Integrated primary care for mental health in the Eastern Province

Case summary
In the Eastern Province of Saudi Arabia, Ash-Sharqiyah, primary care physicians provide basic mental health services through primary care, and selected primary care physicians, who have received additional training, serve as referral sources for complex cases. A community mental health clinic provides complementary services, such as psychosocial rehabilitation.

As a result of training and ongoing support by mental health specialists, physicians’ knowledge and management of mental disorders have improved. Many people, who otherwise would have been undetected or hospitalized, are now treated within the community.

1. National context
Key indicators for Saudi Arabia are displayed in Table 2.26. Saudi Arabia’s main economic sectors are petroleum-based (roughly 75% of budget revenues and 90% of export earnings come from the oil industry). Wealth is unequally distributed, and poverty and unemployment have been addressed formally by the Government since 1995. Dependence on oil and a growing population are other systemic problems of the Saudi economy.
A global perspective

Saudi Arabia: national context at a glance

- Population: 25 million (81% urban)
- Annual population growth rate: 2.8%
- Fertility rate: 3.8 per woman
- Adult literacy rate: 79%
- Gross national income per capita: Purchasing Power Parity International $: 14 740
- Population living on less than US$ 1 per day: data not available or not applicable
- World Bank income group: high-income economy
- Human Development Index: 0.812; rank 61/177 countries

Sources:

Saudi Arabia’s main religion is Islam (Salafism or Wahhabism) and its official language is Arabic, although English is also used widely in business and commerce.

2. Health context

Saudi Arabia has experienced a large decline in mortality and morbidity from communicable diseases and perinatal conditions. Major causes of deaths are now heart disease, congenital abnormalities, road traffic accidents, and diabetes. Additional health indicators are displayed in Table 2.27.

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Saudi Arabia has a national health care system in which the government provides services through a number of agencies. The private health sector is also growing. The Ministry of Health is responsible for preventive, curative and rehabilitative health care. Its mission is, “The provision of comprehensive health care comprising preventative, curative and rehabilitative health services in addition to taking care of the health personnel in a means that will influence an acceptable performance.” The Ministry of Health budget represents 10% of government expenditure. Total expenditure on health is 77% from the government and 23% from private sources.

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<td>Life expectancy at birth: 60 years for males/63 years for females</td>
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<td>Total expenditure on health per capita (International $, 2004): 601</td>
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Mental health

Studies in Saudi Arabia have revealed low detection rates for mental disorders. In the city of Al-Khobar, 22% of health clinic patients had mental disorders such as depression and anxiety, however only 8% were diagnosed. In Riyadh, 30% to 40% of those seen in primary care clinics had mental disorders and again, most were not diagnosed. In central Saudi Arabia, 18% of adults were found to have minor mental morbidity. Rates were higher among the young (15–29 years, 23%), divorced people and widows (more than 40%). Suicides have been estimated to occur at a rate of 1.1/100,000 population per annum, and to be most common among men, people aged 30 to 39 years, and immigrants.

Psychiatric hospitalizations occur in a range of settings:

- the main psychiatric hospital in Saudi Arabia, Taif Hospital: 570 beds;
- other psychiatric hospitals (14 total): 30–120 beds each;
- psychiatric departments and clinics attached to general hospitals (61 total): 20–30 beds each;
- hospitals for treatment of alcohol or drug dependence (3 total): 280 beds each;
- military, national guard and university hospitals: 165 beds total;
- general private hospitals for psychiatric care: 146 beds total.

Rehabilitation services are concentrated mainly in the private and nongovernmental organization sector. Criminals with mental disorders are treated in secure units in Taif hospital and certain other hospitals. Child psychiatric services are delivered mainly on an outpatient basis.

3. Primary care and integration of mental health

Free curative, preventive, promotive, and rehabilitation services, provided by general practitioners, are available in 1850 primary care units across the country. Primary care is regarded as the foundation of the health service and most patients are seen at this level – about 83% of public sector attendances occur in primary care clinics. Three types of primary care centres exist, covering populations of up to 500, 5000, and 25,000; however, some clinics, particularly those in urban areas serve up to 100,000 people. Primary care practitioners are largely expatriates. Most services have developed from vertical programmes, and attempts are now under way to provide more coherent services at the primary level.

The Ministry of Health established a National Mental Health Committee in 1990 to work towards primary care for mental health. One of its first activities was to implement a training programme for improving primary care physicians’ ability to diagnose and manage mental disorders. Two manuals were prepared: one for primary care physicians, and a second for other health team members. Workshops were organized for psychiatrists to teach them how to effectively support primary care physicians in diagnosis and management of mental disorders. All primary care workers across the country were subsequently required to attend training programmes on the recognition and treatment of common mental disorders. The format varied between regions, but frequently the primary care physicians met the psychiatrists, either at the primary care centre or a hospital, for a few hours a week for two months. The training covered three important areas: general psychiatry; child and adolescent psychiatry; and the psychiatry of women.
Importantly, all antidepressant and neuroleptic medications were exempted from the controlled drug list so that they could be prescribed by primary care physicians. The initiative also established community mental health rehabilitation centres.

