Report

Integration of mental health into primary care in Al-Qassim Region, Saudi Arabia: planning phase I

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Introduction

The World Health Organization (WHO) has defined health as "a state of complete physical, mental and social well-being and not merely the absence of disease or infirmity". "Health for All by the Year 2000" was the slogan raised by the Alma Ata Declaration, 1978 and mental health was considered an important component of primary health care because, as with physical diseases, many psychological problems and disorders are preventable.

It has been reported that approximately 30% to 40% of primary health care (PHC) patients present with some form of psychological problem of variable severity [*1*]. Almost one-third of them have purely psychiatric complaints [*2*]. In another study, it was found that about 15% of PHC patients suffer from current anxiety or depressive disorders [*3*]. Such disorders are associated with substantial disability and functional impairment [*4*], and chronicity or incomplete recovery [*5*], which result in higher health-care costs [*6*]. Moreover, a strong association has been found between psychiatric disorders and the use of general medical services [*7*] and certainly patients with chronic depressive illness overuse these services [*8*]. This happens because the symptoms of depression are often unrecognized, dismissed but not diagnosed and are left untreated by general practitioners (GPs) [*9*]. About 5% of PHC attendees with psychological disorders suffer from major psychotic disorders and are referred for psychiatric consultation [*10*].

For a variety of reasons, psychological symptoms are often accompanied and masked by somatic symptoms, a leading cause for misdiagnosis. It has been reported that roughly 30% of PHC patients [*11*] and 40% of general hospital patients [*12*] have somatic symptoms, while an epidemiological-based study found the prevalence of chronic somatization disorder to be between 0.38% and 4.4% depending on the criteria for "caseness" [*13*]. Furthermore, it was shown that GPs tend to underdiagnose mental disorders and a substantial number of such cases (ranging from about 50% to 80%) are missed by them [*13*]. They also tend to use polypharmacy and inadequately prescribe various psychotropic drugs to these patients, which unneces-

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sarily prolongs the treament course [*14*]. Moreover, these medications are often associated with unwanted adverse effects, poor compliance and a greater risk of dependence, in particular benzodiazepines. In order to avoid drug-related problems, psychological treatments, i.e. counselling [*10,15*], cognitive therapy [*16*] and behavioural therapy [*17*] have been prescribed in PHC practice.

It should be stressed that as a result of tremendous advances in PHC psychiatry in industrialized countries, the epidemiological data are constantly changing. Most importantly, GPs act as the primary filter between the community and specialized medical care. Moreover, because of their special place and role in community care they must have relevant and adequate skills in order to detect, manage and prevent mental health problems. Unfortunately, GPs frequently lack the skills needed to deal with mental health problems [*18*] and more often they are unaware of the presence of psychosocial problems among PHC attendees. The clinical interviewing skills of the physicians (which can be improved by training) and their ability to identify emotional disorders are related [*19*]. These findings were supported by a recent study which concluded that PHC physicians should be trained in specific interviewing skills in order to improve their ability to identify mental disorders in their practices [*20*]. By and large, they appear to feel that the recognition, diagnosis and management of mental health problems are not their clinical responsibilities.

In contrast to the well developed and researched PHC psychiatry in industrialized countries, there are few reports from developing countries, and there are almost no provisions for delivering mental health services at primary health care centres. In a prospective study of new patients (n = 96) referred by GPs to a psychiatric clinic based in a PHC setting, the authors found that neurotic disorders, including neurotic depression (38%), anxiety disorders (10%) and anxiety–depressive state (21%) were the commonest psychiatric disorders identified [*21–23*]. In Saudi Arabia, it has been observed that a large proportion of patients, i.e. about 47% presented with clinically significant psychiatric disorders [*24–27*]. Taken together, it is thought that the psychiatric problems at PHC centres are of considerable magnitude but they generally remain unidentified and untreated, and are associated with increased medical costs. Therefore, an innovative health project was planned in July 1995. Our paper highlights the steps taken in the planning phase of this project.

