Fostering enabling environments to deliver integrated, people-centred care for mental health conditions and non-communicable diseases

UNITED FOR GLOBAL MENTAL HEALTH

CONTENTS

INTRODUCTION

Non-communicable diseases[1] (NCDs) are the world's leading cause of premature death, directly contributing to 74% of all deaths globally and 86% of deaths in low- and middle-income countries (LMICs).[2] At the same time, mental health conditions[3] are responsible for 1 in every 10 disability-adjusted life years (DALYs) worldwide.[4] Mental health and NCDs are inherently interconnected – mental illness affects and is affected by NCDs.

This year the world will come together for the **2025 UN High-Level Meeting on NCDs and Mental Health in September 2025.** Heads of State will join health leaders and activists in setting a new vision to accelerate the global response for the prevention and control of NCDs and mental health conditions. As this briefing will explain, mental illness and NCDs have a bidirectional relationship and share many modifiable risk factors. Any effective healthcare system should be able to address the management and care of persons with multimorbidities (those living with two or more chronic conditions). This briefing is designed to contribute practical recommendations on how to reform health systems to achieve this goal.

Integrating mental health and NCD services is an evidence-based approach to improving health coverage and outcomes.[5] It involves combining physical and mental care to provide comprehensive and people-centred health services to meet people's specific individual needs. The first step to delivering integrated, people-centred care to individuals living with both NCDs and mental health conditions is by strengthening primary health care. Common mental health conditions and NCDs can be managed at primary care. For most people, primary health care (PHC) is often the first and main point of contact with their healthcare system. Strong PHC is the foundation of efficient health systems – helping to reduce total health spending and improve health outcomes. To maintain continuity of care for people living with multimorbidity, inclusive of mental health conditions, and NCDs, primary care should:

- **help prevent and detect NCDs and mental health conditions early**
- **treat and manage people with certain NCDs and mental health conditions**
- **refer those who need it for specialist care.**

1 By NCDs , we mean Cardiovascular disease, Chronic Obstructive Pulmonary Disease, diabetes, and cancer. Neurological disorders such as dementia, epilepsy, and Parkinson´s are also NCDs but are not grouped under NCDs or mental health. The WHO refers to them as brain health conditions.

2 WHO Website- Factsheet. Accessed June 2024. Noncommunicable diseases (who. int)

3 Mental health refers to the WHO definitions: ´Mental health is a state of mental well-being that enables people to cope with the stresses of life, realize their abilities, learn well and work well, and contribute to their community. It does not focus on brain health or substance abuse.

4 GBD 2019 Mental Disorders Collaborators. Global, regional, and national burden of 12 mental disorders in 204 countries and territories, 1990-2019: a systematic analysis for the Global Burden of Disease Study 2019. Lancet Psychiatry. 2022 Feb;9(2):137-150. doi: 10.1016/S2215-0366(21)00395-3. Epub 2022 Jan 10. PMID: 35026139; PMCID: PMC8776563.

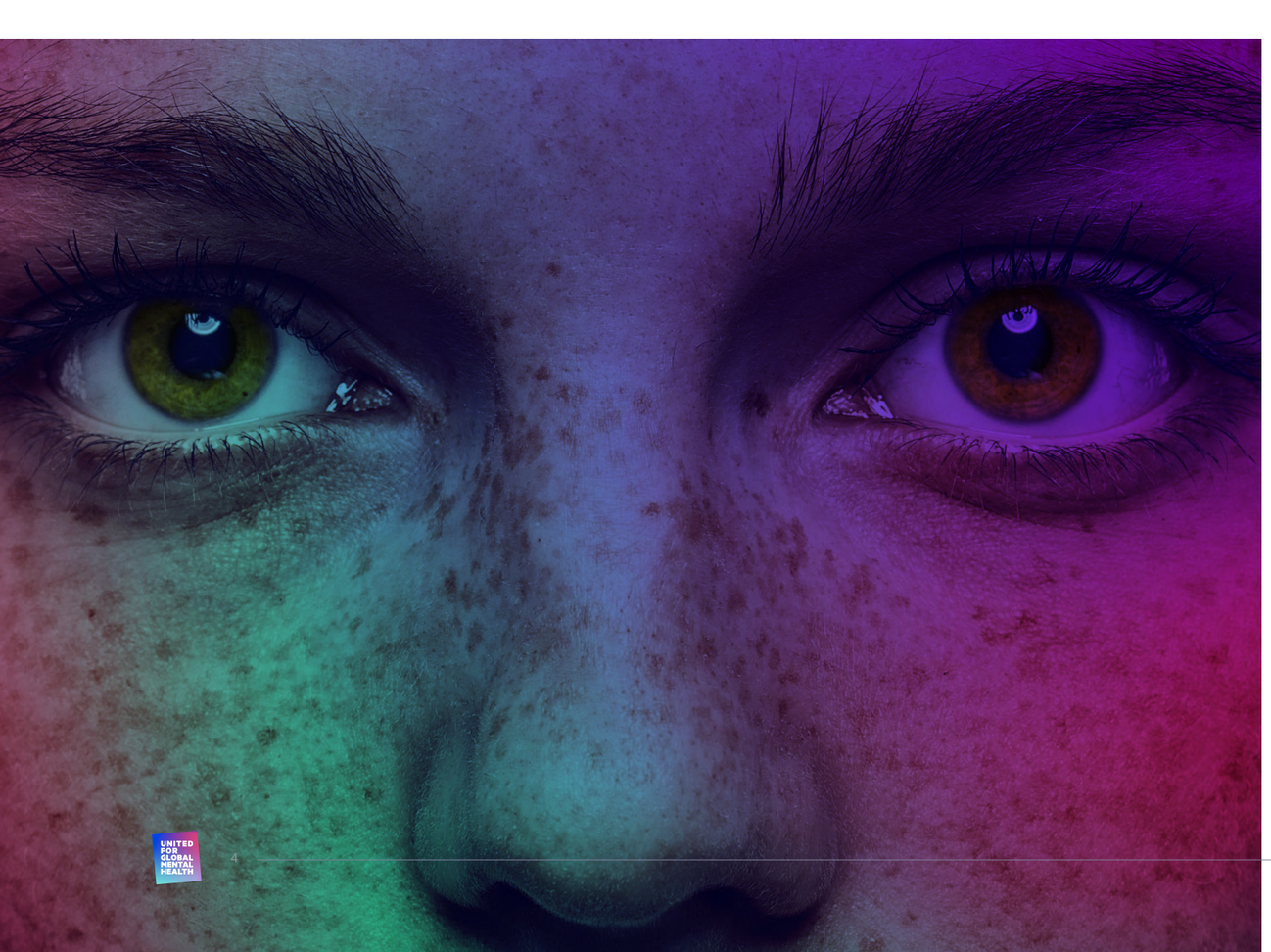
5 Stein DJ, Benjet C, Gureje O, Lund C, Scott KM, Poznyak V, van Ommeren M. Integrating mental health with other non-communicable diseases. BMJ. 2019 Jan 28;364:l295. doi: 10.1136/bmj.l295. PMID: 30692081; PMCID: PMC6348425.

