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Scaling up mental health services within the PHC approach

Lessons from the WHO European Region

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Abstract

Mental health conditions significantly impact health and socioeconomic stability in the WHO European Region, affecting over 125 million people, particularly vulnerable groups. Sociopolitical crises, including the COVID-19 pandemic and ongoing conflicts, further exacerbate this psychological distress. Despite the potentially pivotal role of primary care in addressing mental health needs, various barriers limit its effectiveness in many contexts.

This policy paper outlines a strategic framework to scale up mental health services within primary care and align them with the primary health care approach, emphasizing integrated, people-centred care. Four strategies are proposed: (1) enhancing mental health competencies of primary care workers through education and training; (2) integrating dedicated mental health professionals into primary care teams; (3) strengthening linkages between primary care and specialist mental health services; and (4) fostering multisectoral collaboration to address social determinants of mental health.

Successful implementation of these strategies requires strong policy support, investment in human and physical resources, improved financing mechanisms and collaborative governance. By overcoming existing barriers and adopting these strategies, primary care can significantly improve mental health outcomes across the Region, ensuring patients receive appropriate services that prioritize the least invasive treatments in accessible environments.

Keywords

PRIMARY CARE
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Foreword

Mental health is a cornerstone of our well-being, influencing every aspect of our lives, from physical health to social interactions to economic productivity. Yet, for far too long, mental health has been relegated to the periphery of health systems worldwide, including in the WHO European Region, receiving little priority and few resources. Despite longstanding recognition of the benefits of providing mental health services in the community, close to where those experiencing these conditions live, such settings remain underdeveloped in many countries. As a result, patients are still often isolated from their immediate environment and placed in institutions, which frequently offer little therapeutic benefit and perpetuate mental health stigma.

Today, WHO stands at a pivotal juncture, advocating for increased commitment and investment in the development of community-based mental health care. The urgency to act is underscored by the growing burden of mental health conditions. Depression, anxiety and other mental health disorders are on the rise, exacerbated by the challenges of modern life and the profound impacts of the COVID-19 pandemic, climate events and military conflicts. The lack of appropriate care and the persistent stigma not only diminish quality of life but also impose significant social and economic costs on societies, creating a compelling imperative for action.

This policy paper outlines a strategic framework for scaling up mental health services within the primary health-care (PHC) approach, aligning with WHO's commitment to achieving universal health coverage. By embedding mental health care within primary care, close to where people live, and strengthening linkages between primary care and other levels of care as well as across sectors, we can promote the provision of mental health services that are more accessible, equitable and integrated into the broader health-care continuum. This approach leverages existing primary care provision, enabling early detection, timely intervention, and comprehensive care that addresses both physical and mental health needs, recognizing that the two often go hand in hand.

The four key strategies outlined in this policy paper are rooted in evidence and best practices gathered from diverse contexts across the Region. They encompass a variety of approaches and policy levers that can effectively support the implementation of these strategies. The breadth and depth of this knowledge would not have been reached without those who contributed to the development of this policy paper. For this, we extend our sincere gratitude.

The WHO Regional Office for Europe is committed to supporting our Member States in adapting these recommendations to their unique contexts, providing technical assistance, and fostering partnerships to realize the visions of community-based mental health care and the PHC approach. This can leverage the expertise of various units and teams, particularly the WHO European Centre for Primary Health Care, and the Pan-European Mental Health Coalition – our flagship initiative launched in 2020 to elevate mental health as a critical public health priority across our Member States.

However, the transition to community-based mental health care must extend beyond the strategies outlined in this policy paper. Given escalating mental health challenges, the widening gap between the demand for and supply of mental health services, and varying capacities of primary care across the Region, it is imperative to prioritize implementation of community-based mental health care on a broader scale, within and outside of the health sector. Community-based mental health care is a rich and diverse ecosystem of settings, where primary care plays or can play a crucial role but constitutes just one of its many parts

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Abbreviations

ASSIST	Alcohol, Smoking and Substance Involvement Screening Test
AUDIT	Alcohol Use Disorders Identification Test
CBT	cognitive behavioural therapy
CMHC	community mental health centre
CMHT	community mental health team
COVID-19	Coronavirus disease
EFAMH	European Framework for Action on Mental Health
EPW	European Programme of Work
FFS	fee-for-service
FMT	family medicine team
GHQ	General Health Questionnaire
GP	general practitioner
HLC	healthy life centre
HSCL-25	Hopkins Symptom Checklist
IAPT	Improving Access to Psychological Therapies
ICT	information and communication technology
mhGAP	Mental Health Gap Action Programme
mhGAP-IG	mhGAP Intervention Guide
MNS	mental health, neurological, and substance use
NGO	nongovernmental organization
PAPPS	Programme of Health Promotion and Disease Prevention Activities
P4P	payment for performance
PCMHS	primary care mental health services
PHC	primary health care
PM+	Problem Management Plus
PWP	psychological well-being practitioner
QOF	Quality and Outcomes Framework
SDG	sustainable development goal
SH+	Self Help Plus
UNA	Ukraine-Norway-Armenia

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Executive summary

The profound and escalating health and socioeconomic impacts of mental health conditions underscore the urgent imperative for action in addressing them.

