
Report

“Defining the package of mental health services appropriate for being integrated into primary health care”

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Introduction

Mental health and wellbeing are critical to securing the quality of people's life in particular and the whole society in general and are key elements of the objectives set forth in the EU Lisbon Strategy and in the updated sustainable development strategy, as prevention, early detection, interventions and treatment of mental disorders significantly reduce the personal, financial or social consequences of those.

Mental health problems are a common phenomenon in Europe, with one-in-four people facing mental health problems at least once in their life-time, whereas many more are affected by those indirectly, as mental health care standards differ significantly across countries, in particular an issue between the old and the new member-states.

Moldova's aspiration to join the EU is directly linked to the issue of providing care to people with mental disorders and mental disabilities. No country in the world may be considered developed if it turns a blind eye to the needs for proper lives and adequate care for people with disabilities.

At all levels of healthcare delivery, there are some MH services that may be provided through PHC facilities, and which may be topped up with services ensuring access to specialists for training, consultations, assessments with subsequent hospitalization and specialized treatment. This "link" with specialists is extremely important, as most MH problems are often noticed within the PHC first, which has relatively limited options to identify and manage common MH issues, such as depression, for instance. Streamlining the way the PHC practitioners are trained requires combining several strategies – including, access to information and correlation with feedback got from other professionals from the health care system (Gilbody et al., 2004).

PHC reform efforts aim to improve the quality of health services, including MH services. Integration of MH services into PHC would significantly reduce the burden and cost of specialized care, while the savings may be used to raise quality and ensure the continuity of care provided to people with MH issues and to public at large.

PHC physicians have to be capable of preventing, detecting and diagnosing MH problems that their enrolled population is facing, including children and adolescents, whereas setting up a referral system would allow physicians to refer their patients with severe disorders to relevant specialists. One task of the PHC is to keep track of the health status of patients who benefitted or still are benefiting from specialized care.

This report is a review of data gathered towards facilitating the implementation of the Mental Health Strategic Plan at the request of the World Health Organization country office in the Republic of Moldova and the Ministry of Health. The review draws upon qualitative data originating from the assessment carried out during the period of 1 October – 15 November 2012 all throughout Moldova and at all three levels of PHC layout – municipal, district and rural.

The goal of this review is to *define the package of MH services appropriate for being integrated into PHC*.

This review is structured by research objectives, namely:

1. Assess the knowledge and the training needs of family doctors in the area of MH;
2. Evaluate the layout and quality issues related to the MH services provided at PHC level;
3. Identify funding mechanisms and additional incentives for family doctors to provide MH services;
4. Define referral mechanisms and intra- / cross-sector collaboration in the area of MH in the work of PHC specialists.

Chapter I Methodology

The review presented below draws upon qualitative data gathered during focus group interviews with PHC specialists and provides for an overview of knowledge and training needs, layout issues, funding mechanisms, as well as of ways to cooperate within and across sectors in the area of MH, that family doctors are facing.

Focus group interviews imply group work focusing on a certain well-defined topic and led by a moderator; it is a type of qualitative techniques gathering data to assess needs, perceptions, motivations, feelings and people's opinions.

Focus groups is a technique that one may use to study / evaluate a situation or problems through one's personal opinions on certain events, phenomena, programs, products, services, ideas etc.

The exploratory nature of focus groups may be an advantage for:

- Defining a number of issues that the community was not aware of, because according to Blumer, "there is a problem in the community if the community becomes aware of its existence" (Blumer, apud. Cojocaru St, 2003b:68);
- Defining the profile of a potential target group for certain social services being designed;
- Capturing some perceptions as to certain facilities, organizations, some social services provided to population by local authorities and/or NGOs;
- Highlighting the effects that a certain decision has had at community level regarding the providing of population with certain facilities;
- Identifying a certain social service and adding it to the roster of services available to the population;
- Revealing one's perceptions, opinion and reaction as to the quality of certain services provided to community members;
- Piloting some messages for the campaigns used to advocate for certain ideas, services or organizations;
- Identifying the prevailing type of social vulnerability (Cojocaru St, 2003a: 533-547) specific to a certain target group and for defining the most effective interventions used in the past to cut down such vulnerabilities;
- Identifying certain reactions, behaviors or motivations under real circumstances;
- Assessing the resources available in the community that may be used to the benefit of its members;
- Identifying the specific "underused resources" (Miftode, 2002: 74-76) that the community may get access to etc.

The qualitative data are the result of a study conducted between 1 October and 15 November 2012 by a team of interviewers (2 persons) at 5 sites in the Republic of Moldova.

