Editorial

iMedPub Journals
www.imedpub.com

Journal of Healthcare Communications
ISSN 2472-1654

2017
Vol. 2 No. 4: 58

DOI: 10.4172/2472-1654.100099

Integrating Sustainable Mental Health Programs in Primary Care

Bianca Lauria-Horner*

Department of Psychiatry, Dalhousie University and the Primary Mental Healthcare, Canada

Received: August 17, 2017; **Accepted:** August 21, 2017; **Published:** August 31, 2017

***Corresponding author:**
Bianca Lauria-Horner

Bianca.Horner@Dal.Ca

Department of Psychiatry, Dalhousie University and the Primary Mental Healthcare, Canada.

Tel: 902-473-5593

Citation: Lauria-Horner B (2017) Integrating Sustainable Mental Health Programs in Primary Care. J Healthc Commun. Vol. 2 No. 4:58.

According to the World Health Organization's (WHO), mental illness is becoming the number one cause of years lived with disability worldwide [1-3], with a high economic cost to society [4]. Depression, one of the most prevalent and costly conditions in our society, affects over 400 million people globally [5,6]. When mental illness is concurrent with other conditions like addictions or physical illnesses, there is higher morbidity and cost to the healthcare system [7]. A recent study conducted by May and colleagues found that a depression diagnosis at any time following coronary artery disease increases the risk of death 2-fold [8]. These facts underscore the need for effective, feasible and sustainable programs, which promote early recognition and evidence-based treatment strategies [9,10].

In recent years, integration of mental health in primary care has become an area of focus when redesigning mental healthcare service delivery. Primary care is often the first point of contact [11-13], the vast majority of common mental health problems can be handled early and effectively in this setting [14,15], and many patients preferred to be treated by their physician. There is an established trust as such they are more comfortable, likely, and feel less stigmatized sharing problems [16-18]. However, even when the diagnosis is made, a large majority of patients do not receive adequate treatment [19]. For example, depression and anxiety disorder studies show that in mild to moderate cases, most patients receive antidepressants [20-22] but antidepressants in this group are not necessarily associated with improved long-term clinical outcomes [23,24]. The majority of patients prefer non-drug options [25], and although we agree that antidepressants are necessary in many cases, when clinically acceptable, patient choice of evidence-based treatment options improves outcomes [26]. So, what are we missing, what is needed to fill this gap? We hear time and again that physician knowledge gaps contribute to unrecognized and undertreated mental illness in primary care, but the extent to which training programs effectively translate knowledge and skills into improved clinical outcomes remain questionable [27-30].

The truth is that it is not that simple. Although training is a first step, there is interplay of factors to consider if efforts of providing adequate mental healthcare are to be successful. The following is by no means an exhaustive list, but it gives us the big picture of this multifaceted problem. First, we need to recognize that primary care physician factors contributing to this gap expand well beyond training. Physicians extend care to a large number of domains resulting in competing training demands. If physicians feel unprepared, there can be associated anxiety in managing mental illness, especially if specialty back up proves to be difficult or non-existent. Then there are time factors. Mental health is intertwined with physical health, therefore not only confuses symptoms, but mental illness can be overlooked when physicians have to deal with on average 2-5 problems within one visit of 10-15 minutes. Additionally, primary care physicians' burden of managing mental illness compared to other medical conditions is higher [31]. When the burden is intensified by a lack of systems support for chronic disease management such as lack of resources, reimbursement, legislation, collaborative teams, government funded psychotherapy or evidence-based allied health professional services for patients with financial restraints, one begins to understand how not taking these factors into account only serves to perpetuate the problem. Patient factors also are significant in the equation. For example, the lack of knowledge or awareness between common symptoms and mental illness which delays treatment. Reluctance to seek help due to stigma [32-37], or non-adherence to treatment for various reasons including financial restraints. Time factors are also prevalent when patients are unable or unwilling to attend frequent doctor/professional visits only to resurface in primary care at which time are in crisis or the condition is much harder to treat [38-41].

