Mental health and primary care

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The World Health Organization (WHO) has dedicated World Health Day on April 7, 2001, to mental health. Two themes that are important aspects of mental health and specific to mental illness form the basis of the WHO mental health campaign: "Stop exclusion — Dare to care." The first element of the WHO slogan emphasizes that "there is no justification in ethics, science, or society to exclude persons with a mental illness or a brain disorder from our communities."[1] The second reminds us that mental illness can happen to anyone. It also invites us not to "fear those experiencing a mental illness" and to challenge the myths and misconceptions about these conditions.[1] Some of the myths that are believed by large segments of the public are described in Table 1.

Why is mental health important? Mental illness and the resulting disabilities cause unmeasurable suffering to patients and their families. Mental disorders rarely cause premature death, but their frequency and chronic course make them important causes of disability, resulting in substantial costs to health care budgets,[2] and they have a broad negative effect on the general economy because these conditions occur frequently among younger people.

The WHO uses disability-adjusted life years (DALYs), which combine measures of premature mortality and years lived with disability, instead of standardized mortality ratios to gauge the health of populations and countries. This has made governments realize that mental conditions contribute disproportionately to the global burden of disease. It is projected that, by the year 2020, mental disorders will account for about 15% of global disease[2] and that depression will become the leading cause of disability.

The prevalence of schizophrenia seems to have remained stable worldwide at about 1%, however, other conditions such as depression and dementia are being reported more frequently. Dementia is reported to be increasing at a faster pace than the expected increase in the number of elderly people in the population.[3] The increasing need for mental health care is demonstrated by increases in the use of mental health services. For example, in Ontario, between 1992 and 1998, while the percentage of all health care users rose by 4%, the percentage of patients requiring mental health services rose by 13%.[4]

Because of their frequency, severity, and chronicity, mental conditions have a major, direct impact on health care budgets. For example, in Ontario, the costs of all health services rose 11% between 1992 and 1998, but the cost of mental health services (accessed by 28% of patients) increased by 18%. In addition, the number of patients using mental health–related procedures such as psychotherapy provided to patients with medical rather than psychiatric conditions rose by 47% in the same period, and costs for this type of care rose by 60%.[4]

The frequency of mental health disorders among the young, compared with other chronic diseases, means that such disorders have a disproportionate and direct effect on productivity resulting from absenteeism, substandard performance, the need to hire substitute workers, accidents, litigation and legal settlements. In addition, unlike other conditions, mental disorders often have an indirect impact on other budgets such as those for welfare, justice and corrections.

The direct and associated costs of depression, mostly in the form of the effect on the labour force, already amount to $60 billion a year in the United States, and the cost of loss of productivity due to mental disorders alone is estimated at $80 billion a year.[5] In Canada, it has been reported that 50% of long-term disability claims among a white-collar workforce group were psychiatric in nature and that there had been a 4-fold increase in claims due to psychiatric disability in 4 years. Goeree and colleagues have estimated that the cost of schizophrenia to yearly produc-

Table 1: Public myths and the facts about mental illness

Myth	Fact
• Mental and brain disorders only affect adults in rich countries.	• Everyone is affected – children and adults, rich and poor. The frequency of these disorders is about the same in developed and developing countries.
• Mental and brain disorders are a figment of one's imagination.	• These are real illnesses that cause suffering and disability.
• It is impossible to help somebody with a mental or brain disorder.	• Treatments exist and are effective. Caregivers can be assisted.
• Mental or brain disorders are brought on by weakness of character.	• These disorders are caused by biological, psychological and social factors.
• People with mental illness should be locked up.	• People with mental illness can function and should not be isolated or restricted.

tivity in Canada is $105 million.[6] Goeree and coworkers place the total cost of this condition in Canada at $2.35 billion in 1996, equivalent to 0.3% of the gross domestic product.[7] The direct and indirect costs of all mental conditions in Canada were equivalent to about 3% of the gross domestic product and to about 13% of the net annual profits of all Canadian companies.[8]

Other conditions that are less well recognized, such as reactions to stress in the workplace, are more insidious in their effects. Reasons for high levels of stress in the workplace include the demand for higher levels of knowledge to remain competitive in an information age, larger workloads and prolonged schedules, ambiguity of roles and hierarchical conflicts, poor communication channels, constant reorganizations and job insecurity, and lack of balance between work demands and expected roles at home and in the community. Stress associated with labour practices, for example, is already known to be a major factor in disability. Globalization, rapid technological change and accelerating competitiveness are taking a toll as the less able are squeezed out of their jobs or lose opportunities for advancement. In the United States, the average loss of productivity caused by reactions to stress amounts to 25 days per person per year among those suffering from job stress,[5] and these losses amount to over $200 billion a year. In Japan, karoshi, or death due to excess work, has been described as resulting from stress, hypertension and death from cerebrovascular accidents.[9]

In line with the WHO theme of stopping exclusion, mental health reform in many countries emphasizes the need for regionalization and community care. This means that our approaches to the care of mental illness should focus on early detection and prevention and should be delivered at a local level. The theme of nonexclusion means that patients suffering from mental disorders should be cared for in their own communities and, preferably, in primary care settings.

It is evident from the data noted earlier for Ontario that general practitioners already contribute substantially to the care of seriously mentally ill patients and to the care of individuals who suffer from depression and reactions to stress. In Ontario, between 1992 and 1998, general practitioners were the sole source of mental health services for the majority of patients (76%–84%), and they delivered mental health services in association with psychiatrists to an additional 8%–9% of patients.[4]

General practitioners are, thus, in a pivotal position to affect mental health outcomes. A further step, however, would be to turn their practices into mini–epidemiological laboratories, assuming a circumscribed catchment area for a primary care practice of about 1000 families. From their practices, general practitioners could coordinate interventions and track the quality and outcomes of mental health services at primary and consultative levels. Such a public health model of mental health would take into account diagnostic, treatment and etiological considerations, as well as epidemiological surveillance of the health of the population. It would include health promotion, disease prevention and evaluation of mental health services,[10] including working with patients and their families and with community agencies such as suicide hotlines, the police or specialized housing agencies. Such an approach would fit perfectly with the aims of the WHO to challenge the myths about mental illness and to stop the exclusion of mental patients from their own communities.

A public health model for general practitioners would also help to promote better work practices and, thus, would help to prevent reactions to job-related stress and, in consequence, would prevent these reactions from turning into depressive disorders. An active public health primary practice would also carry out mental health epidemiological surveillance to alert practitioners to other scourges in their catchment area such as domestic violence, alcoholism, drug abuse and community violence.

Primary care physicians should be alert to the presence of mental health issues in their communities in the same way that they are to epidemics of flu, or contaminated water. Following the WHO initiative, would that World Mental Health Day could encourage general practitioners to approach patients integrally in mind and body and look after the mental health needs of their patients and the population as assiduously as they do their physical health needs.

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