# What does really mean Integrated Mental Health Care?

Benedetto Saraceno

University of Geneva

University of Lisbon

# Service Organization: Optimal Mix of Services



COSTS — HIGH / LOW

FREQUENCY OF NEED — LOW / HIGH

**Mental Hospitals & Specialist Services**

**Psychiatric Services in General Hospitals**

**Community Mental Health Services**

**Mental Health Services through PHC**

**INFORMAL COMMUNITY CARE**

**SELF CARE**

QUANTITY OF SERVICES NEEDED

# Optimal mix?

**1. Where the needs are there is no care**

**2. Funding allocation is not matching with needs**

**3. Location of Care is not matching with needs**

# The voice of the pyramid:
## we need care where the needs are

1. **Where the needs are there is no care**

   a) absolute lack of coverage

   b) relative lack of coverage (care exists but is not where the needs are)

# Absolute Gap (lack of coverage)

The proportion of people with mental disorders receiving treatment is far to be adequate:


a) in USA: 32.9% treated, all mental disorders (Kessler,2005)
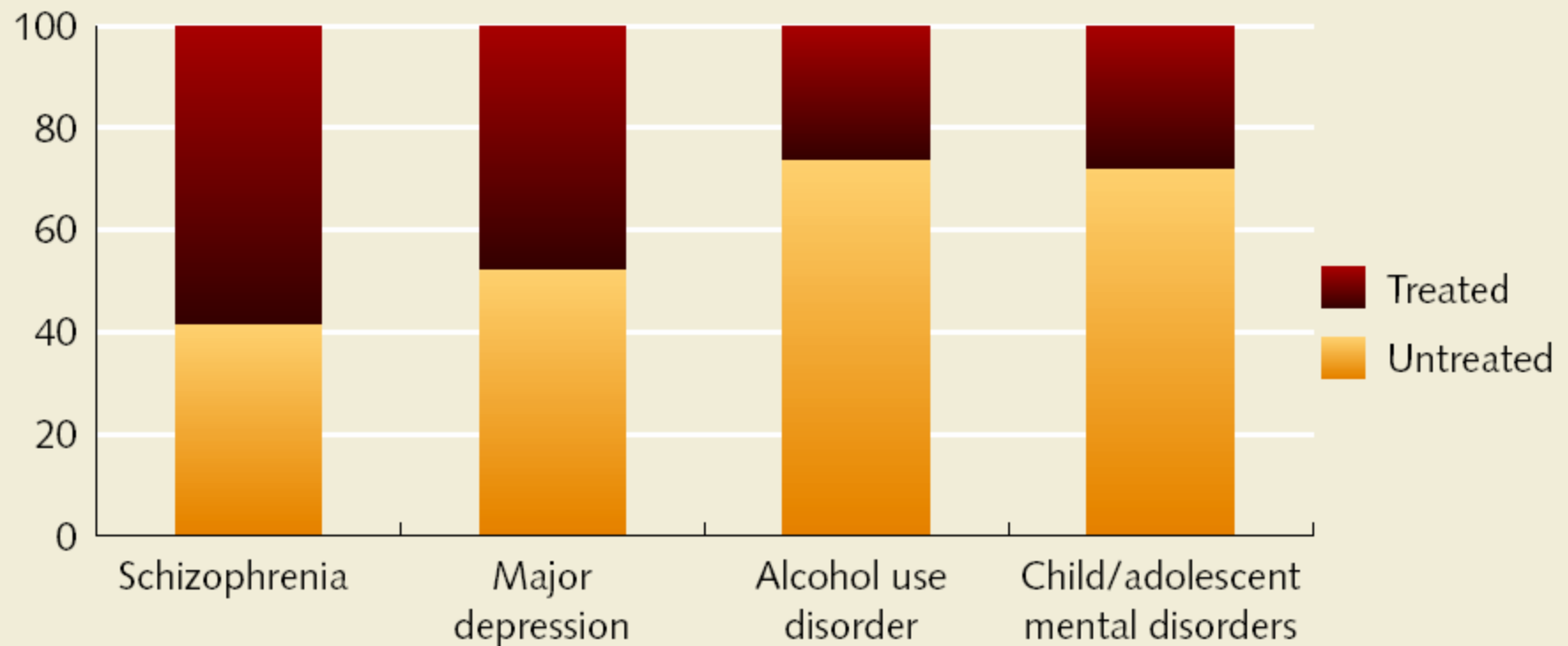
b) In Russia: 25% treated, depression