Rationale and justification of the project

1. In line with the WHO declaration, mental health was decisively considered to be an element of primary health care in Al-Qassim Region.
2. Al-Qassim Region would be perceived as a pioneer among other regions in Saudi Arabia. Furthermore, the project would undoubtedly be of considerable benefit to other regions of Saudi Arabia. It was felt that this pilot project would help achieve several objectives related to primary care psychiatry. In general, there is a lack of awareness of psychiatry among PHC physicians in the country. In one related study it was revealed that the knowledge, attitude and skills of GPs in the field of psychiatry were insufficient [*18*]. It was also found that the psychiatric knowledge and inter-

viewing skills of physicians increased when they were given 1-week extensive psychiatric training. Although their psychiatric skills were evaluated at the time of the study, the enhanced knowledge tended to persist on a long-term basis. Thus it was assumed that condensed psychiatric training of PHC physicians would enhance both their knowledge and their awareness of psychiatry.

3. The project would bring about recognition of the fact that prevention of a disease is much better than cure. Some psychiatric disorders are as preventable as physical illnesses. So early and timely detection of vulnerable groups of people and proper intervention and management will lead to a reduction in the development of full-blown psychiatric disorders and consequently chronic psychiatric problems in the community will be minimized.
4. The project would bring about recognition of the fact that psychological stresses are often presented as somatic complaints to the GPs at PHC centres. As mentioned earlier, this "somatic language" in the absence of organic pathology is the chief cause for misdiagnosis at PHC centres. At the PHC level, approximately 80% of acute and chronic psychiatric problems enmeshed in the "somatization web" are undetected and missed. The patients are in fact extensively investigated and treated as having physical diseases. Some of them are merely dismissed and they live with these somatic preoccupations, which cause chronic disability and poor quality of life.
5. Health education and research at the PHC level would be promoted.
6. The delivery of mental health services at PHC centres would decentralize the mental health services, which are curently mainly available at hospital and research centre levels.
7. The project would "deprofessionalize" the delivery of mental health services.
8. Psychiatric training of PHC physicians and paramedical staff would be a cost-effective venture. It has been found that about 40% of PHC attendees showed psychiatric morbidity, and if they were detected and managed properly, the health care resources would be utilized proportionately and patients would gain tremendous satisfaction.
9. The project would be the most innovative of its kind as no other region in Saudi Arabia has conducted such a comprehensive psychiatric training programme in order to integrate mental health into PHC services.

Aims and objectives

The primary aim of the project was to promote and integrate mental health into primary health care by training all physicians and paramedical staff, including all nurses, social workers, health educators and some administrators working at PHC centres in Al-Qassim Region. The training programme included a 4-week condensed course encompassing clinical as well as community psychiatry. To achieve these aims, the following objectives were set forth:

- to increase the awareness of the targeted groups (PHC physicians, nurses, health educators, administrators) of psychiatric problems;
- to improve the knowledge of the targeted groups of community psychiatry, which essentially deals with the preven-

tive aspects of psychiatry and also the delivery of mental heath services at various community levels;

- to improve psychiatric clinical and interviewing skills of the targeted groups;
- to modify the attitudes of GPs and the health team at PHC centres toward psychiatry, mental patients and psychiatric hospitals;
- to improve the ability of GPs to manage the uncomplicated cases of psychological problems;
- to improve the ability of GPs to identify patients who require referral to the secondary and tertiary psychiatric care facilities;
- to promote relevant research and training related to community psychiatry.

Target groups for training

The PHC team comprises physicians, nurses, social workers, health educators and selected administrators. This team screens PHC patients and also provides medical and administrative services to them. Therefore, the planners of this continuing project decided to give basic psychiatric training to all members of the PHC team affiliated to the various PHC centres of Al-Qassim Region.

