World mental health report

Transforming mental health for all

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7.2 Mental health integrated in health services

Integrating mental health into general health services is a crucial ingredient of mental health reform *(473)*. Integrated care helps to increase access and reduce stigma. It means physical and mental health problems can often be treated simultaneously. It also makes mental health services much more accessible, because general health services are usually closer to where people live. Therefore, integration advances UHC.

Integrating mental health into general health care has been an agreed policy objective since the 1970s *(474)*. It can be implemented in different ways, at different levels and through different services *(475, 476)*.

In the sections that follow we explore how strategies for integrating mental health care can and have been used in multiple settings, including primary care, specific health programmes, and general hospitals.

7.2.1 Mental health in primary care

At primary levels of care, appropriate actions for mental health are listed in WHO's UHC Compendium (see section 5.1.3 Evidence to inform policy and practice) and operationalized through WHO's mhGAP programme *(306)*.

In practice, these interventions can be made available within primary care by expanding the mental health workforce in one of two main ways:

- building the capacity of general health care staff in primary care settings to identify, assess and manage mental health conditions, including in children, adolescents, adults and older adults (see Combining responsibilities for physical and mental health in primary care); or
- developing and embedding mental health care providers into primary care settings (see Adding staff to primary care).

In both cases, collaboration between mental and general health care providers can vary in intensity – from operating independently and simply referring people from one service to another through to working as part of the same team to deliver care at one site, using one treatment or care plan *(477)*.

Integrated care is feasible, affordable and cost–effective.

For most common conditions, integrated care by primary care staff trained in mental health has been shown to deliver better health outcomes compared with usual primary health care (read Amira's experience) (*296*). It is also feasible, affordable and cost–effective, including in LMICs *(478)*.

But integration is not without difficulty. Some of the most frequently reported barriers include *(479, 258)*:

- stigmatizing attitudes of health workers and the public towards mental health;
- inadequate training and supervision of health workers;
- high workloads among primary care staff;
- low mental health awareness in the community;
- health workers' low interest and motivation for change;
- lack or inconsistent availability of essential psychotropic medicines ;
- disjointed management and leadership for mental and physical health care; and
- limited and inequitable funding.

NARRATIVE

Join us as we spark a renaissance in mental health

Amira's experience

My experience with postpartum depression was severe and painful. Like any mother, I waited impatiently for my first child. But instead of being happy to hold him to my chest, I found myself drowning in sadness, isolation and aversion. At that time the term "mental health" was not used much in Jordan.

I suffered for a long time. My depression became chronic because of my ignorance and the ignorance of those around me. I was exhausted by the psychological pain and made multiple suicide attempts.

I thought the solution to my suffering might lie in psychotherapy. But I was worried about being stigmatized. I decided to visit a private mental health clinic and I wore the niqab, so that no one who knew me would see me. Here I found another type of suffering: high prices and harassment. I couldn't afford the care I needed and experienced relapses and setbacks. Eventually I decided to go a government mental health clinic but even here there were violations of human rights. We were all suffering but no one dared to speak. Recovery was slow.

Then God's mercy descended, my country committed to improving mental health, and mental health care was integrated into a local clinic. I was one of the first people to get it. A multi-speciality team gave me psychological treatment and community rehabilitation to support me to become an active member of the community.

The clinic specialists believed in our abilities and we were invited by WHO to a workshop on human rights. I was surprised and honoured to get to know a group of people with psychological disabilities like me who were terrorized and stigmatized by society. We decided to establish an association, Our Step, to support the rights of people with mental health issues to be included in the community. Our cause is beginning to see the light of day. We actively participated in the production of Jordan's first national mental health strategy in 11 years.

I have spent more than 15 years advocating and raising awareness of the issues affecting people with mental health conditions. I am very happy to have represented them for the first time on the Board of Trustees of the Supreme Council for the Rights of Persons with Disabilities, after working to amend the Law on the Rights of Persons with Disabilities in keeping with the CRPD, which was ratified by Jordan in 2008.

We have achieved a lot, but much remains to be done to realize the full rights of people with mental health conditions. Don't hesitate. Join us as we spark a renaissance in mental health.

Amira Ali Al-Jamal, Jordan

Heavy workloads can be particularly difficult obstacles to overcome. Primary care workers are often overburdened even before integrating mental health care – which can be relatively time-intensive – into their schedules.

Combining responsibilities for physical and mental health in primary care

The first and most common way of integrating mental health into primary care involves training primary care medical staff in mental health care, so that they can combine their usual physical health care with caring for mental health conditions (see Box 7.8 Integrated primary mental health care in the Islamic Republic of Iran).

Primary care staff need to develop competencies for mental health care through pre-service training, in-service training or both (see section 5.4.2 Strengthening general health care providers' competencies). Even once they are trained, these non-specialists need to be supported by specialist services, whether in general hospitals or through community mental health services, for consultation, quality improvement and, if needed, referrals. In countries where specialists are few in number and widely dispersed, digital technologies can be particularly important for supportive supervision and mentoring.