# Treatment Gap

- **Serious cases receiving no treatment during the last 12 months**

    – **Developing countries-**      **76.3 to 85.4 %**
    – **Developed countries-**      **35.5 to 50.3 %**

# The treatment gap



Treatment gap rates (%) by disorder (world)

# Relative Gap (lack of focus)

- Many people receive treatment for mental disorders but they do not have mental disorders

- In 2003 in the USA only half of the people who received treatment had conditions that met diagnostic criteria (Kessler 2005)!!

# The voice of the pyramid:
# we need care where the needs are

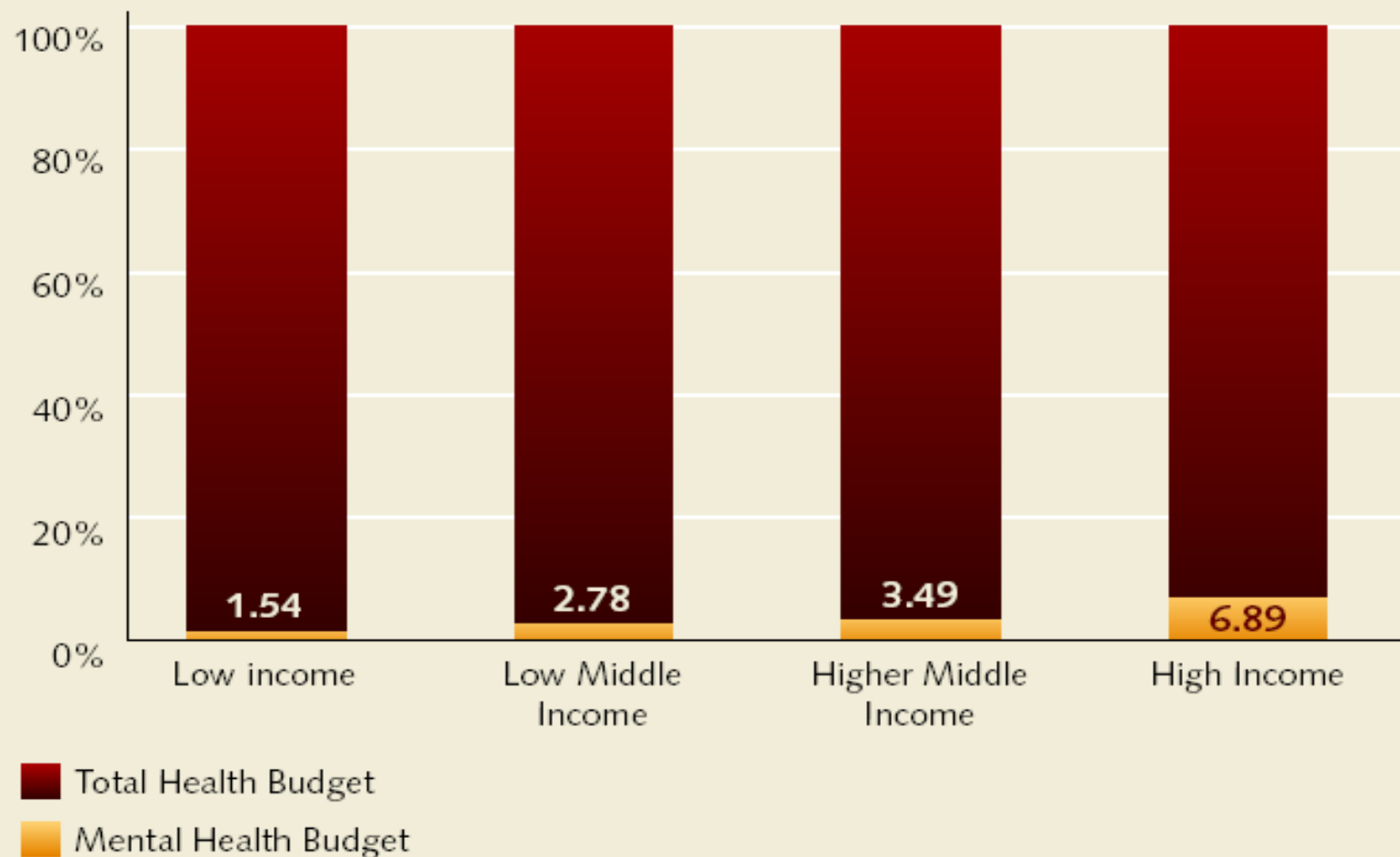**2. Funding allocation is not matching with needs**