The target group for the research was the family doctors selected by theoretical sampling from the 3 tiers of the PHC layout, i.e. municipal, district and village.

Selected locations:

Tier of care	With MH community center	Without MH community center
Municipality / town	Chisinau (TMA Ciocana)	Family Medicine Center Cahul
District center	Family Medicine Center Ungheni	Family Medicine Center Cimislia
Village	Health Center in Peresecina, district of Orhei	

The sites of the qualitative research were selected primarily on the following grounds:

- They belong to different parts of the country – center, north, and south;
- They are representative of the research goal and objectives – community MH services are available or missing;
- The town of Cahul is rather an "exception" to the rule in terms of home care, given that the

- southern part of the country is inadequately covered with MH services;
- The town of Ungheni is an “success story”, i.e. a model for action and good practice in the area of MH;
- The municipality of Chisinau is the capital city of the country, with the best infrastructure of all, but extremely heterogeneous.

There have been 5 focus groups (8-10 participants each) convened and 5 interviews with PHC specialists organized. As many as 45 people took part overall in this qualitative research – both family doctors and family nurses. Interviewees’ workplace was:

- PHCF Territorial Medical Association (TMA) Ciocana – 10 people;
- PHCF Family Medicine Center Cahul – 9 people;
- PHCF Family Medicine Center Cimislia – 8 people;
- PHCF Family Medicine Center Ungheni – 10 people;
- PHCF Health Center Peresecina – 8 people

In a nutshell, the review may be summarized as follows:

Working element	Group
Working format	Group interview
Size	8-10 people
Duration	1.5-2 hours
Number of sessions	One in each site
Participants	Selected by invitation, with like professional traits
Type of data	Qualitative
Data gathering	Audio cassette, transcription
Moderator	2 flexible, yet focused, people
Working tool	Interview guidelines (Annex 1)
Venue	A neutral site within an existing public healthcare facility (PHCF)
Reporting format	Selection of text excerpts, review of recurrent topics

The review was carried out as per interview guidelines for family doctors and family nurses.

The **Interview Guidelines** (Annex 1) was designed specifically for the selected groups of participants and includes 4 (four) blocks of thematic questions around the key objectives of the research. Each thematic block included 4-5 specific questions, the purpose of which was to steer and deepen the discussions, subject to group specifics and responsiveness.

The first block of questions refers to the layout and quality of MH services provided at PHC level.

The topic of block II questions gravitate around the knowledge and training needs of family doctors in the area of MH.

Questions under block III are meant to find out the opinion of participants about the funding mechanisms and additional incentives for family doctors providing MH services.

Mechanisms for the referral to specialists and MH facilities and collaboration within and across sectors in this area in the work of PHC specialists are handled in block IV of the interview guidelines.

Chapter II

Outcomes of the Qualitative Research in Focus Groups

In order to get some clarity into the opinions shared by family doctors as part of this research, we shall look into the outcomes by each block of questions presented as quotations.

- I. The block of questions on the layout and quality of MH services provided by the PHC.
1. Do patients coming for a medical consultation feel comfortable to talk about MH problems?”
- “...yes, in particular about stress, insomnia, headaches, anxiety, fear and sadness...”
- “...no, as we lack conditions (separate room, time for this)...”
- “...yes, patients always want to talk...”
- “...not always willing to talk...”
- “...occasionally...”
- “...it depends on the person...”
- “...yes, if the patient is with the physician alone (nurse is not in the room)”

Negative and affirmative answers were distributed almost equal, everything hinging on certain specific factors.

2. Do you have access to information about the patient’s mental disorder?
- “...yes, patients tell us...”
- “...yes, these data may be found in the outpatient chart f025/e”
- “...we have access in part...”
- “...yes, minimum access...”
- “...we have access to information, but some patients do not tell us...”
- “...no, we don’t have access...”
- “...we get information from the psychiatrist (we go to the psychiatrist’s room)...”

Absolutely negative answers accounted for approximately 30% of all.

3. Do you believe that medication for some MH conditions could be prescribed by a family doctor? What specific psychotropic pharmaceuticals do you think could be prescribed by a family doctor?
- “...yes, in particular for the patients with chronic mental disorders, with a well-established diagnosis and having already got the recommendations from a psychiatrist...”
- “...yes, anxiolytics, sedatives, tranquilizers...”
- “...no, no such medicine at all...”
- “...yes, for some conditions...”
- “...yes, for some emergency conditions...”
- “...yes, some drugs...”
- “...no, psychotropic drugs shall be prescribed by a psychiatrist only...”
- “...yes, whenever needed for stressful situations...”

Absolutely negative answers accounted for approximately 10% of all.