CASE STUDY

BOX 7.8

Integrated primary mental health care in the Islamic Republic of Iran

For decades, the Islamic Republic of Iran has progressively integrated mental health care into its primary health care system. Starting in 1989, community health workers (locally known as "behvarzes") were given mental health responsibilities, including active case-finding and referral. General practitioners were trained and supported to provide mental health care as part of their general health responsibilities, referring people with complex problems to psychiatrists and other mental health specialists at district or provincial health centers.

This model worked well in rural areas but was less successful in urban areas, especially in the suburbs of large cities, where health infrastructure and human resources were severely lacking. In 2014, a new framework for integration was adopted specifically focused on overcoming the challenge in marginal urban areas. The new model established two new types of mental health service providers to work alongside general practitioners.

- "Moragheb-e salamat" serve as multipurpose community health workers. They are the urban counterpart to the established behvarzes and have similar mental health responsibilities.
- Psychologists with a master's degree in clinical psychology provide mental health services at urban health centers. They are responsible for educating the public for primary prevention, providing psychoeducation to people with mental health conditions and their families, delivering brief psychological interventions and telephone follow-up for those in need, and referring people to social services where relevant.

Evaluations of the new model show it has expanded availability and access to mental health care in marginal urban areas.

Sources: Ahmed Hajebi, Director of Mental Health and Substance Use, Ministry of Health and Medical Education, Islamic Republic of Iran, personal communication, April 2022; Smith, 2020 *(480)*.

Integrated care by non-specialists forms the basis for WHO's mhGAP roll out, which is being implemented to strengthen skills and scale up mental health care for priority conditions among young people, adults and older adults in non-specialist settings all over the world (see section 5.4.2 Strengthening general health care providers' competencies) *(305)*. Studies show the initiative improves knowledge, attitudes and confidence among primary care providers after training; and leads to improved symptoms and engagement with care for people living with mental health conditions *(308)*. It has also been shown to help reduce the treatment gap and increase effective coverage for priority mental health conditions (see Box 7.9 mhGAP in Nepal: closing the treatment gap).

While mhGAP is most often used to scale up mental health care for the general population, it can also be used for specific groups, such as refugees (see Box 7.10 mhGAP in Türkiye: scaling up services for refugees) or youth. For example, in the Islamic Republic of Iran, the mhGAP-IG is being used to

strengthen the skills and confidence of family doctors in child and adolescent mental health so that they can treat priority conditions themselves, rather than refer them to specialist centres.

A humanitarian version of the mhGAP-IG (mhGAP-HIG) also exists and is used widely by international nongovernmental organizations responding to humanitarian emergencies *(481)*. For example, it has been used to scale up mental health care in the fragile and conflict-affected context of Libya *(482)*. Here, the Ministry of Health, WHO, International Rescue Committee, International Medical Corps and other partners worked together to adapt mhGAP-HIG materials for the local context, engaging stakeholders early on to raise awareness and support for the programme. Non-specialist health workers from 20 primary care facilities received the mhGAP-HIG training; and local psychologists and psychiatrists were also trained in mhGAP supervision and administration to make the programme more sustainable. Once training was completed, mobile units were dispatched and began rotating to fill gaps across various municipalities where services were limited or non-existent.

CASE STUDY

BOX 7.9

mhGAP in Nepal: closing the treatment gap

In Nepal, mhGAP was implemented as part of a comprehensive mental health care plan in Chitwan district. Non-specialists in primary care facilities were trained and supervised to detect, diagnose and begin treatment for priority mental health conditions using the mhGAP-IG. Other strategies in the Chitwan package included awareness raising, active case-finding in the community; evidence-based lay counselling in the community; and strengthening referral, medicine supplies and monitoring mechanisms within services, among other things.

The plan effectively boosted mental health care capacities and increased treatment coverage. After implementing the district plan, the percentage of people in the community receiving treatment increased from 3% to 53% for psychosis, 0% to 12% for depression, 1% to 12% for epilepsy, and 0% to 8% for alcohol use disorder.

The interventions in the Chitwan plan had results. A year after starting treatment, people with depression, alcohol use disorder and psychosis showed improvements in symptoms and daily functioning. Improvements among depressed people were especially driven by the added value of psychological treatment from the community counsellors. For all conditions, combining demand- and supply-side interventions encouraged people to take up treatment and care.

Importantly, people living with mental health conditions, and their care-givers, perceived the primary care-based mental health services provided in Chitwan as accessible, acceptable and effective.

Sources: Jordans et al, 2019 (*265*); Luitel et al, 2020 (*483*).

CASE STUDY

BOX 7.10

mhGAP in Türkiye: scaling up care for refugees

In 2021, Türkiye was home to an estimated 3.7 million Syrian refugees living under temporary protection, which entitles them to free essential health care. Refugees are known to be at higher risk of mental health conditions. And yet they are often less likely to access care.

Back in 2016, Türkiye began using mhGAP to train Syrian and Turkish primary care providers to deliver essential mental health care through refugee health centres and community mental health services.