a) Insufficient allocation
b) Inefficient allocation

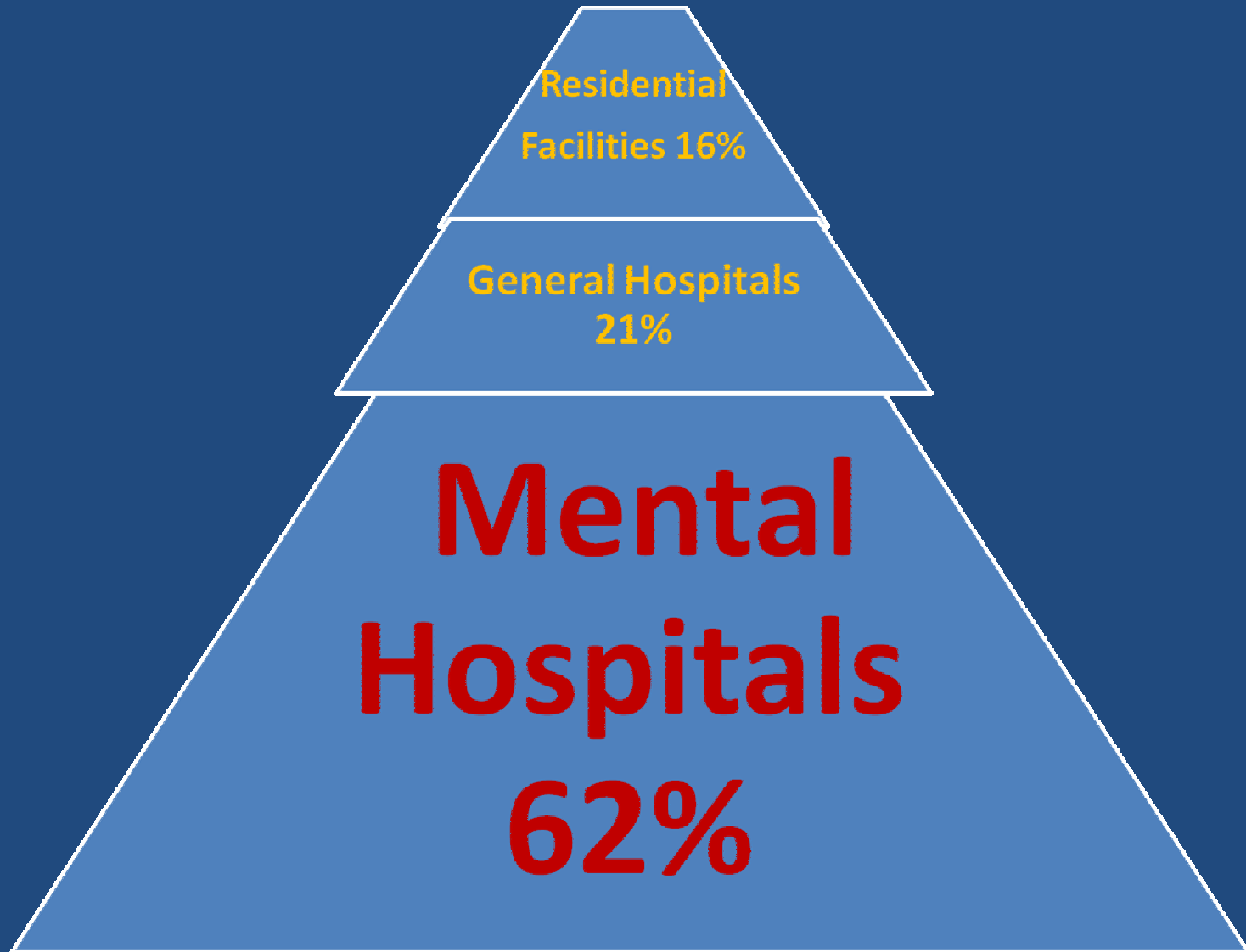**INSUFFICIENCY: Burden/budget gap: too large !**
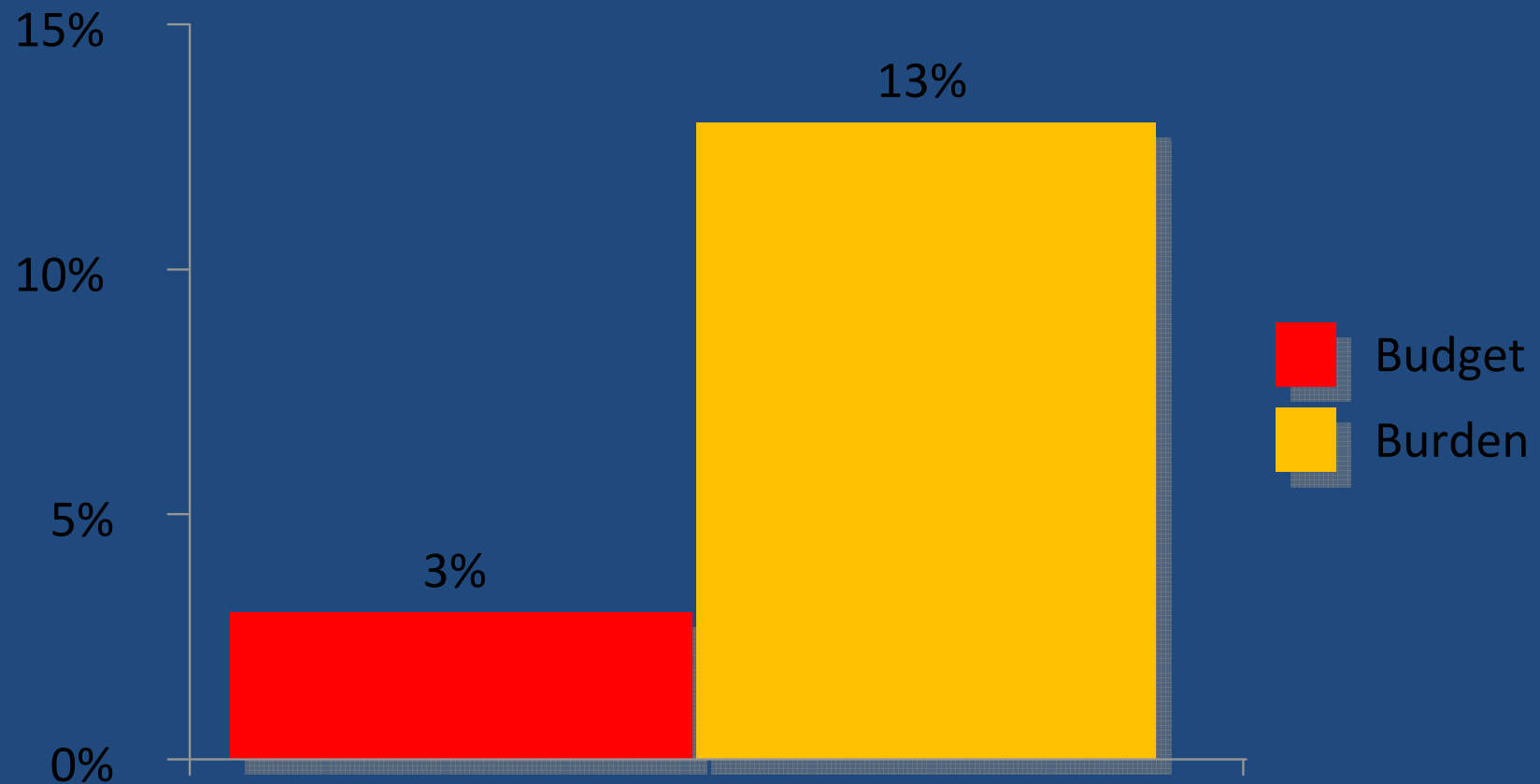
# Mental Health Budget and Total health Budget

**Share of mental health budget in total health budget of countries by income level (%) (World Bank classification)**

| | Low income | Low Middle Income | Higher Middle Income | High Income |
|---|---|---|---|---|
| Mental Health Budget | 1.54 | 2.78 | 3.49 | 6.89 |