4. Are you aware of modern approaches to the treatment of mental disorders, in particular of borderline conditions (depression, anxiety, learning or development disorders etc.)?
- “...in part, general principles only...”
- “...in part, need more reading...”
- “...cursory, just a few modern approaches...”
- “...I am conversant in diagnostic and treatment methods, but not enough...”
- “...yes, from the retraining courses...”

“...not quite...”
“...no, none...”

Absolutely negative answers accounted for approximately 5% of all.

II. Block of questions on the knowledge about MH and training needs in this area.

1. What are the commonest MH issues you are facing today in your practice?

“...depressions...”
“...depression, learning disorders...”
“...depressions, cognitive disorders, asthenoneurotic syndrome, asthenodepressive syndrome, phobias, insomnias...”
“...organic disorders, depressions...”
“...depression, neurosis...”
“...depression, anxiety...”
“...behavior changes of patients with mental disorders...”
“...depression, mental retardation...”
“...anxiety, fear, phobias, depression, neuroses, insomnia, alcohol or nicotine addictions...”

Depression was cited as the commonest condition currently.

2. Which one of those are the most challenging to detect or none?

“...a patient does not want to understand his/her own status, or does not want to acknowledge one’s status...”
“...all...”
“...all are problematic...”
“...organic disorders...”
“...delirium tremens, psychosis...”
“...depression...”
“...hypochondria, psychosomatic disorders, addictions...”

“All” was the commonest of all answers to this question.

3. Do you need additional information about MH issues and how would you like to get it?

“...yes, we need it; trainings would be good...”
“...yes...”
“...we need additional information, which could be delivered through round tables, retraining courses, pamphlets, dedicated webpage...”
“...yes, by any means available...”
“...we need straightforward and useful information...”
“...yes, lectures, workshops...”
“...yes, seminars, trainings, conferences; referral guidelines; national clinical protocols...”

All answers to this question were affirmative, with different details.

4. What are the data sources that should provide information about MH issues?

“...diagnostic protocols, modules...”
“...Internet, textbooks, TV, in-service training...”
“...round tables, in-service training, pamphlets, webpages...”
“...Internet, books...”
“...literature, lectures, debates...”
“...lectures, workshops, books, curriculum...”
“...Internet, specialized literature, colleges...”
“...Internet (www.gov.ms.md, www.cns.gov.md etc.), national protocols and guidelines...”

Internet was cited as one of the most necessary and accessible sources.

III. Block of questions on the funding mechanisms for MH services in PHC.

1. Should some MH services be taken over by family doctors, how do you think one shall evaluate and pay for those?

“...have no clue...”

“...depending on the number of people with MH conditions enrolled with a family doctor and the quality of monitoring...”

“...per consultation...”

“...I am absolutely against it – having a family doctor deal with mental disorders would be too much...”

“...we don't want it...”

“...by topping up one's salary...”

“...per service...”

“...per visit...”

“...based on statistical reports...”

*As many as 5% of respondents stated that family doctors **do not want** to take up on responsibilities for MH conditions.*

2. What performance indicators or criteria you would suggest for MH service delivery?

“...number of patients...”

“...good treatment outcomes...”

“...quality-based criteria, payroll raise...”

“...number of patients...”

“...no worsening, lasting remissions...”

“...I'm sick and tired of indicators...”

“...quality-based criteria...”

“...number of patients referred to a specialized physician...”

3. What incentives would you suggest for family doctors providing MH services?

“...financial support...”

“...material support...”

“...want neither incentives nor any responsibility for MH problems...”

“...additional salary top-up...”

“...bonus...”

IV. Block of questions on intra- and cross-sector collaboration of family doctors on MH matters

1. What medical professional do you refer your patient with mental disorders to?

“...neurologist...”

“...psychiatrist...”

“...psychiatrist...”

“...psychiatrist, psychologist, neurologist, other (as appropriate)...”

“...psycho-neurologist...”

“...psychiatrist, psychologist...”

“...psychiatrist, neurologist, psychotherapist...”

2. How do you refer people with MH issues to other medical professionals?

“...write down a presumptive diagnosis, make an appointment...”

“...on an as-needed basis...”

“...referral with a patient chart, sometimes – in person...”

“...by issuing a referral slip...”

“...together with the patient...”

3. What are the healthcare, social and education facilities that you refer to whenever detecting a MH issue?

“...community mental health center (CMHC), outpatient clinic...”

“...MH centers, “house for all”...”

“...outpatient department, district hospital, social support...”

“...psychiatrist, outpatient department...”

“...CMHC, mayor’s office, social support...”

“...mayor’s office, social support...”