As the number of people living with mental health conditions and NCDs rises, particularly in LMICs, it's critical to foster models of care that integrate mental health and NCDs in primary care settings. That way, patients will have access to care when and where they need it most.

Section 1 explores the lack of infrastructure, workforce and financing in many countries to deliver effective PHC for NCDs and Mental Health. Section 2 addresses the reaffirmed global commitment to PHC and looks at what has to change to facilitate the quality of PHC needed to deliver integrated, people-centred care. Section 3 explores different approaches to integration in more detail, with successful examples of how NCDs and mental health have been integrated within national health systems.

Despite the strong case for integration, implementation is still lagging behind ambition in many countries. With just five years until the Sustainable Development Goals (SDG) deadline, the time to fully implement integrated, people-centred care is now.

This policy brief aims to move the discussion forward. It presents a strong, evidence-based argument in favour of reorienting health systems to place the whole person, not a single disease, at the centre. It is informed by a literature review and key interviews with global thought leaders and country stakeholders in Ghana, India, Kenya, the Philippines, and Zambia.



MENTAL HEALTH AND NCDS – A BIDIRECTIONAL RELATIONSHIP

Mental health conditions and NCDs comprise a huge health burden worldwide, especially in LMICs. The connection between mental health and NCDs is intricate and operates in both directions. For example:

- People living with severe mental illness (e.g., schizophrenia, bipolar disorder, or major depressive disorder) die up to 15 years prematurely due to chronic physical comorbidities.[6][7]
- People living with hypertension are more likely to experience anxiety, and those with comorbid anxiety disorders are more likely to face more severe physical disabilities.[8]
- People living with diabetes are two to three times more likely to have depression than people without diabetes, and only 25% to 50% of people with diabetes who have depression are diagnosed and treated.[9]
- Depression can lead to a substantially increased risk of coronary heart disease.[10]
- There are multiple shared risk factors across NCDs and mental health, including physical inactivity, unhealthy diet, and harmful use of alcohol and tobacco, as well as shared social determinants of health, such as poverty, which exacerbates mental health conditions and NCDs.[11]

Existing global policies and guidance acknowledge this bidirectional relationship between mental health and NCDs. For example, the World Health Organisation's '4 x 4' framework – which prioritised diabetes, chronic obstructive pulmonary disease, cardiovascular diseases and cancer – was updated in 2018 to include mental health, and highlight its relationship with NCD risk factors. The WHO recognises that mental and physical health are interconnected, and recommends a holistic approach to addressing physical and mental health issues. The WHO's updated '5x5' framework also acknowledges that the risk factors for NCDs can impact mental health. Meanwhile, the WHO Framework for Meaningful Engagement provides guidance on involving people living with NCDs, and mental health and neurological conditions in shaping health policies, programmes and services.[12]

6 Vancampfort D et al, Firth J, Schuch FB, Rosenbaum S, Mugisha J, Hallgren M, Probst M, Ward PB, Gaughran F, De Hert M, Carvalho AF, Stubbs B. People with severe mental illness (schizophrenia, bipolar disorder or major depressive disorder) die up to 15 years prematurely due to chronic somatic comorbidities. World Psychiatry Oct 2017;16(3):308-315. doi:10.1002/wps.20458. PMID: 28941119.

7 Policy brief: Helping people with severe mental disorders live longer and healthier lives.World Health Organisation, 2017.

8 Hu Y., Huang Y., Wang L., et al.. Disability and comorbidity of mood disorders and anxiety disorders with diabetes and hypertension: evidence from the China mental health survey and chronic disease surveillance in China. Frontiers in Psychiatry 2022 13. doi:10.3389/fpsyt.2022.889823.889823.

9 Diabetes and Mental Health. Centres for Disease Control and Prevention, 2024.

10 Cao H et al, Zhao H, Shen L. 2022. "Depression increased risk of coronary heart disease: A meta-analysis of prospective cohort studies." Front Cardiovasc Med. Aug 30;9:913888. doi:10.3389/fcvm.2022.913888.

11 Stein DJ, Benjet C, Gureje O, Lund C, Scott KM, Poznyak V, van Ommeren M. "Integrating mental health with other non-communicable diseases." BMJ. 2019 Jan 28;364:l295. doi: 10.1136/bmj.l295. PMID: 30692081; PMCID: PMC6348425.

12 Framework for Meaningful Engagement of people living with non-communicable diseases, and mental health and neurological conditions. World Health Organisation, 2023.

The more recent WHO guidance document, the Integrated Operational Framework for Mental Health, Brain Health and Substance Use,[13] reiterates the connection between mental health, neurological and substance-use (MNS) conditions and physical health, and the broader sustainable development agenda. It sets out an operational framework to help countries strengthen person-centred comprehensive care as part of their public health response to MNS conditions, emphasises the importance of the integration of MNS services with other health programmes as a global strategy to promote health equity, reduce health disparities, and improve health outcomes.