Legend:
- Total Health Budget
- Mental Health Budget

# ....where are the resources for mental health care?

a) in psychiatric hospitals

b) in highly specialized units with no catchment area

c) in private institutions with or without contract agreement with public sector

# The voice of the pyramid:
# we need care where the needs are

## 3. Location of Care is not matching with needs

a)  Too many psychiatric hospitals
b)  Too many beds in psychiatric hospitals
c)  Not enough alternative solutions for long stay users
d)  Not enough beds in General Hospitals
e)  Not enough Community Mental Health Centers
f)  Not enough mental health literacy in PHC

# CONCLUSION: resources are **far** from needs

- **People need more services (more absolute coverage)**


- **With more efficient allocation of resources**
- **(reversing the pyramid)**


- **With more focus (less avoidable treatments)**


- **People need services close to home: PHC and CMHC (real availability)**

# LANCET SERIES: Global Mental Health

Benedetto Saraceno, Mark van Ommeren, Rajaie
Batniji, Alex Cohen, Oye Gureje, John Mahoney,
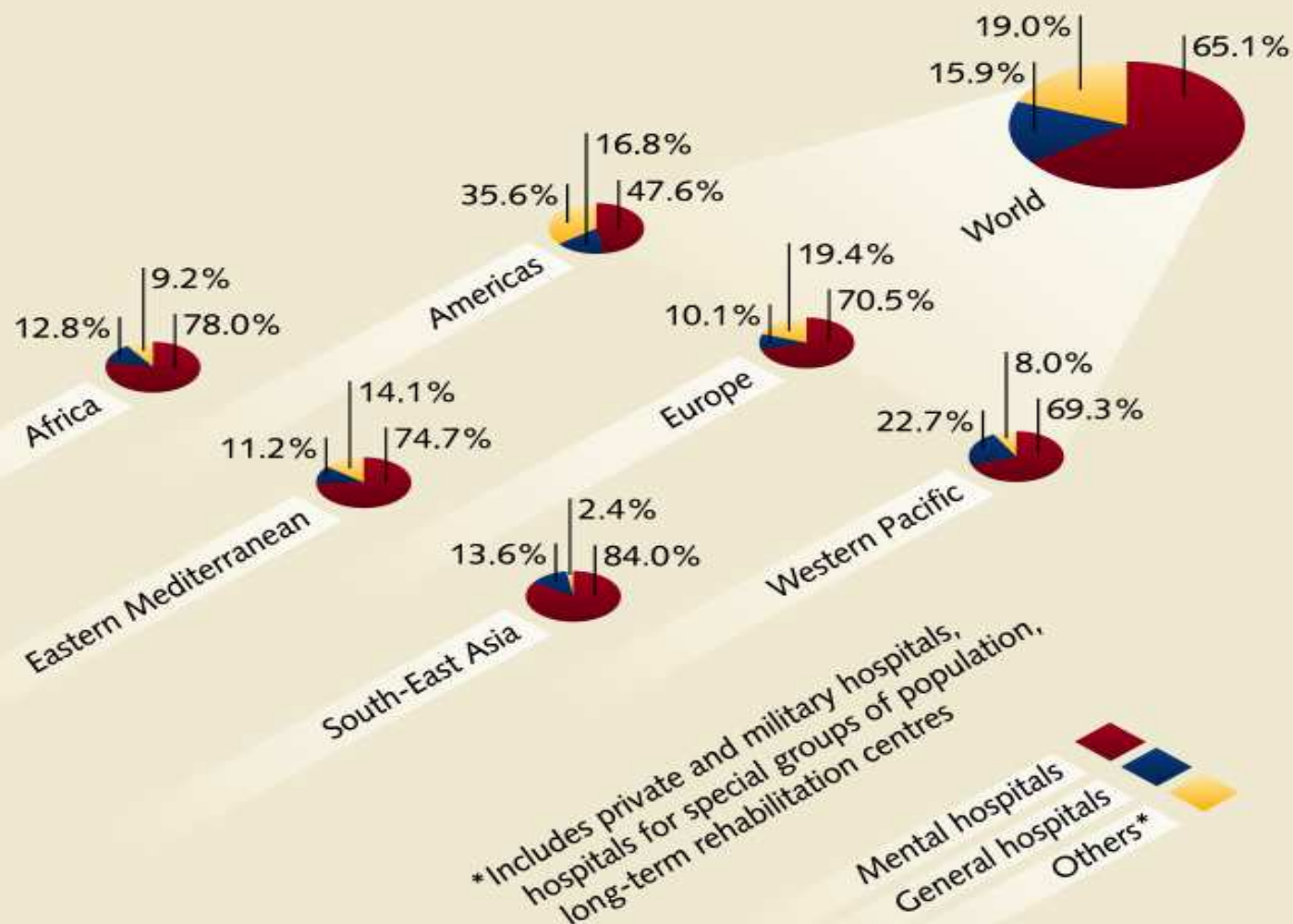Devi Sridhar, Chris Underhill