4. What is the referral procedure when you refer someone to the psychiatric hospital?

“...through the outpatient clinic...”

“...by using form 027/e”

“...we don’t do it...”

“...we cannot do it without the psychiatrist...”

“...referrals are done by specialized physicians...”

5. What are the biggest challenges in handling MH issues?

“...scarce knowledge in this area...”

“...family doctors do not pay due attention to MH issues; no proper follow-up is ensured...”

“...population is not being educated in mental health issues...”

“...people with mental health conditions do not admit they have some problems...”

“...so that they understand it and seek care...”

“...specialized medical professionals are not really dealing with such patient and ultimately the latter becomes the responsibility of the family doctor...”

“...encountered none before, as we have a Community Mental Health Center nearby...”

“...stigma against people with mental disorders...”

Chapter III

CONCLUSIONS

- It is quite obvious that most patients seeking care are willing to discuss about mental health issues with their family doctors, feeling more confident and free;
- Family doctors have limited access to a patient's mental health data and most of the times it is possible merely because of the close relationship between the family doctor and the psychiatrist from the outpatient department;
- Most family doctors believe they should prescribe medication for some mental health conditions, but could not define the list of drugs;
- Up to 95 per cent of family doctors participating in the focus groups claimed they were aware of modern approaches to fixing mental health issues, in particular borderline conditions;
- Some of the commonest mental health conditions that family doctors have been facing were phobias, anxiety, neuroses, and topping this ranking was depression;
- Family doctors have problems to identify most of the mental health issues;
- Family doctors stated they needed additional information and training – be it a workshop, training course, conference – but more importantly, national protocols;
- One may consider as source of information about mental health issues: special pamphlets, retraining courses and specialized webpages;
- Most family doctors said that the payment they get for the health services they provide shall be topped up with salary raises or per visit / consultation. Only 5% declined the invitation to deal with mental health issues;
- A performance indicator could be the number of patients with mental disorders seen by a family doctor and/or no frequent worsening of their condition;
- Family doctors refer patients with mental disorders to the following medical professionals: psychiatrist, psychologist, neurologist or psychoneurologist. The services they referred their patients to were: CMHC, social support, mayor's office, outpatient department;
- Most of the times only the psychiatrist is referring patients to a psychiatric hospital, with no involvement of family doctors;
- The key challenges in handling MH issues were cited: limited involvement of family doctors, information missing at community level, stigma.

Chapter IV

RECOMMENDATIONS

1. PHC professionals shall always follow up most patients with mental health issues seeking care;
2. PHC professionals shall be able to identify early signs and symptoms, thus contributing to better detection of mental disorders and prevent the occurrence of acute conditions;
3. Integration of mental health care into PHC shall be gradual - 2 diagnosis a year at most, based on the WHO guidelines¹;
4. MoH has to design national protocols for mental healthcare integrated into PHC. Such protocols are meant to define the limited area of interventions and responsibilities of the PHC team;
5. Advocate for an adequate training of PHC professionals;
6. PHC professionals shall be able to prescribe basic psychotropic medication;
7. Ensure collaboration and an operational referral system across sectors in matters of MH;
8. Accessibility of cost-efficient interventions for MH conditions (e.g., depression);
9. Provide PHC professionals with consultative support from psychiatrists and other MH related professionals.

Chapter V

Package of MH Services provided by PHC Physicians

I. Tasks that family doctors shall be vested with if integrating MH services into PHC:

1. Identification of MH issues;
2. Basic treatment delivery;
3. Referral of patients to MH professionals if opposing to treatment;
4. Psycho-education of family and community;
5. Prevention of MH problems and MH advocacy.

II. Diagnoses that ought to be treated at the PHC level:

- Mild and moderate depression;
- Generalized anxiety disorders;
- Psychoses (crisis management and referral to MH professionals);
- Schizophrenia in remission (in particular, maintenance therapy);
- Somatoform disorders;
- Dementia;
- Childhood and adolescence development disorders;
- Sleep disorders.

III. Four groups of psychotropic medicines to be used within PHC:

1. Antipsychotics for psychotic disorders;
2. Antidepressants for affection, obsessive-compulsive and anxiety disorders;
3. Anxiolytics and tranquilizers for anxiety and sleep disorders;
4. Hypothyroid medication, including anticonvulsants and lithium drugs.

IV. Competences of family doctors if integrating MH services into PHC:

1. Diagnostics and treatment of MH conditions;
2. Counseling, support and psycho-education;
3. MH advocacy and prevention of MH issues.

¹ mhGAP Intervention Guide for mental, neurological and substance use disorders in non-specialized health settings, Version 1.0, 2010, WHO