By 2021, nearly 2 600 doctors had been trained across the 29 (out of 81) provinces where large numbers of refugees live. That means around 8% of Turkish general practitioners working in primary care settings (2 100 people) and more than 50% of Syrian doctors (561 people) have now been trained using mhGAP.

Assessments indicate that more than 95% of the trainees found the training useful and beneficial. The training led to a statistically significant knowledge increase in Turkish and Syrian doctors; and participating doctors were also found to be more attentive to people's mental health needs, resulting in more people with mental health conditions being identified and treated. Most doctors were observed to comply with standards of care defined in training. And 96% of people who received services from the newly-trained doctors said they were satisfied with the quality of mental health care provided.

Source: Kahiloğulları et al, 2020 (*484*).

The programme has increased workforce capacity and confidence, and has strengthened referral pathways between community providers and health system facilities. It has also helped increase awareness of mental health's importance and has increased access to services for refugees and migrants. More than 1 000 people living with mental health conditions gained access to the services they needed through this initiative in 2020 alone.

Adding staff to primary care

The second way to integrate mental health in primary care is to embed mental health care providers in primary care settings. Depending on the context and resources available, these additional staff may be child or adult psychiatrists or psychologists, nurses trained in child or adult mental health, social workers, care managers, community workers or other community providers trained in mental health care.

These staff may work full-time in a single clinic (for example, when a care manager or a non-specialist counsellor is added) or they may divide their time across multiple clinics (for example, when a psychiatrist or psychiatric nurse runs fortnightly mental health clinics at different primary care facilities).

CASE STUDY

BOX 7.11

Sri Lanka: adding community workers for mental health to primary health care

In Sri Lanka, the need for and interest in mental health after the 2004 Indian Ocean tsunami led to the creation of a new category of community worker, called the community support officer. Closely connected to the primary health care system, and technically accountable to mental health staff in district hospitals, these community support officers supported thousands of people with mental health conditions living in the community. They were also responsible for a large proportion of referrals to the hospital-based psychiatric units, accounting for up to three-quarters of all referrals in some districts.

Although the programme was not sustained, an evaluation in 2010 showed that 128 community support officers in three districts were case-managing more than 1 500 people with mental health conditions in the community.

Source: Kakuma et al, 2011 *(298)*.

In addition to adding staff to primary care clinics, countries have added community workers to the health care system to better address mental health. Indeed, primary care facilities can extend their reach for mental health through networks of supervised lay workers in the community (see Box 7.11 Sri Lanka: adding community workers for mental health to primary health care).

Collaborative care

Collaborative care is one specific and well-studied example of the second approach to integration *(485)*. It is a multi-component model of integration with a large body of evidence – including from LMICs – strongly supporting its use in managing depression and other common mental health conditions *(17)*.

In collaborative care models, a health team shares tasks, with a care manager playing a central role and coordinating the care.

For example, in collaborative care for depression, people with depression typically:

- are identified with a validated depression measure (a task often done by the care manager);
- are linked with relevant resources in the community to address any social needs or determinants (also often done by the care manager);
- receive evidence-based psychological interventions (a task in LMICs often done by the care manager or, where available, by a non-specialist counsellor);
- are prescribed medication if indicated (a task done by a general medical care provider); and
- have their depression monitored over the course of their care. This is done by administering the same measure at the beginning of every visit, and recording the results in a simple registry that is regularly reviewed to inform changes to care. Changes potentially include stepping up the intensity of care and specialist referral.

As part of the team-based care, a mental health care specialist regularly advises and supervises the care manager and general medical care provider. In all cases, care plans are tailored to the person's needs and preferences.

Collaborative care has been applied in diverse programmes all over the world. This includes some programmes targeted at integrating depression care within care for specific physical health conditions such as diabetes *(486)*.

Most implementation of collaborative care has been done in high-income countries; but experience with collaborative care in LMICs is growing, including for psychosis *(442, 487)*.

In high- and low-resource settings alike, collaborative care ensures that key social, psychological and medical aspects of care are addressed in a holistic way. And it has been shown to be even more effective and cost–effective than routine integration of mental health in general health care *(488)*. But collaborative care requires additional resources (most notably the care manager's time), which has been a barrier to scale-up.

7.2.2 Mental health in specific health programmes

Integrating mental health in health programmes for specific physical diseases or populations has proven both feasible and cost–effective, improving both mental and physical health *(486, 489, 490)*. Providing care in the same place, by the same practitioner or treatment team and at the same time, greatly helps reduce the logistical challenges of receiving care through two or more systems and enables more holistic, person-centred care. Importantly, it can also help services reach vulnerable people with higher risk of mental health conditions.

Mental health in disease-specific services

People with comorbidities who are supported through integrated care models are more likely to have better health outcomes and to experience better quality of life, self-care and adherence to medical and mental health interventions *(476)*.

Global targets for HIV/AIDS in particular underscore the need to better integrate mental health and social care with HIV services, including those led by communities *(491)*. The opportunities for integration are plentiful – from services targeted at HIV prevention and testing to those for starting and managing treatment to services for viral suppression and care for people living with HIV *(166)*. Development agency guidance for TB care similarly recommends integrating mental health services within TB programmes, from training to treatment *(167)*.

