

Integrating mental health into primary health care in Bangladesh: problems and prospects

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Introduction

Integrating specialised health services such as mental health services into primary health care (PHC) is one of the most fundamental health care recommendations of World Health Organization (WHO) [1]. Primary mental health care facilitates is central to the values and principles of the Alma Ata Declaration [2]. Providing mental health services in PHC involves diagnosing and treating people with mental disorders; putting in place strategies to prevent mental disorders and ensuring that PHC workers are able to apply key psychosocial and behavioural science skills like interviewing, counselling and interpersonal skills in their day to day work in order to improve overall health outcomes [3]. Integrated primary mental health services are usually complemented with tertiary and secondary level mental health services like general hospital services to manage acute episodes of mental illness, half way home, community residential facilities and so forth. However, despite relevant need for primary mental health care services, Bangladesh is yet to holistically integrate mental health into its primary health care system.

The burden of mental health disorders in Bangladesh is yet to be measured precisely as done in the developed countries. A recent systemic review reported the prevalence of mental disorders is to vary from 6.5 to 31.0% among adults and 3.4 to 22.9% among children in the country [4]. Mental health services are concentrated around tertiary care hospitals in big cities and there is little awareness regarding mental health disorders at the community level [4]. A substantial percentage of people suffering from mental health disorders report to a range of traditional health care providers like kabiraj, totka, faith healers (pirs and fakirs), homeopathic practitioners, rural medical practitioners (village doctors), community health workers and retail medicine sellers as their first point of contact for health care [5-8]. Uddin et al., found among 21 clozapine treated patients that, about 52% (11) of the respondents contacted first time the traditional healers, 14% contacted general physicians and only one in three patients consulted the psychiatrist [6]. Arafat *et al.*, found in 120 schizophrenic patients that for their illness about 59% patients the traditional healers, 27% consulted general physicians, and only 14% consulted psychiatrist as first line service provider [7]. Bithika Mali studied 120 respondents with suicidal ideation in a tertiary care hospital of Dhaka city where she found that about 43% of the respondents visited traditional healers, about 23% visited the general physicians (GPs) and about 34% visited psychiatrist as first line service provider [8]. Such repeated evidences suggest that more than two-third of patients are visiting other than the mental health professionals [6-8]. Moreover, health literacy in poor in Bangladesh that further complicates to get proper health services

[9,10]. Previous study revealed that up to 83% of committed suicides have had contacts with primary care physicians within a year and two third of them within a month [11]. A meta-analysis of studies regarding general practitioners' ability to recognize mild depression showed a detection sensitivity of only 56.5% [12]. However, there is cost-effective treatment for depression and timely screening, treatment and follow up can reduce morbidity and mortality associated with depression [13]. Depression is a significant cause of suicide and recent evidences suggest that the use of antidepressants in the primary care level accelerates suicide reduction [11]. Addressing, screening, treatment and follow up of the depressed patients in PHC is a very important strategy to reduce suicide [11,14,15]. Treating mood disorders is a central approach of suicide prevention and primary care can be a very potential area for the same. Improved and regular screening of depressed patients with better treatment subsequently should be ensured in the primary care level [11]. In Iran there was a reduction in the rate of suicide completion in the intervention region compared to the control site where many programs were attempted to improve the knowledge and skills of GPs in regard to the screening, detection, and management of depression, and some methods were appeared more effective than others [16].

Bangladesh is a densely populated country having population density 1063 per square kilometer and total population is about 160 million [17]. Health sector is advancing dramatically with its existing manpower significantly empowering the primary health care [17]. However, the referral system between the care levels is very poor in Bangladesh [17]. Hence, to provide the better mental health coverage and services integration of mental health support with PHC is somewhat obligatory. There are options of general physicians training in assessing, planning and prescribing the common mental health problems but they are insufficient in frequency and quantity due to different factors such as fund problem [18]. Furthermore, motivations and enthusiasm in training provisions of GPs seem to be inadequate. Human, logistic and financial resources for mental health in terms of psychiatrists, psychologists, psychiatric nurses, social workers, occupational therapists, hospital bed, community services allocation and budget for mental health are extremely poor [19].

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As the burden of mental disorders in Bangladesh is high and the benefits of integrating mental health in primary care are enormous in terms of reducing disease burden, treatment gap and cost burden for individuals and families, promoting respect for human rights and overall good health outcomes [20]. Adequate training during undergraduate education, refresher training and continued medical education in mental health for primary care physicians is crucial for identifying individuals with mental health disorders in primary care [21]. Considering the scarcity of human resources for health and that a majority of the people access informal providers in Bangladesh, training the traditional healers under the formal umbrella subject to required rules and regulations may be explored. Utilizing the informal sector may not only reduce load on the existing human resource crisis but facilitate in reducing stigma associated with mental health disorders [22]. Feasible collaboration and communication with the secondary and tertiary level specialist services using modern technology cannot be underestimated [23]. The primary care focused mental health care and general practice focusing on screening, detection, treatment, referral and follow up of the depression and other mental disorder can play as the most effective way of covering the majority of the mental health patients at community level [11]. Tele psychiatric approach such as video conferencing, teleconferencing consulting methods can be used to support the primary care services [11,24]. Furthermore, extensive research can pave pathways to what works and what does not.

Bangladesh has demonstrated good leadership and capacity in successfully integrating specialized health services like maternal and child health in PHC followed by significant reduction in maternal and under-5 child mortality rates to targets set by the Millennium Development Goal (MDG) [17,25,26]. Similar commitment and leadership is likely to facilitate integration of mental health in the PHC system in Bangladesh.

Conflict

None

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