**Barriers to improvement of mental health services in low-income and middle-income countries**
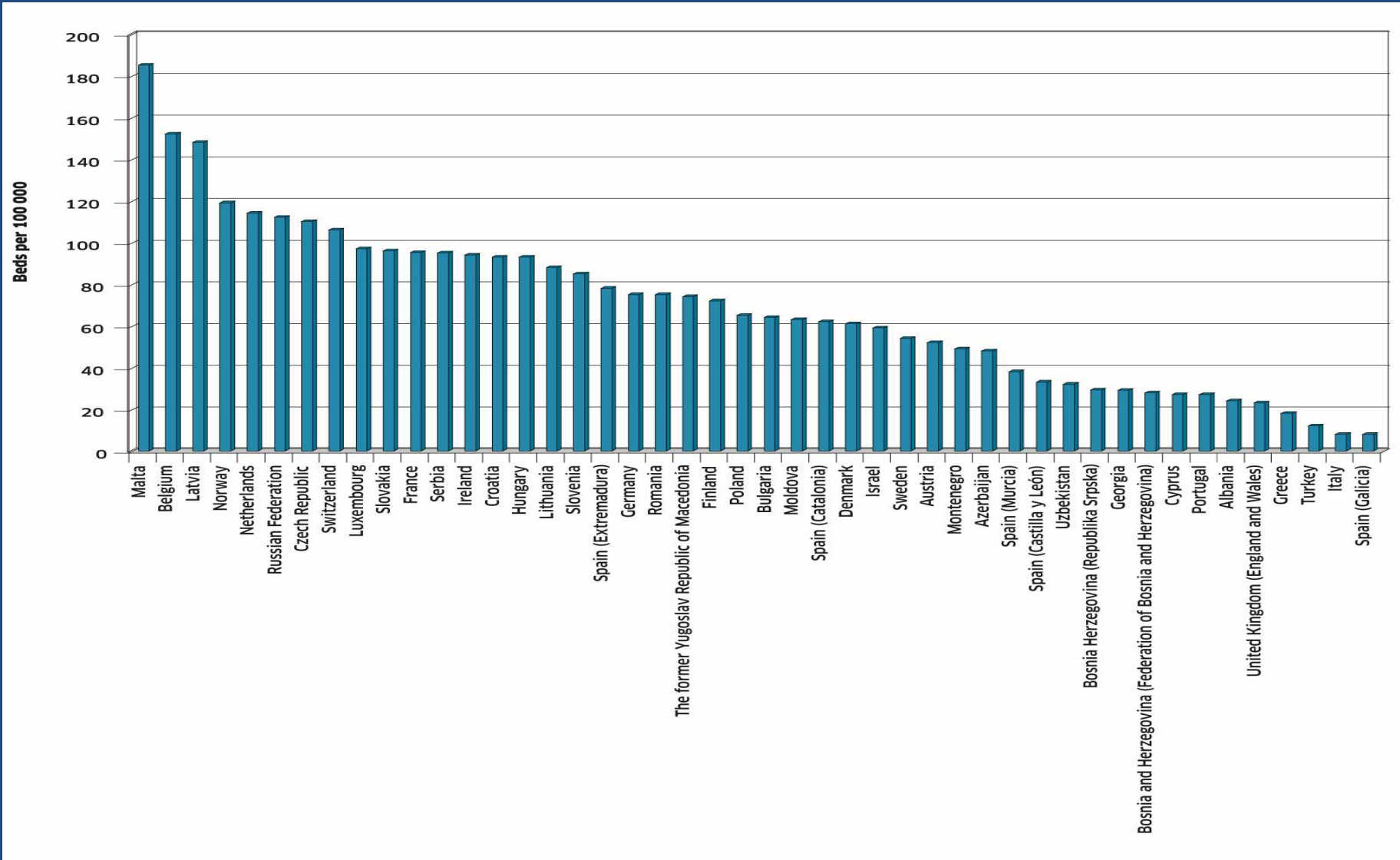
## Barrier 1: Mental health resources centralized in and near big cities and in large institutions