There is plenty of evidence to show that integration, for example through task-sharing with lay health workers, can improve the mental health of people living with HIV; even in extremely remote and disadvantaged communities *(492)*. It can also improve the physical health of HIV-affected communities by reducing the risk and stigma of infection and boosting adherence to antiretroviral treatment.

Integrating mental health into HIV programmes has the potential to avoid nearly a million new infections by 2030.

Incorporating mental health care into TB programmes can be similarly beneficial. In Pakistan, for example, psychological counselling for people attending TB clinics with signs of depression and anxiety has been found to both reduce symptoms and improve TB treatment completion *(493)*.

Research suggests that integrating mental health into HIV programmes has the potential to reduce the rate of infection for HIV by 10–17%, avoiding possibly nearly a million new infections by 2030 *(494)*. For TB the research predicts an even greater decrease (13–20%) in infection rates, with the potential to avoid up to 14 million infections by 2030.

Beyond HIV and TB, there are many opportunities to integrate mental health into disease-specific care, including programmes for NCDs or NTDs *(174, 168)*.

In South Africa, an integrated chronic disease management model has been developed to increase systems efficiencies and cost–effectiveness, and deal with comorbidities *(495)*. The model is supported by Adult Primary Care, a clinical decision support tool that primary care providers can use to deliver comprehensive, quality clinical care to adults in every consultation. The model is innovative in that it enables care providers to treat all chronic conditions – both physical and mental – together. So, for example, rather than running separate clinics for diabetes, hypertension, HIV and mental health, the primary care facility uses routine consultations to provide chronic care for all these conditions at once. For people with comorbidities this approach makes care logistically easier; it also enables a more holistic and person-centred approach to their care.

Mental health in population-specific services

Just as mental health can be integrated into physical disease programmes, so too can it be integrated into health services for specific groups, including women, parents and caregivers, children, adolescents and older adults.

Programmes for women's health can offer a discrete way of providing not only reproductive health care but also mental health care to women affected by sexual violence, a highly potent risk factor for mental health conditions. Such programmes are quite often made available to populations affected by armed conflict and forced displacement.

Similarly, perinatal programmes offer a good platform for educating parents and other caregivers about mental health, screening them for mental health conditions, delivering basic therapies and proving peer support *(496)*.

Integrating mental health in perinatal programmes is especially important because maternal mental ill-health is common and impacts both mothers and infants (see section 6.3.2 Protecting and promoting child and adolescent mental health) *(497)*.

Maternal (and paternal) mental health conditions are treatable, including by trained non-specialists through maternal and infant health services *(498)*. For example, in Uganda, trained and supervised midwives screen pregnant women for perinatal depression in maternal care settings; and treat those screening positive with group-based problem-solving therapy given during scheduled antenatal visits. Studies show significant improvement in treated women's clinical and functional outcomes after six months *(499)*.

7.2.3 Mental health in general hospitals

However much mental health services are provided through primary health care, it is essential to have dedicated mental health services at secondary care level. Without these, investments in primary health care are unlikely to be sustainable *(258)*. Providing mental health in secondary care is a cornerstone for mental health reform.

> *Providing mental health in secondary care is a cornerstone for mental health reform.*

Secondary level services – which may employ both specialists and non-specialists – can be provided through general hospitals (as discussed in this section) or through a range of formal community mental health services (as discussed in section 7.3 Community mental health services).

General hospitals have a multifaceted role in the mental health system, which may include:

- **Outpatient care** to assess and manage people of all ages (including children and older adults) with complex, refractory and severe presentations that cannot be easily dealt with in primary health care.
- **Short-term inpatient care** for people experiencing acute episodes or mental health crises that may benefit from hospitalization. This may be through acute inpatient units or, when resources are very scarce, through psychiatry beds in general wards.
- **Support for non-specialists** in primary care through training, supportive supervision and mentoring.
- **Support for long-term care** of people with chronic mental health conditions living in the community in circumstances where community-based mental health services are unable to help sufficiently.
- **Liaison psychiatric care** for people hospitalized for physical health problems.
- **Mobile teams** to provide outreach or crisis services in the community.

General hospital-based mental health services are usually well accepted by the community. Those in urban centres in large districts may be hard to access for remote communities but they are much more accessible than, and preferable to, psychiatric institutions.

> *General hospital-based mental health services are more accessible than psychiatric institutions.*

Experience shows that it is possible to provide quality mental health care in general hospital settings and that this can complement other community-based mental health services (see Box 7.12 Dominican Republic: putting regional hospitals centre stage). In Brazil, for example, hospital-based services complement local community mental health centres by reserving a limited number of beds specifically for referrals, usually during a crisis situation or because of a comorbidity that requires both psychiatric and medical care. Only staff from the community mental health centre can ask for a bed, which prevents inappropriate use and unnecessary hospitalizations *(500)*.

In Brazil and beyond, countries have shown that hospital-based services can be delivered in a non-coercive way that respects a person's autonomy and treatment preferences and supports them towards recovery *(500)*.