And yet, in practice, the world is still failing people living with mental health conditions and/or NCDs. In the NCD Alliance's Our Views, Our Voices,[14] such individuals speak out about the trauma and financial costs of seeking care in fragmented health systems[15] that don't address their holistic needs. Currently, health systems often focus on treating single diseases, rather than seeking to meet the needs of people with multiple chronic conditions, including mental health conditions and NCDs.

Evidence shows integrated care can improve patient satisfaction, access to services, and quality of care.[16] It may also reduce costs by eliminating service duplication, improving care coordination, and reducing administrative inefficiencies.[17] It encourages a paradigm shift away from long-stay psychiatric institutions – where people frequently experience a poor level of care, and even neglect and abuse – towards primary level and community-based care.[18] It helps address stigma and discrimination and is a move towards rights-based, recovery-orientated and high-quality care, which encompasses the needs of the whole person – including housing, employment and their complete reintegration into society. Ultimately, it allows people their fundamental right to participate in decisions about their own health.[19]

Whilst the evidence for integrated care is compelling robust research is still needed to determine which models are applicable across different regions and their health care systems.

13 Integrated operational framework for mental health, brain health and substance use. World Health Organisation, 2024.
14 Diary Theme the Experience Of Living With Multiple Chronic Conditions | Our Views, Our Voices. NCD Alliance website 'ourviewsourvoices'. https://www.ourviewsourvoices.org/ncd-diaries/the-experience-of-living-with-multiple-chronic-conditions. Accessed 14 November 2024
15 As per the WHO definition, a health system promotes, restores and maintains health. It is a complex whole made up of all the actions, actors, resources, and mechanisms involved in delivering health care services to meet the health needs of populations. 05_What-is-a-Health-System_Factsheet.pdf (who.int). Accessed 10 November 2024
16 Baxter, S., Johnson, M., Chambers, D. et al. The effects of integrated care: a systematic review of UK and international evidence. BMC Health Serv Res 18, 350 (2018). https://doi.org/10.1186/s12913-018-3161-3
17 Kaufman Hall.The Benefits of Integration: Healthcare in a Time of Rapid Transition. Kaufman Hall, California, USA.2021. https://calhospital.org/wp-content/uploads/2021/10/KH-CHA-Benefits-of-Integration-Report_Final.pdf
18 Innovation in deinstitutionalization: a WHO expert survey. World Health Organisation, 2014.
19 WHO Website: Integrated People-Centered Healthcare Services. Integrated people-centred care - GLOBAL (who.int). Accessed 20 November 2024

STRONG PHC IS VITAL FOR INTEGRATED, PEOPLE-CENTRED CARE

Primary health care (PHC) is essential, universally accessible care, responsive to people's needs.[20] PHC provides a whole-of-society approach that brings health services as close as possible to where communities live, and those communities participate in its design. PHC can be the most inclusive, equitable, and cost-effective[21] way to improve physical and mental health.

The 2018 Astana Declaration reaffirmed global commitments to PHC around the world – yet strong PHC is not the reality in many countries. Many gaps, challenges and opportunities remain, especially in LMICs.

For many people across the world, PHC remains the first point of contact with a national health system. Investment in PHC can improve the equity and quality of health services, and help ensure people's mental health and NCD needs are met in times of both crisis and calm.

When it comes to mental health conditions, PHC offers unique opportunities for prevention, early detection and early intervention close to the community – all crucial to generating better health outcomes. PHC can also reduce the stigma that surrounds mental health conditions through education. And it can facilitate the seamless management of mental health and NCD comorbidities, as well as closer collaboration with other levels of the health system.[22,23]

HEALTH SYSTEMS ORIENTED AROUND PRIMARY HEALTH CARE CAN OFFER:

- Preventive care and early intervention**:** health promotion, early detection, early screening, early treatment for better health outcomes
- Greater equity: enhanced access to mental health and NCD services that are available closer to where communities live
- Economic benefits: by reducing hospitalisation and the use of secondary care, lowering overall health care expenditure over time
- Coordination and continuity of care: as a central hub of the health system, it can help seamlessly manage care for people with multimorbidities, and facilitate communication with a range of health specialists
- Better quality: through empowering people and engaging communities to help design effective, integrated and people-centred care models.

20 What is primary care mental health?: WHO and Wonca Working Party on Mental Health. Ment Health Fam Med. 2008 Mar;5(1):9-13. PMID: 22477841; PMCID: PMC2777553. https://pmc.ncbi.nlm.nih.gov/articles/PMC2777553/
21 WHO Website- Primary health care factsheet. Accessed 10th October 2024 https://www.who.int/news-room/fact-sheets/detail/primary-health-care
22 Funk M, Saraceno B, Drew N, Faydi E. Integrating mental health into primary healthcare. Ment Health Fam Med. 2008 Mar;5(1):5-8. PMID: 22477840; PMCID: PMC2777555
23 Integrating mental health into primary care: A global perspective. World Health Organization, 2008.

With the renewed emphasis on PHC, countries now have an opportunity to invest today in stronger PHC to generate opportunities tomorrow for better-integrated, people-centred mental health and NCD care.

Three ways countries can strategically invest in robust PHC to strengthen and support integrated, people-centred care:

1 Prioritise, promote and progress towards primary health care – to ensure first contact, comprehensiveness, coordination and continuity

Many LMICs do not have even basic primary care infrastructure, and don't consistently deliver an essential package of services. Currently, health systems often focus on treating single diseases, and fall short of providing accessible, person-centred, high-quality services to people with multiple chronic conditions, including mental health conditions and NCDs. This is particularly true in many LMICs. These weaknesses make it difficult to integrate mental health and NCD services.