- Need for extra funding to shift to community-based services

- Resistance by mental health professionals and workers, whose interests are served by large hospitals

# Psychiatric beds in each WHO Region and the world
## (ATLAS Data, per 10,000 population)



World
19.0%
15.9%
65.1%

Americas
16.8%
35.6%
47.6%

Africa
9.2%
12.8%
78.0%

Europe
19.4%
10.1%
70.5%

Western Pacific
8.0%
22.7%
69.3%

Eastern Mediterranean
14.1%
11.2%
74.7%

South-East Asia
2.4%
13.6%
84.0%

*Includes private and military hospitals, hospitals for special groups of population, long-term rehabilitation centres

Mental hospitals
General hospitals
Others*

# Total mental health beds in Europe per 100 000 population

**Barrier 2: Difficulties in integrating mental health care in primary health care services**

- Primary care workers already overburdened
- Lack of supervision and specialist support after training,
- Lack of continuous supply of psychotropics in primary care in many countries

# Learning core competencies for PHC

- **Assessment and diagnosis: simplified but reliable**

    **GHQ, ICD 10phc, AUDIT, ASSIST, mhGAP**

- **Listening and Support (key principles)**

- **Treatment  (simplified but evidence based)**

- **Referral (to whom? A responsible  specialist service)**

- **Community Intervention (community alliances)**

# Barrier 3: Lack of investment in secondary care: the missing number

- 3

- ?

- 1

# Severe Mental disorders determine disabilities

**Mental disabilities are chronic conditions and require**

**long-term care**

# Are Psychiatric Hospital providing adequate long-term care?

**Too often Psychiatric Hospitals determine**

1. accumulation of deficit symptoms
2. social isolation
3. ill-treatment to patients
4. very low cost-effectiveness
5. users' dissatisfaction

# Severe Mental Disabilities: history of a denial

- **Asylum**        the « invented city »

- **Unplanned de-hospitalization**
-            abandonment and family burden

- **Homelesness**    the diffuse asylum

- **Trans Institutionalization**
           « the imbroglio »

# But why institutionalization?

- a) long term protection

- b) long term care and assistance

- c) family relief

# Mental disabilities are <u>chronic conditions</u> and require long-term care

Deinstitutionalization

=

De-hospitalization

+

Long-Term <u>Care</u>

**Deinstitutionalization is needed**

**….but**

**Deinstitutionalization**

**is more than**

**De-hospitalization**

**Deinstitutionalization is**

**De-hospitalization + Long-Term Care**

# Long Term Care= 5 C

- **Comprehensiveness:** broad spectrum of offers (psychiatric care, family support, housing, employment, inclusion strategies)

- **Community Long Term Care:** long term perspective (spectrum from permanent care to full recovery)

- **Continuity of care**: continuity across time and across space: ONE service

- **Collegiality:** multiprofessional team + users & families

- **Capacity:** new skills are needed

# Axes of Psychosocial Rehabilitation

- Habitat ➡️ Home ➡️ House

- Learning, Applying Knowledge and Communicating ➡️ Socialization

- Social Value ➡️ Work ➡️ Employment

# Barrier 4: Mental health leadership often lacks public health skills and experience

- Those who rise to leadership positions often only trained in clinical management
- Public health training does not include mental health

# Barrier 5: Political will (& thus funding) for mental health is low, because of

- Inconsistent and unclear advocacy by MH advocates
- People with disorders not organized in a powerful lobby in many countries
- Incorrect belief that care is cost-ineffective

# Pending Issues

1. the balance (resources and weight) between hospital and community care (hospital means general hospital **and not** psychiatric hospital)

2. community care means comprehensive care **and not** ambulatory care