CASE STUDY

BOX 7.12

Dominican Republic: putting regional hospitals centre stage

The Dominican Republic has been reforming its mental health care since 2014. Its mental health plan, which is backed by policy and legislation and overseen by the Ministry of Public Health, has long focused on closing the country's only psychiatric hospital while simultaneously building up a network of community-based services. These include clinical services and support embedded in general health facilities, alongside day centres and supported living services to support psychosocial rehabilitation.

Mental health units within general hospitals play a critical part in enabling the country's plans for mental health reform. These crisis intervention units were conceived to respond to the psychiatric hospital closure, initially for the capital metropolitan area and later expanding to the rest of the country. Today, these units cater for all people with mental health conditions that cannot be easily looked after in primary health care.

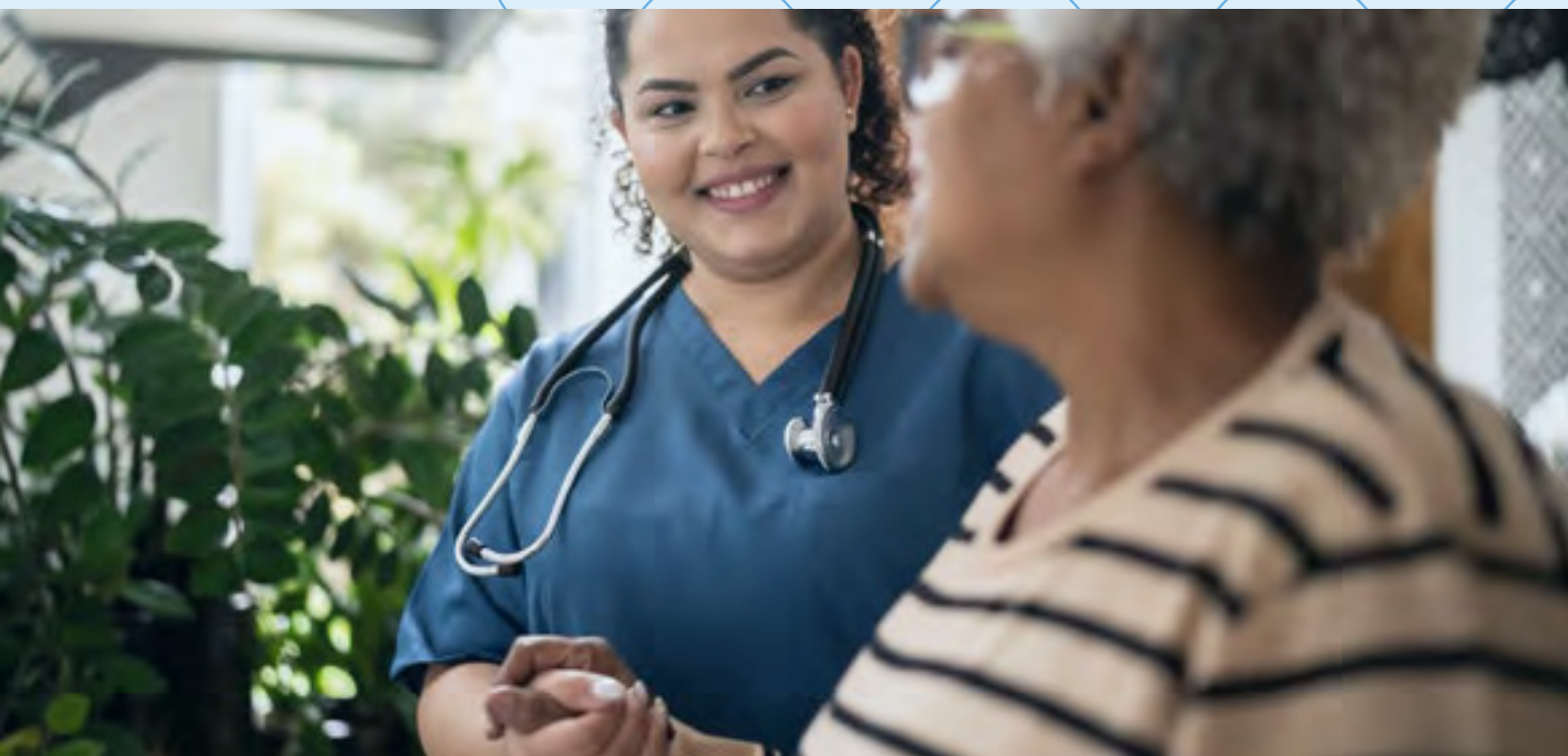
The hospital-based units provide:

- crisis services, including beds for short-term stays where needed;
- outpatient psychiatric and psychological care for people who have been discharged from hospital but not yet referred to outpatient services; and
- liaison psychiatry and health psychology with other hospital services.

The hospital-based mental health units are closely linked to both primary and tertiary care facilities, providing the lynchpin for a robust referral system that spans all three levels of care.