Another barrier to integration is the focus in most countries on providing mental health care in institutions – long-stay mental hospitals, traditional institutions such as prayer camps and other NGO- or government-run asylums.[24] Institutional care comprises on average 67% of the entire global mental health budget.[25] Institutionalising people with mental health conditions increases their risk of isolation and vulnerability to NCDs.

The locus of care needs to shift away from institutions and over-medicalisation towards a network of community-based mental health services.[26] Such services should respond to people's needs as early as possible and along a continuum of care – health promotion, prevention and treatment. They should be a point of seamless coordination with specialists and across the different levels of the health system.

In many LMICs, strong, integrated, person-centred and context-appropriate primary care will rely on contributions from both donors and national governments.

Unless efforts are made to strengthen PHC – especially in LMICs – it will be very difficult, if not impossible, to advance integration.

24 Innovation in deinstitutionalization: a WHO expert survey. World Health Organisation, 2014.
25 Comprehensive Mental Health Action Plan 2013-2030.World Health Organisation, 2021.
26 Comprehensive Mental Health Action Plan 2013-2030.World Health Organisation, 2021.

2 Strengthen, scale-up and optimise the human resources for health – to drive improved access and quality care

Many LMICs lack mental health specialists, exacerbating the care gap[27] and making it harder to integrate mental health services into primary care.

The first step towards addressing this shortfall and strengthening the mental health workforce is for countries to better capture human resources data for primary care.

Amid the global calls for renewed commitment to PHC,[28] It is important to acknowledge that integrated, people-centred care cannot be achieved until the PHC workforce has the skills and support to manage and treat mental health conditions and NCD in primary care and community settings.

The WHO has stressed the importance of strong PHC in addressing the shortage of mental health care professionals in many countries and closing the mental health treatment gap.[29] To meet global health workforce recruitment and retention needs, countries need to invest in the education, training, development and motivation of the PHC workforce, including equipping them with the skills to identify and treat mental health conditions and NCDs across the spectrum of promotion, prevention, care and recovery. This should also include an increase in specialists to support the PHC workforce when care needs to be escalated which can help lay the foundation for more integrated, people-centred care.

The WHO recommends continuous mental health care training (i.e pre-service education and training) for the PHC workforce – supplemented with continuous supervision by mental health professionals[30] – to ensure the effective management of mental health conditions in primary care.

Countries should promote attractive working conditions to encourage health care workers to join the PHC workforce and remain part of it, especially in rural, remote and less developed areas, where the shortfall of skilled staff is most pronounced. [31]

27 Mental Health Gap Action Programme (mhGAP): Scaling up care for mental, neurological, and substance use disorders. World Health Organisation, 2008.
28 Implementing The Astana Declaration – What Alma-Ata Taught Us, Health Affairs Blog, 25 October 2018. DOI: 10.1377/hblog20181024.24072
29 The World Health Report 2001. Mental Health: New understanding, new hope. World Health Organisation, 2001.
30 Integrating mental health into primary care: A global perspective. World Health Organisation, 2008.
31 Global strategy on human resources for health: Workforce 2030. World Health Organisation, 2020.

3 Increase, improve and integrate mental health and NCD financing – to ensure PHC is fit for purpose

According to the Lancet Commission, government spending on PHC is meagre: "at $3 in low-income countries and $16 in lower-middle-income countries, which falls short of the WHO estimate of the per capita recurrent cost for PHC of $65 in low-income countries and $59 in lower-middle income countries." [32] Across the world, mental health and NCDs remain chronically underfunded.[33] The global public finance gap for mental health is more than US$200 billion annually.[34]

Integrated, people-centred care relies on adequate funding. NCD and mental health financing should be integrated where possible, and always complementary. Countries must raise adequate finance for mental health systems in sustainable and equitable ways.

Financing that prioritises the integration of mental health into primary and community-based health care needs to be the priority. Therefore, domestic resources for mental health should be increased. Government spending targets for high-income countries should allocate at least 10% of health budgets to mental health and for LMICs at least 5%.[35]

In LMICs, domestic resources will not be enough to support robust, people-centred, integrated care. So catalytic donor finance is needed to create systemic change and sustainable financing solutions. Bilateral and multilateral donors should immediately allocate at least 0.5% of their Development Assistance for Health (DAH) to mental health, increasing to 1% by 2027 and 5% by 2030 to contribute to global commitments.[36]

32 Hanson K, Brikci N, Erlangga D, et al. The Lancet Global Health Commission on financing primary health care: putting people at the centre. Lancet Glob Health. 2022 May;10(5):e715-e772. doi: 10.1016/S2214-109X(22)00005-5

33 Chisholm D, Lee YY, Baral PP, et al. Cross-country analysis of national mental health investment case studies in sub-Saharan Africa and Central, South and South-East Asia. Front Health Serv. 2023 Jul 18;3:1214885. doi: 10.3389/frhs.2023.1214885. PMID: 37533704; PMCID: PMC10392930.

34 Increase, improve and integrate: the way forward for financing NCDs and mental health. United for Global Mental Health, 2024.

35 Patel V, Saxena S, Lund C et al. The Lancet Commission on global mental health and sustainable development, The Lancet, Volume 392, Issue 10157, 2018, Pages 1553-1598, ISSN 0140-6736, https://doi.org/10.1016/S0140-6736(18)31612-X.

36 Increase, improve and integrate: the way forward for financing NCDs and mental health. United for Global Mental Health, 2024.

DELIVERING INTEGRATED, PEOPLE-CENTRED CARE FOR PEOPLE LIVING WITH NCDS AND MENTAL HEALTH CONDITIONS

In LMICs, where NCDs are growing at alarming rates, integrating services for people who live with NCDs and mental health conditions is a major challenge. Nevertheless, many LMICs are making progress on mental health integration, particularly in primary care, and development partners have an opportunity to advance the agenda quickly and at scale.