In other words, although training is central to help improve clinical outcomes, a comprehensive program, which incorporates as much as possible these contributing factors, should be considered in order to create a paradigm shift in primary mental health care. Both top-down government systems supports and bottom-up approaches are required [42-56]. Without these components in place, this not only affects the feasibility to effectively integrate training programs in primary care, but also efforts by policy and decision-makers in restructuring services to deliver comprehensive, cost-effective, and patient-centered care could prove fruitless.

References

1 http://www.euro.who.int/en/what-we-do/health-topics/noncommunicable-diseases/mental-health/news/news/2012/10/depression-in-europe

2 GBD 2013 DALYs and HALE Collaborators, Murray CJ, Barber RM, et al. (2015) Global, regional, and national disability-adjusted life years (DALYs) for 306 diseases and injuries and healthy life-expectancy (HALE) for 188 countries, 1990-2013: quantifying the epidemiological transition. Lancet 386: 2145-2191.

3 Whiteford HA, Degenhardt L, Rehm J, Baxter AJ, Ferrari AJ, et al. (2013) "Global burden of disease attributable to mental and substance use disorders: findings from the global burden of disease study 2010." Lancet 382: 1575-1586.

4 Lim K, Jacobs P, Ohinmaa A, Schopflocher D, Dewa C (2008) A new population-based measure of the economic burden of mental illness in Canada. Chronic Dis Can 28: 92-98.

5 Kessler R, Aguilar-Gaxiola S, Alonso J, Chatterji S, Lee S, et al. (2009) The global burden of mental disorders: an update from the WHO World Mental Health (WMH) surveys. Epidemiologia E Psichiatria Sociale 18: 23-33.

6 http://www.who.int/mediacentre/factsheets/fs369/fr/

7 Naylor C (2013) SP0115 the link between long-term conditions and mental health. Annals of the Rheumatic Diseases 71: 28.

8 May H, Horne BD, Knight S, Knowlton, Bair TL, et al. (2017) The association of depression at any time to the risk of death following coronary artery disease diagnosis: the intermountain inspire registry. J Am Cardiol 69: 57.

9 GBD 2013 DALYs and HALE Collaborators, Murray CJ, Barber RM, Foreman KJ, Abbasoglu Ozgoren A, et al. (2015) Global, regional, and national disability-adjusted life years (DALYs) for 306 diseases and injuries and healthy life expectancy (HALE) for 188 countries, 1990-2013: quantifying the epidemiological transition. Lancet 386: 2145-2191.

10 http://www.formationprof.ch/download/am211.pdf

11 Butler M, Kane RL, McAlpine D, Kathol RG, Fu SS, et al. (2008) Integration of mental health/substance abuse and primary care. Evid Rep Technol Assess (Full Rep) 173: 1-362.

12 Unutzer J, Katon W, Fan M, Schoenbaum M, Lin E, et al. (2008) Long-term cost effects of collaborative care for late-life depression. Am J Manag Care 14: 95-100.

13 http://www.who.int/mental_health/policy/services/integratingmhintoprimarycare/en/

14 Unützer J, Park M (2012) Strategies to improve the management of depression in primary care. Prim Care 39: 415-431.

15 Kauye F, Jenkins R, Rahman A (2014) Training primary health care workers in mental health and its impact on diagnoses of common mental disorders in primary care of a developing country, Malawi: a cluster-randomized controlled trial. Psychol Med 44: 657-666.

16 Orleans C, George L, Houpt J, Brodie H (1985) How primary care physicians treat psychiatric disorders: a national survey of family practitioners. Am J Psychiatry 142: 52-57.

17 Azrin S (2014) Integrated care: High-impact mental health-primary care research for patients with multiple comorbidities. Psychiatr Serv 65: 406-409.

18 Jorm AF, Korten AE, Jacomb PA, Christensen H, Rodgers B, et al. (1997) "Mental health literacy": a survey of the public's ability to recognise mental disorders and their beliefs about the effectiveness of treatment. Med J Aust 166: 182-186.

