, health authorities, and primary care workers about the importance of mental health integration.
3. Adequate training of primary care workers is required. This includes training of medical student and recent graduates, but also experienced family doctors. 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. Initially each health system needs to look at the capacity of their primary care workforce and then the functions of primary care...
workers can be expanded over time 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 must be accompanied by complementary services, particularly secondary care components to which primary care workers can turn for referrals, support, and, when required, supervision.

6. Patients must have access to essential psychotropic medications in primary care. This requires countries to directly distribute psychotropic medicines to primary care facilities rather than through psychiatric hospitals. Countries 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 including training and appropriate staffing, and adequate funding.

8. A mental health service coordinator is crucial. Unexpected problems can sometimes threaten a program’s outcomes or even its survival. Mental health coordinators are crucial in steering programs around these unexpected 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. These organizations can play an important role in supporting primary care for mental health. Village and community health workers can be especially valuable in identifying and referring people with mental health disorders to primary care facilities; community-based nongovernmental organizations can provide great ancillary support to people with mental health problems.

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, as well as additional mental health specialists to provide support and supervision and specialist consultation. As we better meet mental health needs, demands for services will increase, and cannot be met by expecting existing services to cope with increased demand.

Finally a word about our own mental health as doctors. One of the major life lessons we need to learn as doctors is to find balance in our lives. Balance between caring for our patients and caring for ourselves. If we don’t look after ourselves, then we will not have the capacity and resilience to provide continuing high quality care to our patients and our communities.

We need to ensure that we stay as physically and mentally well as possible. And we need to look after each other. The words of Sir William Osler: «A physician who treats himself has a fool for a patient».

Every doctor needs their own doctor, someone we can trust for our own medical care and advice. If we are going to prevent major physical and mental health problems in ourselves, we need to have our own trusted doctor. As doctors we deserve to have access to the same high quality medical care that we provide to each of our own patients. And our families also deserve this standard of care. So please, and this applies to everyone in this room, if you don’t have your own family doctor, please find one.

Look after your own mental health. One way to do this is to find the meaning in our everyday work, and in so doing discover and then rediscover every day of your life, the great joy and the privilege of being a doctor.

This presentation includes some content previously published in the 2008 joint publication of the World Health Organization (WHO) and the World Organization of Family Doctors (WONCA) on Integrating Mental Health into Primary Care, and on the publication by MR Kidd and P Coker on the role of primary and specialty care physicians in the 2010 World Mental Health Day Report of the World Federation for Mental Health, on Mental Health and Chronic Physical Illnesses: the need for continued and integrated care.

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