Project strategy

The planners of the project divided it into four stages:

I training of all PHC physicians;

II training of all nurses;

III training of all social workers, health educators and selected administrators at PHC centres;

IV monitoring and evaluation.

Stages I to III will have specific curricula and training programmes designed according to the trainees' allocated tasks and jobs. Special training courses will be offered to male Saudi staff nurses. The language of instruction and communication for PHC GPs will be English. Arabic-speaking nurses will have their training courses in Arabic and non-Arabic-speaking nurses will have theirs in English.

Duration of the project

The total expected duration of the project is 4 years. This time limit is intended to cover the following stages:

I Training of all PHC physicians within 1½ years. They will be divided into 10 groups for training purposes and each group will include approximately 25–30 GPs. The duration of each training course is expected to be 4 weeks. A period of 1 week between each course will be allotted for the preparation of the next training course. The training course will consist of a relevant and suitable curriculum designed by experts and consultants. The coverage of PHC centres by GPs in place of those under training, and other unforeseen events at the centres, will be properly managed.

II Training of all PHC nursing staff within 1 year. All PHC nurses will be divided into 20 groups and each group will have 35–40 nurses. The duration of each course is expected to be 1 week. The relevant and appropriate curriculum will be designed for them.

III Training of all PHC social workers and some administrators within 6 months. Social workers, health educators and administrators will be divided into 10 groups and each group will include 35–

40 persons who will have an orientation course for 3 days and they will have a specific but simple curriculum designed by experts.

IV Monitoring and evaluation which will last for 1 year. The simultaneous monitoring will bring about immediate changes and modifications in the curriculum or ways of delivering the messages to the trainees. This stage will include the design of special forms for course piloting, and initial, middle and summative evaluation. Follow-up evaluations will be carried out at multiple points within a year of the end of the course, i.e. immediately after training, after 6 months and then at 1 year.

Place of training and budgeting of the project

The following places are proposed for this training project:

- King Fahad Specialist Hospital Auditorium
- Buraidah Mental Health Hospital
- Continuous Medical Education and Community Services Centre PHC, Buraidah
- PHC Training Centre, Unaizah
- PHC Training Centre, Al-Rass.

The budget is expected to cover the following items:

- manpower
- stationery equipment
- logistics.

These training centres are equipped with modern audiovisual aids and other facilities required for training.

Comment

The integration of mental health into PHC is a timely project which will de-emphasize and decentralize the mental health professional services. It will also substantially support the concept of community psychiatry and, as a consequence, that mental health services could be delivered at PHC centres. The psychological problems seen in patients at PHC centres are generally of the type that could be well managed at the centres by GPs who have received sufficient psychiatric training. Hence, this pilot project has well defined underlying concepts with specific objectives and aims as well as target groups for psychiatric training.

The psychiatric training will provide the target groups with the basic clinical skills to: conduct a comprehensive interview; collect and analyse data; identify psychiatric symptoms and signs in order to recognize the psychiatric illness; formulate the case with the best possible diagnosis; manage the case at the PHC centre; and finally refer difficult cases to higher mental health institutions. This training will also underline the basic concepts of research needed at PHC centres.

The elected training techniques, including formal lectures by psychiatric consultants, demonstrations with extensive discussion of clinical cases, interactive workshops and role-playing will help achieve all the objectives. The training programme, supported by a scientifically designed curriculum, will put particular emphasis on the active participation of the target groups. The methods of designing an appropriate curriculum and the implementation and evaluation of the project will be described in subsequent papers. It is a continuing project so various aspects, such as

methods of delivering lectures and curriculum, are likely to be modified according to the feedback from the target groups.

Summary and conclusions

This pilot project indeed aims to fulfil an important commitment by the relevant authorities that mental health should be one of the components of the PHC services. The magnitude of mental morbidity among PHC clients is well documented and researched. If this proposed project succeeds in achieving its specific aims and objectives, Al-Qassim Region will be the pioneer in the promotion and integration of mental health into primary health care in Saudi Arabia.

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