Challenges and opportunities in implementing and scaling-up integrated, people-centred care

In LMICs, limited resources often make it more difficult to integrate care. By addressing key barriers and leveraging local resources, however, LMICs can make progress in adopting integrated, people-centred care. Table 1 overleaf provides a summary of some of the main challenges and opportunities identified in the literature for integrating mental health and NCDs across the health system. It also provides details of the key informant interviews (KIIs).

Table 1: Summary of health system challenges and opportunities for integrating mental health and NCDs

Domain	Challenges	Opportunities
Leadership and governance	National policies and plans for NCDs and mental health do not concretely mention integration. Global normative guidance on NCDs and mental health is very siloed and does not easily facilitate integration (e.g., PEN Package does not mention mental health integration nor reference WHO Mental Health Gap Action Program). Health providers often resist integration due to the absence of an enabling environment.	Ensure that national NCD and mental health plans explicitly mention the bidirectional relationship between NCDs and mental health, and policies and programmes to support integration. Convert integration policies and plans into concrete budget proposals highlighting capacity development and technology needs. Reform health financing policy to support integration (e.g., global budgets, programme budgeting or capitation contracts with performance measures).
Health workforce	Weak referral mechanisms are in place, and there are few specialists (e.g., psychiatrists, endocrinologists, cardiologists, pulmonologists), with those there are often clustered in major urban centres, leaving gaps in rural areas. Workforce shortages do not allow for team-based care to be implemented as a strategy for addressing multimorbidity. There is inadequate training and supervision for task-sharing to be implemented with quality assurance. The primary care workforce is experiencing burnout at alarming rates globally.	Address recruitment, retention and distribution through improved health workforce policies and public financial management systems. Leverage technology to strengthen referral mechanisms. Link primary care providers to specialists through telemedicine and teleconsultation services. Strengthen the quality of task-sharing interventions. Implement mandatory pre-service mental health education and training to enhance the mental health knowledge and practice of the primary care workforce. Acknowledge burnout and prioritise the wellbeing of the primary care workforce.
Service delivery	Primary care is fragmented due to the implementation of multiple vertical programmes. This makes it difficult to integrate mental health, since mental health would have to be integrated into each of the vertical programmes. Practical guidance (e.g., service delivery protocols) for providers to adequately deliver integrated mental health and NCD services is limited. There is an absence of guidance on practice transformation to foster a supportive environment for the integration of mental health and NCD services.	Adopt policies and capacity-strengthening programmes that promote horizontal integration across disease programmes. Develop practical guidance for a range of providers who are delivering integrated mental health and NCD services. Develop guidance on practice transformation. This may include tools to support changes in organisational culture, team dynamics and team-based care, workflow redesign, and data-driven quality improvement, for example, all activities aimed at providing more integrated, people-centred care.
Information (data and data systems)	Patient-level and facility-level NCD and mental health data collection is weak. There is limited use of registries. The existence of parallel and/or fragmented data systems presents challenges with interoperability.	Strengthen primary care facility-level and patient-level data collection and use dashboards to support periodic reviews at health-facility, subnational, and national level to get a better understanding of how patients' multiple physical and mental health needs are being met in primary care. And include mental health and NCD data within the overall health information system. Promote registries that both facilitate empanelment and enable primary care providers to deliver integrated, people-centred care to the population. Invest in IT infrastructure and promote system interoperability. Encourage local IT training and support.
Medical products, vaccines and technologies	Access to essential NCD and mental health diagnostics and medicines is lacking. There are large gaps in the availability of essential mental health medicines. Patient trust in integrated care is compromised when medicines are not available.	Enhance primary health care financing mechanisms through a basic benefits package that includes medicines and diagnostics.
Financing	Financing for mental health and NCDs is one of the biggest challenges. Financing streams are fragmented and underfunded. Strategic purchasing mechanisms are missing. So even if money is increased, it is not likely to have an impact. Civil society funding for supporting integration is not available, yet civil society has much to offer.	Increase financing for mental health and NCDs, particularly in LMICs. Ensure integrated mental health and NCD services are a fundamental part of social health insurance schemes. Make sure funding is channelled through strategic purchasing mechanisms such as global budgets, programme budgeting or capitations that would encourage and support providers to integrate through team-based care. Hold providers accountable through performance measures that include metrics on integrated, people-centred care.

Approaches to integration at the service-delivery level

There are a variety of approaches to integration at the service-delivery level. They vary depending on the needs of the population, the strengths of the health system and the resources available, most notably workforce capacity. Importantly, there is no one-size-fits-all approach to integration.

As primary care is where most patients with NCDs and mental health conditions seek care, all countries should prioritise integrating mental health into primary care as part of their commitment towards integrated, people-centred care. Complementary approaches should include culturally-attuned processes to transition mental health services from institutional settings to community-based models of care. They may also include integrating mental health services into speciality NCD care settings, and integrating primary care – including NCD prevention, treatment and care – into mental health settings (e.g., community mental health clinics, psychiatric hospitals, etc).

The WHO Mental Health Gap Action Program (mhGAP) has scaled-up mental health services in primary care in more than 100 countries since its introduction in 2008. The mhGAP Intervention Guide 2.0[37] helps frontline health providers integrate the management of priority mental health conditions into primary care. It uses algorithms for clinical decision-making that enable non-specialist health providers to screen, diagnose, and treat a range of mental health conditions, including people living with comorbid NCDs.

Globally, there has been a lot of emphasis on strengthening the existing healthcare workforce as a way of promoting integration. This has included task-sharing, a strategy in which tasks are delivered collaboratively by different staff categories. In some instances, new cadres of health providers have been created. Regular supervision, the availability of resources, tools and technological updates, and the quality of training are crucial factors in ensuring the successful redistribution of tasks.

There are examples of successful integration in LMICs. In Malawi, for example, depression screening and treatment have been integrated into hypertension and diabetes care (see box 2),[38] and in Mexico[39] a pioneering programme supports mental health and diabetes self-management (see box 3).