4. Best practice

Local context

The Eastern Province, Ash-Sharqiyah, is the largest province of Saudi Arabia. It has an area of 710 000 square kilometres and a population of 3.4 million people (2004 census). Due to industrialization (oil production), many people have migrated from other parts of the country, mainly rural areas, to the province's main cities.

Dammam city is the capital of the province and has 22 primary care centres served by 78 physicians. Al-Khobar, the second largest city, has 10 primary care centres served by 26 physicians. There is a psychiatric hospital in Dammam city and a psychiatric unit at King Faisal Hospital in Al-Khobar. Both have inpatient and outpatient services. Two other cities in the province also have outpatient psychiatric clinics.

Two community mental health centres have been established in the province, the first in 2003 and the second in 2006. These centres provide care for referred patients, and also offer support and supervision to primary care practitioners in the area.

The districts covered by this best practice example have a population of around one million people, who are seen at 112 primary care centres staffed by 257 primary care physicians. (As yet, not all have been included in the mental health programme. The service will be expanded in the future.)

Description of services offered

Training for primary care physicians has been offered at two progressive levels of skill development.

The first level is one month of basic training in mental health issues, diagnosis of common mental disorders, appropriate use of psychotropic medications, and provision of brief psychotherapeutic interventions. Seventeen primary care physicians have participated in this training and now provide mental health services from their clinics. Families are engaged in the consultation process and provided with information to help them effectively support the ill family member. If the complexity of a case is beyond the primary care physician's level of competency, the patient is referred to one of two community mental health centres in the province.

The second level of training is more intensive and advanced, enabling graduates to manage more complicated mental health problems. Two primary care physicians have participated in this training and are now able to identify and treat people with both common and severe mental disorders through medication and psychotherapy. They also act as important referral sources for complex cases seen by other primary care physicians.
The service also offers home visits to patients discharged from hospital to community care. Patients are supported with social and psychological counselling, and treatments and side-effects are monitored. Relationships within families are also targeted for improvement as needed.

The ultimate aim of the service is to fully integrate mental health into every primary care centre in the province, supported by community mental health centres and other referral clinics. Training is continuing to guarantee at least one trained physician in each primary care centre in the province.

**Process of integration**

**Research to inform the model of integrated mental health care**

A research programme was established in 1999 to establish whether a short training course would improve mental health services in primary care settings. Results showed that training improved primary care physicians’ knowledge and attitudes towards mental disorders; however, it failed to show an improvement in their detection and treatment rates. It was concluded that one-time training was insufficient and instead, a system of ongoing training, support and supervision was required.

**The process of establishing the service**

A committee for community mental health was initiated under the supervision of the Assistant Director General of Health Affairs for primary care in the province. The committee’s task was to support the programme and act as a legally constituted body for the ongoing development of mental health services.

It was agreed that the service would:

- provide mental health services through primary care;
- train primary care physicians and improve their ability to diagnose mental disorders;
- help patients and families cope and reduce social stigma associated with mental disorders;
- provide proper counselling within the community and promote the active participation of patients and their families in problem solving;
- build bridges between primary care and mental health services;
- improve community awareness through mental health education and promotion;
- establish a mental health research centre.

A work team was established to oversee the process. Members were selected from different specialties including family medicine, psychiatry, psychology, social work, and nursing.

**Clinical services through the community mental health clinic**

A community mental health clinic was established to provide complementary services, such as important psychosocial rehabilitation functions that cannot be provided in the primary care centres. The community mental health clinic receives patients from all primary care centres in the catchment area.
**Training programmes**

Two types of training courses were established: long-term training (Training Course-I), and short-term training (Training Course-II).

**The long-term training programme**

The long-term training equips primary care physicians with the skills to manage a diverse range of common and severe mental disorders. Physicians completing this training can continue to work at the community mental health centre, or they can return to their clinic, which is then designated as a “referral primary care clinic”, because of the new mental health services that can be delivered. The course consists of six to nine months in the community mental health clinic; and three months in the psychiatry department, King Fahad University Hospital, Al Khobar.

Objectives of the long-term training are to:

- improve the capacity of primary care physicians to manage severe mental disorders through direct clinical treatment and referral;
- enhance the skills of primary care physicians to diagnose common mental health problems;
- teach psychotherapy techniques, especially patient-focused techniques, and equip primary care physicians to use medication appropriately in the management of depression, anxiety, and somatoform disorders;
- sensitize primary care physicians to the interwoven nature of physical and mental health and illness, and to the social factors that influence mental health;
- strengthen links between psychiatrists and primary care physicians in providing mental health services.