Since 2008, the number of mental health units in district hospitals has grown from 9 to 15, with the number of short-stay beds available similarly growing from 76 to 113. Overall, these units make up more than half (53%) of all public sector mental health beds available in the country, compared with 33% in 2008.

Sources: PAHO, personal communication, January 2022; Ministerio de Salud, 2019 *(501)*; WHO, 2021 *(454)*.



7.3 Community mental health services

Community mental health services such as general hospital services are part of the secondary care system and, compared with psychiatric institutions, generate better mental health outcomes *(426)*.

Community mental health services comprise a mix of services that provide clinical care and support, psychosocial rehabilitation and residential services, as described in the sections that follow.

They have a large role in providing outreach services to deliver care and support in people's homes or in public spaces; and to disseminate information about mental health and engage in mental health prevention and promotion.

7.3.1 Community mental health centres and teams

Clinical care and support for people with mental health conditions, including crisis and outreach services, are often provided through community mental health centres or teams, but can also be delivered through drop-in centres. In all cases, community mental health centres and teams may offer links with peer support services (see section 7.3.2 Peer support services).

Community mental health centres

In many countries, community mental health centres are the cornerstone of community-based care. These centres are typically staffed by multidisciplinary teams and need to be well connected with primary care facilities, local hospitals and with organizations beyond the health sector (see Box 7.13 Peru: comprehensive community-based mental health care).

CASE STUDY

BOX 7.13

Peru: comprehensive community-based mental health care

In 2013, Peru's Ministry of Health estimated mental health conditions were very prevalent but few people could access the care they needed. So began a series of reforms to enable mental health care for all. Following progressive legislation to add mental health care coverage to the national health insurance scheme and secure the rights of people with mental health conditions, health authorities have adopted a multi-pronged approach to establish comprehensive community-based care across the country (see Figure).

At the core of Peru's approach lies a network of community mental health centres that has grown ninefold from 2015 to 2021, stretching across every region. These centres are staffed by a multidisciplinary team and serve a population of around 100 000, providing mental health treatment and rehabilitation for adults, adolescents and children. Each one organizes community activities including mental health promotion and prevention initiatives. They also support primary health care providers with training and technical assistance.

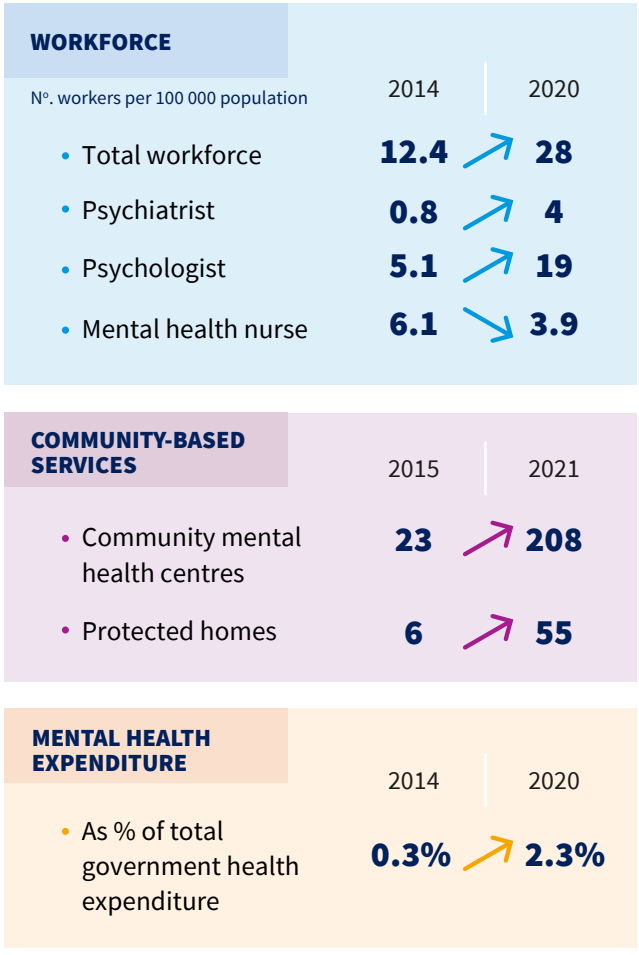
The community mental health centres are complemented by 30 specialized units in general hospitals and 55 protected homes (hogares protegidos) that provide accommodation and 24/7 care for people with relatively high support needs or weak family support systems, and for women who are victims of domestic violence. The specialized units in general hospitals offer short-term hospitalization only.

Together, the community mental health centres, protected homes and specialized units in general hospitals ensure that people who would otherwise end up in psychiatric hospitals can be cared for in their own communities. As such, these facilities play an important part in providing accessible and acceptable mental health care.

The Ministry of Health plans to continue expanding the network to ensure that comprehensive community-based mental health care is available to all.

FIGURE

Expanding mental health care in Peru, 2014–2020.