19 Mulsant B, Whyte E, Lenze E, Lotrich F, Karp J, et al. (2003) Achieving long-term optimal outcomes in geriatric depression and anxiety. CNS Spectrums 8: 27-34.

20 https://www.nivel.nl/sites/default/files/bestanden/ns2_r2_h00.pdf

21 Schulberg HC, Block MR, Madonia MJ, Rodriguez E, Scott CP, et al. (1995) Applicability of clinical pharmacotherapy guidelines for major depression in primary care settings. Arch Fam Med 4: 106-112.

22 Schulberg HC, Block MR, Madonia MJ, Scott CP, Lave JR, et al. (1997) The 'usual care' of major depression in primary care practice. Arch Fam Med 6: 334-339.

23 Fournier JC, DeRubeis RJ, Hollon SD, Dimidjian S, Amsterdam JD, et al. (2010) Antidepressant drug effects and depression severity: a patient-level meta-analysis. JAMA 303: 47-53.

24 Kirsch I, Deacon BJ, Huedo-Medina TB, Scoboria A, Moore TJ, et al. (2008) Initial severity and antidepressant benefits: a meta-analysis of data submitted to the Food and Drug Administration. PLoS Med 5: e45.

25 Van Schaik DJ, Klijn AF, Van Hout HP, Van Marwijk HW, Beekman AT, et al. (2004) Patients' preferences in the treatment of depressive disorder in primary care. Gen Hosp Psychiatry 26: 184-189.

26 Sherbourne CD, Wells KB, Duan N, Miranda J, Unützer J, et al. (2001) Long-term effectiveness of disseminating quality improvement for depression in primary care. Arch Gen Psychiatry 58: 696-703.

27 van Os TW, Ormel J, van den Brink RH, Jenner JA, Van der Meer K, et al. (1999) Training primary care physicians improves the management of depression. Gen Hosp Psychiatry 21: 168-176.

28 Kroenke K, Taylor-Vaisey A, Dietrich AJ, Oxman TE (2000) Interventions to improve provider diagnosis and treatment of mental disorders in primary care: a critical review of the literature. Psychosomatics 41: 39-52.

29 Kalet AL, Gillespie CC, Schwartz MD, Holmboe ES, Ark TK, et al. (2010) New measures to establish the evidence base for medical education: identifying educationally sensitive patient outcomes. Acad Med 85: 844-851.

30 Sikorski C, Luppa M, König H, Van den Bussche H, Riedel-Heller S (2012) Does GP training in depression care affect patient outcome? - a systematic review and meta-analysis. BMC Health Serv Res 12: 10.

31 Nease DE, Maloin JM (2003) Depression screening: a practical strategy. J Fam Pract 52: 118-124.

32 Nicholas MK, Asghari A, Corbett M, Smeets RJ, Wood BM, et al. (2011) Is adherence to pain self-management strategies associated with improved pain, depression and disability in those with disabling chronic pain? Eur J Pain 16: 93-104

33 Turner A, Anderson JK, Wallace LM, Bourne C (2015) An evaluation of a self-management program for patients with long-term conditions. Patient Educ Couns 98: 213-219.

34 Sevick MA, Trauth JM, Ling BS, Anderson RT, Piatt GA, et al. (2007) Patients with complex chronic diseases: perspectives on supporting self-management. J Gen Intern Med 22: 438-444.

35 Theeboom T, Beersma B, Van Vianen A (2014) Does coaching work? A meta-analysis on the effects of coaching on individual level outcomes in an organizational context. J Positive Psychol 9: 1-18.

36 Linden A, Butterwoth MS, Prochaska JO (2009) Motivational interviewing-based health coaching as a chronic care intervention. J Eval Clin Pract 16: 166-174.

37 Butterworth S, Linden A, McClay W, Leo MC (2006) Effect of motivational interviewing-based health coaching on employee's physical and mental health status. J Occup Health Psychol 11: 358-365.