**The short-term training programme**

The short-term training enables primary care physicians to diagnose and treat mental health problems within their clinics. Specifically, it increases physicians’ awareness of mental health problems in their patients and helps them to provide adequate treatment and care. The training consists of a one-month rotation in the main community mental health clinic. Trainees are involved directly in observation, interviews and management of mental disorders together with centre staff.

The training covers both the use of psychotropic medicines and psychotherapeutic techniques. Trainees are taught how to appropriately use the restricted number of psychotropic medications available at primary care level. They are also trained in basic cognitive-behavioural therapy and the use of narrative techniques as part of brief patient-focused therapy.

Objectives of short-term training are to:

- improve the ability of primary care physicians to identify mental health problems and diagnose common mental disorders at an early stage;
- enable primary care physicians to identify patients with serious mental disorders and make appropriate referrals to higher levels of service;
- enhance primary care physicians’ ability to work with patients and families to improve treatment adherence and outcomes;
help primary care physicians increase the awareness of other primary care workers about mental health issues.

5. Evaluation/outcomes

Services provided

Knowledge and skills assessment of mental health issues and provision of mental health care by primary care physicians

Primary care physicians’ knowledge of mental disorders was assessed before and after training. After the one-month training course, their average test scores improved from 54% to 71%.

Trainees were also evaluated by assessing their ability to detect patients with mental disorders in their clinics, and by measuring the extent to which they provided counselling, psychotherapy, medication, and appropriate referrals. Six months post-training, seven randomly selected physicians from the short-term training course detected more than three times the number of people with mental disorders, compared with the six months prior to the training – 173 patients compared with 41 patients. Physicians also provided more brief psychotherapy, counselling, reassurance, and support, rather than relying solely on prescription of medication (see Table 2.28).

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<tr>
<th>Management</th>
<th>Before training</th>
<th>After training</th>
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<tr>
<td>Psychotherapy</td>
<td>12</td>
<td>67</td>
</tr>
<tr>
<td>Referred to community mental health services</td>
<td>16</td>
<td>66</td>
</tr>
<tr>
<td>Referred to hospital</td>
<td>10</td>
<td>18</td>
</tr>
<tr>
<td>Refused treatment or referral</td>
<td>3</td>
<td>22</td>
</tr>
<tr>
<td>Total</td>
<td>41</td>
<td>173</td>
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Research has not yet assessed patient health outcomes, however it is clear that many more patients are being identified and provided with treatment, or referred to the community mental health centre.

Referral to and treatment within the community mental health centres

Between 2003 and 2006, 1037 patients were seen at the first community mental health centre, and more than 4540 consultations were conducted with patients aged 3 to 70 years. After treatment, 56% showed significant improvement and 21% were in complete remission. The most common problems seen within the community mental health centre were anxiety (30%) and depression (27%).

Patient satisfaction

A random sample of community mental health centre patients (137 patients) was asked to provide feedback after their clinical visits (usually after their second or third visit). Most patients indicated “great” (58%) or “partial” (33%) benefit from the services. Importantly, most patients greatly appreciated the community-based nature of the centre. More than one quarter of
patients stated that they would not seek hospital-based services and would prefer to forego treatment than to be hospitalized. A further one quarter stated that they would hesitate to receive hospital-based treatment, despite their awareness of the importance of mental health management.

6. Conclusion

An important feature of the community and primary care programme is that it is a comprehensive service with a number of linked components. The community mental health centre depends on the accurate identification and appropriate referral of patients from primary care settings. On the other hand, primary care settings depend on the support of the community mental health centre. Both settings provide a combination of psychotherapies and medication management. Secondary and tertiary facilities are available to accept referrals when needed. Home visits form an important part of the overall service. Finally, the public is being educated on mental health issues and stigma is being reduced.

Key lessons learnt

- Training on integrated mental health care is ineffective without ongoing support and supervision.
- Community mental health centres are central to the success of integrated programmes. Primary care physicians must feel supported and be able to easily refer patients.
- Primary care physicians form the backbone of mental health care in the province. Not only are trained primary care practitioners identifying, treating and referring patients within primary care settings, but with additional training, certain physicians have become responsible for the community mental health centres.
- The model allows many people, who would otherwise need to be hospitalized, to be treated within the community. At the same time many people who would otherwise receive no mental health care are now being treated.
- In the absence of community-based services, identification of mental disorders within primary care can be highly frustrating for primary care physicians and patients alike – especially given that many patients refuse hospital referral.

References – Saudi Arabia


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13 Khathami A. The implementation and evaluation of educational program for PHC physicians to improve their recognition of mental illness, in the Eastern Province of Saudi Arabia [Dissertation]. Al-Khobar, King Faisal University, 2001.