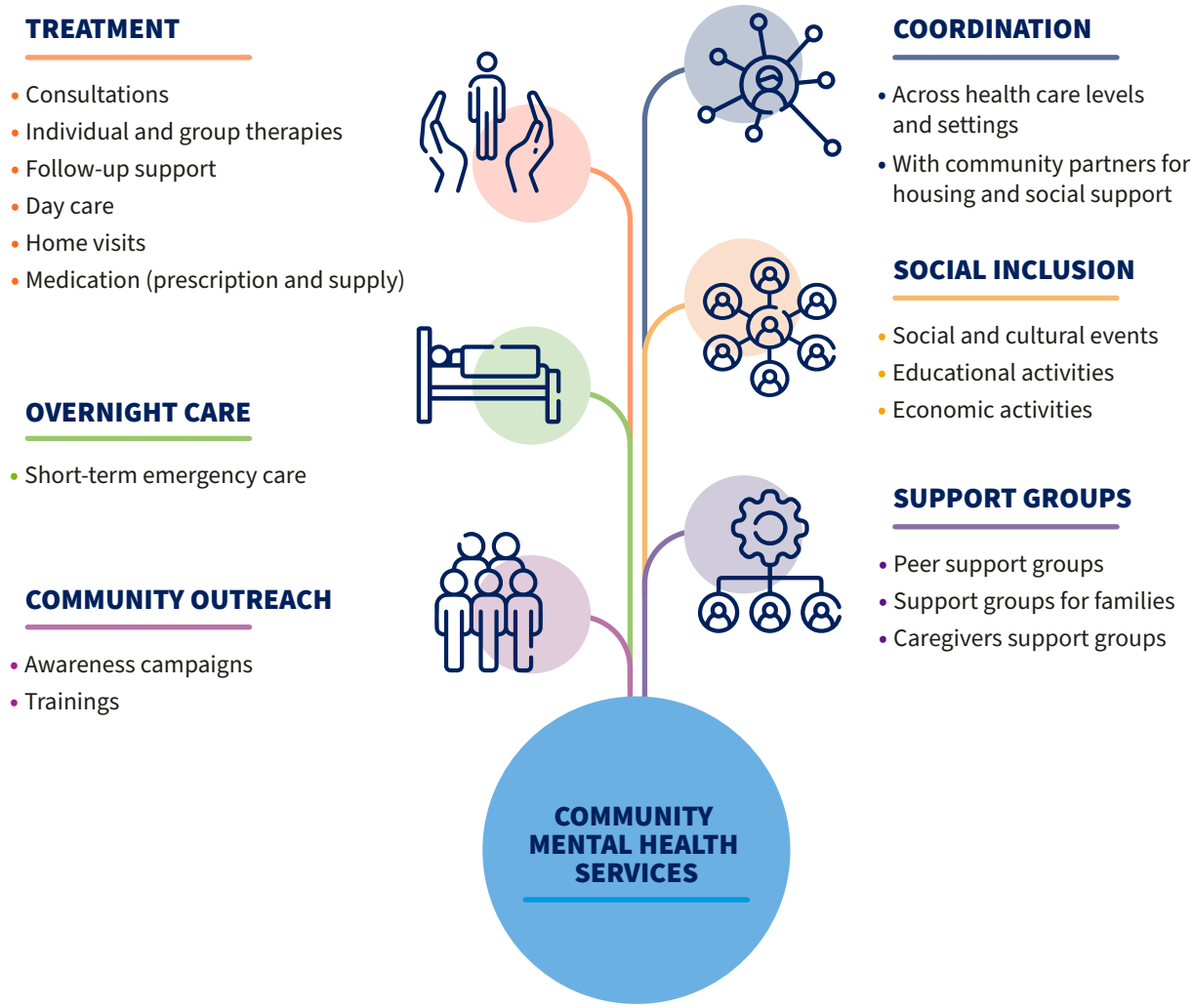
Source: Ministerio de Salud, 2021 *(502)*. Figure source: Mental health atlas, WHO, unpublished raw data, 2014 and 2020.

Community mental health centres may cater for a range of mental health conditions in adults, children and adolescents alike. They look different in different countries but often have a multi-faceted role in supporting people (see Fig. 7.4). In community mental health centres people usually receive services for acute episodes or relapses in functioning, and may be admitted for short periods. Individuals may also be admitted as part of respite care. Or they may attend the centre during the day for regular check-ups and to receive daytime medical or psychological care, or to take part in therapeutic groups and recovery programmes.

Often, community mental health centres also have spaces and activities to support participation in community life *(503)*. In Brazil, for example, each centre includes common areas for socializing, interacting and eating alongside individual counselling rooms and a group activities room. Some centres will also hold activities and events in the community using public spaces such as parks, community leisure centres and museums.

FIG. 7.4.

Examples of services that can be provided by community mental health centres



Community mental health teams

Some countries use community mental health teams to provide community clinical care and support. These teams may work across different facilities, such as general hospitals, primary care clinics or community health centres. There may be different teams for different age groups. They may provide clinical services in non-health settings such as prisons. And they may provide home-based care if it is needed.

Members of the community mental health team work together to support multiple needs of people living with mental health conditions. They fill the gap between care provided by generalists, as part of primary health care, and hospital care. They can support people to avoid hospitalization during periods of crisis.