Collaborative care has also emerged as a promising approach to integrating NCDs and mental health in primary care. The collaborative care model typically augments the medical team with an additional team member called a ‘care manager’, and features coordinated consultation with mental health care providers. The WHO has included a conditional recommendation on collaborative care in its updated mhGAP guidance. It notes that collaborative care should be considered for adults

37 mhGAP intervention guide for mental, neurological and substance use disorders in non-specialized health settings: mental health Gap Action Programme (mhGAP) – version 2.0. World Health Organisation, 2016

38 Pence BW et al. Two implementation strategies to support the integration of depression screening and treatment into hypertension and diabetes care in Malawi (SHARP): parallel, cluster-randomised, controlled, implementation trial. Lancet Glob Health. 2024 Apr;12(4):e652-e661. doi: 10.1016/S2214-109X(23)00592-2. Epub 2024 Feb 23. PMID: 38408462; PMCID: PMC10995959.

39 Aceves, B., Ruiz, M., Ingram, M. et al. Mental health and diabetes self-management: assessing stakeholder perspectives from health centers in Northern Mexico. BMC Health Serv Res 21, 177 (2021). https://doi.org/10.1186/s12913-021-06168-y

with depression and/or anxiety, and physical health conditions.[40] Most of the available research on collaborative care comes from high-income countries, with implementation challenges in LMICs. However, experiences from Nepal and India demonstrate that a range of strategies can be used to address these challenges and enhance scalability in resource-limited settings,[41] as illustrated below in Box 1 on Nepal.

Promising practices – learning from countries

Health systems in LMICs are typically less prepared and lack the resources to implement integrated, people-centred care, but there are some emerging practices from Brazil, Ghana, India and the Philippines that show promise. These countries have worked to strengthen governance frameworks for health systems and have implemented local solutions to bring integrated, people-centred care for mental health and NCDs closer to the community.

Many LMICs recognised the importance of community-based mental health care long before the global health community started to talk about it. **Ghana** has used task-sharing models to give cadres of 'community mental health officers (CMHOs)' responsibility for meeting the needs of mental health patients, including those living with NCDs. They are trained to deliver the bulk of mental health care at community level, supervised by community psychiatric nurses (CPNs), who also run community outreach clinics.

Brazil and India have worked to take integrated, people-centred care a step further.

In **Brazil**, the unified health system 'Sistema Único de Saúde' (SUS) shifted mental health services to community levels more than three decades ago. People with mild to moderate mental health conditions are treated in primary care settings by general practitioners under the supervision of mental health specialists. Here, individuals living with diabetes, hypertension and depression, for example, receive comprehensive care.

Similarly, since 1996, **India** has been promoting community participation in mental health service development through the District Mental Health Program (DMHP). The programme has involved the careful transfer of mental health care to primary care physicians. They have been trained and supervised to diagnose and treat a range of mental health conditions commonly encountered in primary care.

40 Mental Health Gap Action Programme (mhGAP) guideline for mental, neurological and substance use disorders. World Health Organisation, 2023. https://www.who.int/publications/i/item/9789240084278

41 Acharya B, Ekstrand M, Rimal P, et al. Collaborative Care for Mental Health in Low- and Middle-Income Countries: A WHO Health Systems Framework Assessment of Three Programs. Psychiatr Serv. 2017 Sep 1;68(9):870-872. doi: 10.1176/appi.ps.201700232. Epub 2017 Aug 1. PMID: 28760096; PMCID: PMC5790311.

Finally, the ambitious global vision for universal health care (UHC), in theory involves integrating mental health and NCDs into the existing health system, because it advocates against competition among diseases for attention and resources, which may lead to duplication and inefficient use of resources and instead push for better access to care. The UHC Law in the **Philippines** has embraced this in practice, integrating mental health and NCDs into the broader healthcare system. Both are addressed through accessible, community-based, and preventative services, as part of primary care and essential public health services. At the same time, PhilHealth (Philippine Health Insurance Corporation) offers financial risk protection covering a broad range of NCD and mental health care, including consultations, diagnostics, and essential medicines. PhilHealth also covers various outpatient mental health services and medications, ensuring that NCD and mental health treatments are accessible.

With the launch of the Philippine Council for Mental Health Strategic Framework (2024-2028) and the overarching Mental Health Act 2018, the Philippines is also spearheading new mental health governance and accountability structures, which will accelerate national efforts to improve mental health care. They will make sure strong legal frameworks and mandate the integration of mental health services into basic health services to increase access to integrated, people-centred care.

BOX 1

COUNTRY CASE STUDY: COLLABORATIVE CARE FOR DEPRESSION IN RURAL NEPAL

In Nepal, there are less than 100 psychiatrists – and they are concentrated in urban areas, leaving remote and rural areas even less well resourced. Only a few district facilities offer specialist mental health services. To help address these unmet mental health needs, the collaborative care model (CoCM) was introduced in a large primary care clinic in rural Nepal between 2016 and 2018.

Three core aspects were central to the model in Nepal:

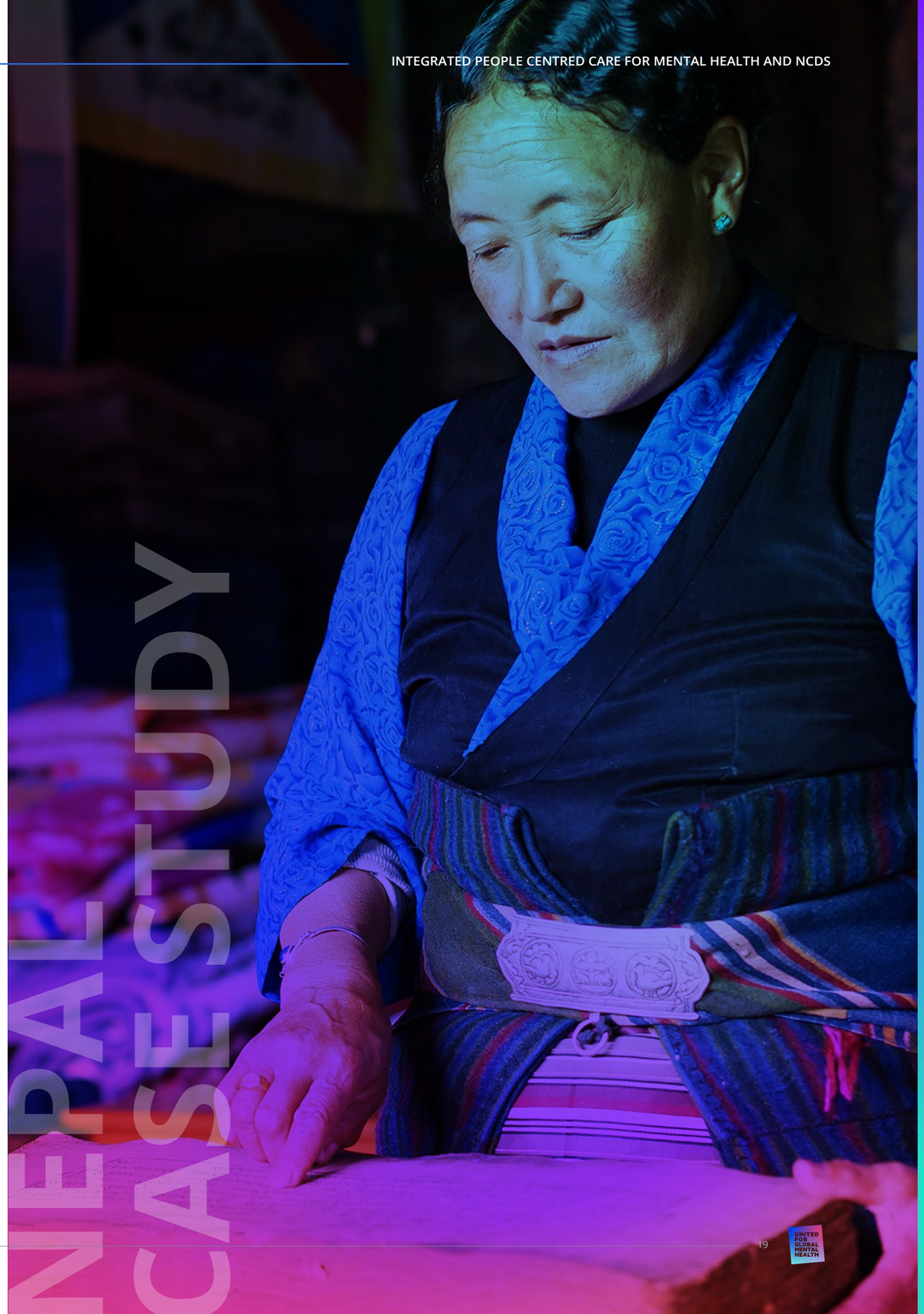
- Primary care providers were trained in mhGAP to increase capacity and motivation for integrated, people-centred care
- In the absence of social workers or other specialist behavioural health professionals, the counsellor/care coordinator role was fulfilled by a team of psychosocial counsellors with 3–6 months of training – they conducted psychosocial evaluations and provided support using relaxation techniques, psychoeducation and basic psychotherapy
- Given the resource constraints of hiring an on-site psychiatrist, a part-time off-site psychiatrist was employed to conduct remote panel reviews of cases, train the local team, and directly evaluate complex cases.

Following the CoCM's introduction, it was noted that:

- the primary care workforce reported improvements in their 'clinical knowledge,' 'self-efficacy' and their competency to 'identify and treat mental illness'
- from observed clinical outcomes, there was a substantial improved clinical response in the patient cohort presenting with moderate or severe depression.

This example from rural Nepal demonstrates that local adaptations to the CoCM in resource-limited settings can enhance health providers' perceptions of mental health care and improve the delivery of mental health services.[42]

42 Rimal P, Choudhury N, Agrawal P, et al. Collaborative care model for depression in rural Nepal: a mixed-methods implementation research study. BMJ Open 2021;11:e048481. doi:10.1136/ bmjopen-2020-048481



BOX 2

COUNTRY CASE STUDY: INTEGRATING DEPRESSION SCREENING INTO HYPERTENSION AND DIABETES CARE IN MALAWI

In Malawi, the mental health workforce is scarce. The country has just four psychiatrists and fewer than three psychiatric nurses per 100,000 population. Specialised mental health care is found in only four hospitals providing crisis inpatient care, and there is a clear need to decentralise mental health services.

After proving their success in other LMICs, an integrated depression care model was adapted and implemented in Malawi. It was scientifically evaluated to understand how to effectively integrate depression care into NCD services to improve outcomes for patients with hypertension and diabetes.

The core elements of the integrated depression care model included:
A basic strategy: Internal champions in the clinical care pathway integrated three core elements for screening and treating depression:

- a standardised tool to screen all patients for depression
- psychosocial counselling using the Friendship Bench[43] model
- algorithm-guided non-specialist antidepressant management.

An enhanced strategy: The internal champions care was supplemented by external supervision whereby government ministry officials and clinical specialists visited the relevant facilities every four months, evaluating quality of care and providing staff with constructive feedback.

Following the introduction of the integrated depression care model, it was noted that:

- High initiation rates of depression treatment (i.e., percentage of patients who started treatment) were noted in both the basic and enhanced strategy
- The inclusion of external supervision, audit and feedback in the enhanced strategy fostered increased rates of appropriate follow-up care and led to better mental health outcomes.

