

## Article

# Mental health and primary health care

Norman Sartorius MD PhD FRCPsych

President, Association for the Improvement of Mental Health Programmes, Geneva, Switzerland

Thirty years ago the Ministerial Conference in Alma Ata reached consensus on principles that should govern the organisation and functioning of primary health care.<sup>1</sup> The promotion of mental health is listed among the essential elements of primary health care in the report of the Alma Ata Conference, but found no place in the text of the Alma Ata Declaration. This difference – which gave many of those responsible for mental health programme a considerable disadvantage in the search for funds – is the consequence of the fact that, immediately after the government representatives in Alma Ata had accepted the text of the declaration by acclamation, a representative of the Government of Panama objected to the fact that mental health was not mentioned in the declaration, although it was seen as worthy of inclusion among essential elements of care earlier in the course of the conference. The declaration had already been adopted: to change it would have required another session, and time on the last day of the conference was short. So, the World Health Organization's representative in the secretariat of the conference proposed to include the promotion of mental health in the report of the conference without changing the text of the declaration that had just been adopted. This was accepted and thus the matter was closed.

Promotion of mental health can mean several things.<sup>2</sup> The simplest interpretation is that the promotion of mental health equals the reduction of numbers of people with mental illness in a community. A more comprehensive interpretation considers that the promotion of mental health should include the prevention and treatment of mental illness as well as the enhancement of the coping capacity of individuals and communities. The latter is close to the notion of reaching 'positive' mental health, a vague concept defined in a great variety of ways. A still more comprehensive view could be that the promotion of mental health has to do with the elevation of mental health on the scale of values of individuals and communities.

For the drafters of the primary healthcare documents in Alma Ata it was possible to include 'positive'

mental health into the report because, although vague, the requirement was harmonious with the general spirit of the definition of the contents of primary health care (similar, for example, to the protection of mothers and children). The treatment of mental illness was not a worthy task in their eyes – nor in the eyes of the majority of decision makers in the field of health – because they did not consider mental disorders as a major public health problem (although these disorders satisfied all the criteria for a problem of major public health importance; see Box 1).<sup>3</sup> Mental health decision makers and many of the leaders in the field of mental health, however, interpreted the 'promotion of mental health' among the essential elements of primary health care as being an invitation to deal with mental disorders at the level of primary contact between community members and the health service.

### **Box 1** Definition of a major public health problem

The criteria for the designation of a disease as a major public health problem are high prevalence, severe consequences if left untreated and the tendency to remain stable or grow in the future unless prevented or reduced by health-care interventions.

Some countries included mental health among the essential components of primary health care but many did not. In Thailand, for example, the government decided to do so and defined a mental health component of primary health care that was wider than others. In addition to the treatment of mental disorders, the Thai authorities also indicated that they would pay attention to the psychosocial aspects of health care in general and of primary health care in particular: this, however, was an exception and different from other countries that focused 'primary mental healthcare' activities on the treatment of a small number of disorders. With such a definition of the promotion of mental health care, the shift of

mental health activities from tertiary care facilities to the periphery was successful in a relatively small number of countries – for example in Iran which has trained a large number of primary health care workers to recognise and deal with the mental disorders they encounter in their work. There were notable examples of other successful introduction of mental health into primary health care, but they also remained isolated stories rather than contagious models.<sup>4,5</sup>

The Alma Ata Declaration affected national priorities in the field of health to a different degree in different countries. In general, the priority of mental health programmes in developing countries remained low. This meant that it was very difficult to introduce changes in the manner of providing mental health services that were, in many countries, restricted to a few large mental hospitals built in colonial times. The introduction of mental health elements into primary health care thus happened only infrequently, often restricted to a geographical area defined by the medical school as 'its' territory for demonstration programmes. Demonstration and pilot programmes were in fact quite frequent: it is their generalisation that was the main challenge that has not been overcome in any of the developing countries – in part due also to the gradual weakening of enthusiasm for the strategy of primary health care, which remained an important set of ethical aims but proved unsuccessful as a recipe for the provision of care to the majority of those who need it most.

As time went by, the concept of mental health elements incorporated into primary health care became restricted to the recognition and treatment of mental disorders at the primary level of contact between the population and the health system. In countries in which there is a significant cadre of general practitioners, this meant that the general practitioners were invited to take on the treatment of common mental disorders such as depression and anxiety. In other countries where the role of general practitioners is played by internists or by nursing staff, the same principle prevailed – that is to place emphasis on the training of primary care personnel so that they can recognise mental disorders and then participate in their treatment, directed by a mental health specialist, or carry it out themselves and consult specialists only if they have difficulties in the process of treatment.

This strategy – providing all staff at primary health care level with knowledge about mental disorders and their treatment – has also changed over time. While at the beginning emphasis was on providing knowledge, it soon became clear that it is necessary to pay as much if not more attention to teaching skills that are needed in dealing with mental disorders. Similarly, important changes happened with other parts of this strategy. The notion of training all

health personnel has gradually been replaced by the emphasis on training primary care personnel who have expressed an interest and wish to learn more about the management of mental disorders at their level. The offer of knowledge about mental disorders has also become more restricted – focusing on the recognition of disorders that need referral and the recognition and treatment of mental disorders that are very frequent and can be handled at the primary healthcare level, such as depression and anxiety states. The teaching faculties have also been changing – while, at the beginning, psychiatrists were teaching general practitioners, it became obvious that it is much more effective to organise teaching sessions in which a psychiatrist and a general practitioner share the responsibility for the training sessions. Lectures and systematic presentation of knowledge gave way to the discussion of cases that the primary healthcare workers brought forward. A similar procedure has also gained popularity in teaching specialists of medical disciplines who were the primary contact personnel – for example internists and gynaecologists.

The definition of primary health care adopted by the Ministerial Conference in Alma Ata announced some of the principles of providing health care. These dealt with issues of equity in the provision of care and with the need to consider the improvement of the health of the population as a whole when constructing the health systems. Over time, two important trends emerged. The first of these was the growing difference of what was named primary health care – between and within countries. The second was the realisation that, in the organisation of health care in the community, governments must give special attention to matters that were hardly mentioned in the original definition and the accompanying documents about primary health care. These included the need to involve the private sector in the planning and evaluation of care, the imperative to provide significant moral and material support to families who are taking care of people with chronic illnesses, and the need to consider matters such as stigma and other psychosocial issues in the organisation of health services.

The goals of the mental health component of primary health care have also changed, and its goals, over time, became restricted to the treatment of a small number of frequent mental disorders by primary care workers. While the treatment of some mental disorders is a laudable effort, this restriction of the role that mental health could play at the level of first contact between the population and the health system is harmful. The mental health effort at all levels of care, and particularly at the primary care level, should be wider and include not only the treatment of mental disorders, but also an involvement

in dealing with psychosocial aspects of health care in general; the prevention of mental illness and the promotion of mental health (understood as an effort to give greater value to mental life and functioning). Defined in this way the mental health component of primary health care would make a much more significant contribution to health care than it can do if it remains restricted to the treatment of a small number of (frequently seen) mental disorders – no matter how useful this contribution is by itself.

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#### ADDRESS FOR CORRESPONDENCE

Norman Sartorius, 14 Chemin Colladon, 1209 Geneva, Switzerland.

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