38 Crabtree B, Nutting P, Miller W, McDaniel R, Stange K, et al. (2011) Primary Care Practice Transformation is Hard Work: Insights From a 15-year Developmental Program of Research. Med Care 49: S28-35.

39 Unützer J, Schoenbaum M, Druss B, Katon W (2006) Transforming mental health care at the interface with general medicine: Report for the president's commission. Psychiat Serv 57: 37-47.

40 Pereira B, Andrew G, Pednekar S, Kirkwood BR, Patel V (2011) The integration of the treatment for common mental disorders in primary care: experiences of health care providers in the MANAS trial in Goa, India. Int J Ment Health Syst 5: 26.

41 Fortney J, Enderle M, Mcdougall S, Clothier J, Otero J, et al. (2012) Implementation outcomes of evidence-based quality improvement for depression in VA community based outpatient clinics. Implement Sci 7: 30.

42 Ruggles B (1998) The improvement guide: a practical approach to enhancing organizational performance. Quality Progress 31: 108.

43 Weinerman R, Campbell H, Miller M, Stretch J, Kallstrom L, et al. (2011) Improving mental healthcare by primary care physicians in British Columbia. Healthc Q 14: 36-38.

44 Maccarthy D, Weinerman R, Kallstrom L, Kadlec H, Hollander M, et al. (2013) Mental health practice and attitudes of family physicians can be changed! Perm J 17: 14-17.

45 Alweis R, Greco M, Wasser T, Wenderoth S (2014) An initiative to improve adherence to evidence-based guidelines in the treatment of URIs, sinusitis, and pharyngitis. J Community Hosp Intern Med Perspect 17: 4.

46 Ginsburg LR, Lewis S, Zackheim L, Casebeer A (2007) Revisiting interaction in knowledge translation. Implement Sci 2: 34.

47 Stange KC, Goodwin MA, Zyzanski SJ, Dietrich AJ (2003) Sustainability of a practice-individualized preventive service delivery intervention. Am J Prev Med 25: 296-300.

48 Parker LE, Kirchner JE, Bonner LM, Fickel JJ, Ritchie MJ, et al. (2009) Creating a quality-improvement dialogue: utilizing knowledge from frontline staff, managers, and experts to foster health care quality improvement. Qual Health Res 19: 229-242.

49 Rubenstein LV, Mittman BS, Yano EM, Mulrow CD (2000) From understanding health care provider behavior to improving health care: the QUERI framework for quality improvement: quality enhancement research initiative. Med Care 38: I129-I141.

50 Mendel P, Meredith LS, Schoenbaum M, Sherbourne CD, Wells KB (2008) Interventions in organizational and community context: a framework for building evidence on dissemination and implementation in health services research. Admin Policy Ment Health 35: 21-37.

51 Walters ST, Matson SA, Baer JS, Ziedonis DM (2005) Effectiveness of workshop training for psychosocial addiction treatments: A systematic review. J Subst Abuse Treat 29: 283-293.

52 Tamburrino M, Nagel R, Lynch D (2011) Managing antidepressants in primary care: physicians' treatment modifications. Psychol Rep 108: 799-804.

53 Davis D, Thomson M, Oxman A, Haynes R (1995) Changing physician performance: a systematic review of the effect of continuing medical education strategies. JAMA 274: 700-705.

54 Greenhalgh T, Robert G, Macfarlane F, Bate P, Kyriakidou O (2004) Diffusion of innovations in service organizations: systematic review and recommendations. Milbank Q 82: 581-629.

55 Miller W, Crabtree B, McDaniel R, Stange K (1998) Understanding change in primary care practice using complexity theory. J Fam Pract 46: 369-376.

56 Plsek P (2003) Complexity and the adoption of innovation in health care. In: Accelerating quality improvement in health care-strategies to speed the diffusion of evidence-based innovations. Washington, DC, USA.