This example from Malawi reinforces the evidence of the success of the integrated depression care model and demonstrates the benefit of combining external supervision with internal champions to advance the integration of depression treatment into primary care for resource-limited settings.[44]

43 Website: The Mental Health Innovation Network.The Friendship Bench. Accessed 1st November 2024. https://www.mhinnovation.net/innovations/friendship-bench

44 Pence BW et al. Two implementation strategies to support the integration of depression screening and treatment into hypertension and diabetes care in Malawi (SHARP): parallel, cluster-randomised, controlled, implementation trial. Lancet Glob Health. 2024 Apr;12(4):e652-e661. doi: 10.1016/S2214-109X(23)00592-2. Epub 2024 Feb 23. PMID: 38408462; PMCID: PMC10995959.

BOX 3

COUNTRY CASE STUDY: DIABETES SELF-MANAGEMENT INTERVENTION THAT ADDRESSES MENTAL HEALTH IN SONORA, MEXICO

In Mexico, the prevalence of type-II diabetes mellitus has increased from 9.2% in 2012 to 10.3% in 2018. And a 2019 Mexican Health and Aging study found that people living with diabetes had an increased likelihood of experiencing severe depressive symptoms. Understanding and addressing the bidirectional relationship between depression and diabetes is critical for improving health outcomes.

People living with diabetes access health services through health centres offering diabetes screening and treatment, self-management programmes and mental health services. Self-management programmes have shown promise in helping people address and prevent both physical health complications from diabetes, and mental health issues, particularly in resource-limited settings.

Meta Salud Diabetes (MSD) has been implemented and evaluated in the state of Sonora, in collaboration with the Ministry of Health. MSD is a 13-week programme which includes weekly team-based sessions led by doctors, nurses and community health workers. These sessions help participants increase their understanding of diabetes complications, mental health, health services and the benefits of lifestyle changes.

There is existing evidence on the significant impact of diabetes self-management and education programmes in reducing depressive symptoms. MSD builds on this by incorporating elements of health promotion that address mental health indicators, including motivation and distress.

A qualitative study in 2021 assessed the perspectives of health centre staff and people using MSD on mental health outcomes.

On the perceived mental health benefits:

- Health centre staff and those using MSD noted an increase in the efficacy of diabetes self-management, which contributed to better mental health especially among people living with depression.
- MSD helped build stronger social bonds between participants, and the peer support helped address the challenges of isolation and anxiety related to diabetes.

On opportunities for improving mental health:

- The increased involvement of families in the self-management of diabetic care helped give them a deeper understanding of both the physiological changes related to diabetes but also the potential mental health challenges living with it entails.
- There was recognition of the need to prioritise mental health services as an essential component in primary care for people living with diabetes – to have primary care staff that can identify mental health issues and better coordinate care.

Programmes like MSD promote a comprehensive approach to diabetes self-management and education that offers opportunities to promote positive mental health outcomes for people living with diabetes, especially in LMIC settings.[45]

45 Aceves, B., Ruiz, M., Ingram, M. et al. Mental health and diabetes self-management: assessing stakeholder perspectives from health centers in Northern Mexico. BMC Health Serv Res 21, 177 (2021). https://doi.org/10.1186/s12913-021-06168-y

RECOMMENDATIONS

The burden of mental health and NCDs is growing globally, especially in LMICs. People living with these conditions continue to face challenges in accessing robust, high-quality health services, compromising their right to good quality and affordable health care.

There is no perfect system. All health systems, whether high- or low-resource, experience gaps in PHC and are far from providing comprehensive mental or physical health care. But integrating people-centred care for people living with mental health conditions and NCDs could provide the key to addressing these gaps. Global policy frameworks for integrated people-centred health services exist. WHO guidance on mental health and NCDs supports integration with a strong foundation in PHC.

National governments and development partners need to come together to strengthen their commitment to ensuring communities and individuals enjoy the highest possible level of health and mental well-being. In implementing primary health care strategies that prioritise greater access to mental health and NCD services, national governments can offer a people-centred approach to prevention, early intervention, treatment and recovery that considers both the physical and mental health of a person.

The following recommendations require governments to lead PHC reform through strong political commitments, actionable policies and sustainable finance. They require development actors to support and invest in national mental health and NCD strategies to advance people-centred primary health care.

- ### INTEGRATED, PEOPLE-CENTRED CARE
  Governments should integrate mental health and NCD services into primary care. This is the fastest way to close the mental health and NCD treatment gap and ensure people receive the comprehensive health care they need.

- ### SERVICE REFORM
  Governments should take active steps to provide human rights-based, person-centred care for people with mental health conditions by gradually shifting resources from long-stay institutions towards a comprehensive network of community-based care, including strengthening primary and secondary care.

- ### THE PRIMARY CARE WORKFORCE WE NEED
  The PHC workforce needs to be well equipped with mental health pre-service education and training. They need to feel well supported and supervised enough to deliver the quality of PHC necessary to effectively identify, diagnose, treat and care for people with mental health conditions and NCDs.

- ### DIFFERENT SETTINGS, DIFFERENT STAGES OF INTEGRATION
  Every country is at its own unique stage along the integration journey. A one-size-fits-all integration model for countries to follow does not exist. Countries should take into account the overarching principles for integrated, person-centred care within the context of their own health and PHC system.

- ### SHARED LEARNING TO SPARK CHANGE
  Integration is possible. Numerous countries have successfully made the transition to integrating aspects of mental health and NCD services into primary care. These examples should be celebrated and promoted through regional and global networks of development partners, for cross-country learning opportunities.

- ### POLITICAL WILL HAS TO MATCH POLICY CHANGE
  Countries should have actionable policies and other incentives that promote the integration of mental health and NCD care into primary care. They should take advantage of existing operational guidance on strengthening PHC and ensure that discussions and initiatives promoting integration are not fragmented.

- ### DOMESTIC AND DONOR RESOURCES SHOULD INCREASE, IMPROVE AND INTEGRATE MENTAL HEALTH AND NCD FINANCING
  To deliver optimal integrated, people-centred care, sustainable and equitable ways to finance the integration of mental health and NCDs into primary and community-based health care should be a national priority.

Fostering enabling environments to deliver integrated, people-centred care for mental health conditions and non-communicable diseases

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