Mental health teams can also be providers of specialized early interventions for people in a clinical high-risk state for psychosis, often blending home-based care with inputs from family and friends (see Box 7.14 Services for people with first-episode psychosis). Specialized early intervention in psychosis is becoming common practice in high-income countries. Experts suggest that these preventive interventions may be adapted for LMIC settings by incorporating the principles and therapeutic ingredients of early intervention into mental health services in LMICs *(504, 505)*.

Depending on resource availability, teams may be large and fully multisectoral, comprising a psychiatrist, psychologist, psychiatric nurse, social worker and occupational therapist, or they may be much smaller and made up of one or two mental health professionals that focus on specific services.

As a specialized and dedicated service, community mental health teams can fulfil various important functions within a community-based network of services. Some of the roles they have may include:

- training, supervising and supporting non-specialist primary health care providers;
- delivering clinical interventions for people who are experiencing conditions that are too complex to be cared for in primary care, but that do not necessarily require hospitalization; and
- carrying out preventive and promotive activities in their area.

In some countries, where primary health care is run by nurses who are not allowed to prescribe psychotropic medicines, an important function of community mental health teams may be to provide initial assessment and prescription services that can prevent hospital visits (see Box 7.15 Community mental health teams in Georgia).

CASE STUDY

BOX 7.14

Services for people with first-episode psychosis

Over the past three decades, evidence-based early psychosis prevention and intervention programmes for adolescents and young adults experiencing a first episode of psychosis have emerged. Starting in Australia, a range of early psychosis services have been launched in high-income countries worldwide. Such services are typically available 24 hours a day, seven days a week, with referrals from any source and a single telephone contact point.

The first phase of care involves a face-to-face assessment of the young person. The meeting is usually in the young person's home and includes inputs from family, friends and other supports to try to understand what is happening and what kind of support the young person needs.

A multidisciplinary team then provides intensive, home-based case management. Caring at the person's home means friends and family can help the young person as needed, with mental health professionals providing regular support.

Psychosocial interventions vary according to the person's needs. For example, as recovery progresses, counselling can help the young person learn practical ways to prevent further episodes, such as by managing stress and recognizing early warning signs. Treatment also involves working with the person to identify what is important to them in their recovery. This can mean returning to school, getting a job, finding accommodation, getting financial help, or making new friends. One-to-one counselling, group activities and activity-based therapies are used to help achieve these goals.

Although the focus is on community services, spending some time in hospital during an episode of psychosis before continuing with home-based treatment is sometimes part of the care. Overnight care is provided in a youth-friendly setting and in most instances is only short term.

Source: Orygen Youth Health, 2021 *(506)*.

Community mental health teams are usually mobile so that they can reach out to diverse facilities within an area. This generally takes some of the financial burden away from the user and so encourages people to engage in ongoing care.

This is particularly important in more rural areas where, for example, access to the local clinic may be relatively easy while access to the nearest hospital may be too difficult or costly to consider.

Services provided by community mental health teams are not necessarily available all day every day, which may be inconvenient to some people; although they can be provided on an appointment basis for regular, set days.

Having community mental health teams can substantially reduce the number of people needing hospital care, and putting resources into this level is often cost–effective and helps hospitals from being overwhelmed.

CASE STUDY

BOX 7.15

Community mental health teams in Georgia

In Georgia, community mental health teams provide specialized secondary level services designed to care for adults with severe mental health conditions close to where they live.

Each team accepts referrals from outpatient mental health centres, after a person has been diagnosed with a mental health condition, and if that person meets certain criteria (i.e. several past hospitalizations). The teams then provide a range of treatment and rehabilitation services.

Across the country there are 32 community mental health teams in operation, serving 28 locations. The teams work out of mobile clinics and provide mental health care to adults (aged 18 years or more) based on informed consent. People attend the mobile clinics to consult a psychiatrist, review and receive prescriptions for psychotropic medicines where appropriate, receive basic psychoeducation and access psychosocial support in solving social issues.

Georgia's community mental health teams are multidisciplinary in nature and comprise at least three specialists. One member of the team is a team leader who carries out overall supervision of the working process. A psychiatrist is a necessary member of the team while other team members may include social workers, psychologists, nurses or junior doctors.

From 2015 to 2022 the number of community mental health teams in Georgia increased from 3 in Tbilisi to 32 across different districts. As a whole, the network of community mental health teams includes 33 psychiatrists and 66 allied mental health practitioners working to provide community-based mental health care to Georgia's population of more than 3.7 million people.

This growth was made possible by the Health Ministry prioritizing community-based mental health care, including a twelve-fold increase in budget allocation for community mental health teams.

Sources: E Chkonia, G Geleishvili and N Makhashvili, Georgia, personal communications, 2021–2022.

Often one member of the team will take on the role of care coordinator or case manager, working with individuals to codevelop care plans.

The teams can boost people's uptake of, and satisfaction with, mental health services. They increase continuity and flexibility of care. And people cared for by the teams are significantly less likely to be admitted to hospital or to use social services than people accessing standard mental health care *(507)*.