The WHO European Region is grappling with substantial public health challenges posed by mental health conditions, affecting over 125 million of its inhabitants. Most lifetime mental health conditions emerge before the age of 25, stressing the critical need for early interventions aimed at young populations. In adulthood, mental health conditions tend to cluster in vulnerable groups, such as minorities, refugees, postpartum women and individuals with chronic physical conditions – both noncommunicable diseases (NCDs), such as diabetes, and communicable (infectious) diseases, such as hepatitis C. Older populations are disproportionately affected, with dementia prevalence notably rising among those aged 65 and older. Population aging necessitates a heightened focus on mental health care as cognitive impairments become more widespread.

These demographic challenges are compounded by various sociopolitical crises. The Coronavirus disease pandemic has significantly exacerbated mental health issues across demographics, amplifying stress, anxiety and other psychological problems. Additionally, socioeconomic instabilities, such as the cost-of-living crisis; natural disasters, including the devastating earthquake in Türkiye; and climate change-related weather events, such as the recent floods in Central Europe, have heightened mental distress, especially among the most vulnerable populations. Furthermore, ongoing conflicts in regions, such as Ukraine, not only displace populations but also contribute to long-term psychological trauma.

Addressing these multifaceted issues underscores the urgency of enhancing access to both preventive and curative mental health services. However, many barriers hinder access to these services in numerous contexts. These barriers include insufficient provision of services, their high costs, and pervasive stigma associated with mental health issues, which deter individuals from seeking necessary care.

Primary care holds significant potential to address many mental health concerns, yet often lacks the commitment and resources for scaling up these services.

Primary care serves, or aspires to serve, as an integral part of the health system and its people-fronting interface, integrating health services into people's daily lives from birth to end of life. Mental health conditions disproportionately affect children and young people, vulnerable adults, and older people – groups that can be effectively reached by high-quality primary care. Consequently, primary care is ideally positioned to address many mental health needs in the population.

Indeed, mental health conditions account for a large proportion of health issues that present to and are potentially addressed in primary care settings. In robust and comprehensive primary care systems, mental health issues typically account for one third to one half of presenting concerns and health professionals trained to deliver comprehensive care will inevitably identify mental health issues in the course of regular consultations.

However, due to various barriers, including lack of political commitment and resources, primary care currently plays only a limited role in the provision of mental health services in many contexts.

As the burden of mental health conditions continues to increase across the Region, scaling up mental health services within primary care and strengthening connections with services provided at other levels of health care and in other sectors offer an opportunity to enhance overall health outcomes. This approach aligns with the reorientation of health systems towards the PHC approach promoted in the Alma-Ata and Astana Declarations, which rests on three pillars: provision of integrated health services along the life course, with primary care and public health services at its cornerstone; multisectoral action; and community engagement.

This policy paper outlines a strategic approach to scaling up mental health services within primary care and reorienting the provision of mental health services towards the PHC approach more broadly.

Building on available evidence and best practice examples, this policy paper proposes four strategies to align mental health services with the PHC approach. The first two strategies involve strengthening the provision of mental health services in primary care settings, either by introducing or enhancing the mental health competencies of existing primary care workers and/or by integrating dedicated mental health workers into primary care teams. The other two strategies concentrate on enhancing linkages across mental health services within different levels of the health sector and between the health and other sectors. Together, these strategies aim to foster a more integrated and people-centred health system equipped to meet mental health needs comprehensively, while at the same time fostering multisectoral action and community engagement in mental health.

The first strategy, **enhancing the mental health capacities of primary care workers,** is dedicated to fostering the mental health competencies of primary care workers, including primary care doctors, nurses, and health-care assistants. It champions sustained education and training, enabling these professionals to perform mental health assessments, offer initial psychological support, implement foundational interventions, as well as guide individuals towards self-care and other available resources. The development of such capacities is vital for the early identification and management of mental health conditions, setting the stage for effective treatment and care.

Expanding primary care teams through the integration of dedicated health workers with competencies in mental health, the second strategy, advocates for the inclusion of dedicated mental health workers, such as clinical psychologists and other mental health workers trained in psychological interventions, psychiatric nurse practitioners, non-specialist counsellors, and peer support workers with lived experience, into the fabric of primary care teams. This integration promises to bolster the spectrum and competence of mental health services available, ensuring a treatment model that comprehensively encapsulates both the mental and physical aspects of health. This approach can take various forms. For instance, in attached care, mental health workers remain primarily employed in specialist mental health settings but are also "attached to" and regularly practice in primary care. In co-located care, such workers work permanently in primary

care settings. Primary care workers can in turn also be integrated within a specialist mental health service, which is referred to as reversed shared care, to address the general health needs of mental health patients.

The third strategy, **strengthening linkages between primary care and specialist mental health services**, focuses on weaving a seamless network between primary care and specialized mental health services, while allowing primary care and mental health care workers to continue working in their respective settings. This is envisioned through models of care such as consultation liaison, where primary care workers maintain a key role in coordinating patient care, and collaborative care, where mental health specialists take the leading role in patient care.

Promoting linkages between health and other sectors, the fourth strategy, recognizes the multifaceted nature of mental health, which intersects with various social determinants. It urges a concerted approach across sectors, such as education, employment, housing and social services, fostering partnerships that are pivotal in addressing these determinants. This collaborative stance is crucial in devising policies and programmes that underpin mental health promotion and prevention within community settings.

Implementation of the chosen strategies should be guided by the imperative of ensuring that patients receive the most suitable type and level of service.

Regardless of which strategy or strategies are being implemented, the overarching objective should always be to provide the individual with the most suitable and effective treatment tailored to their specific circumstances, taking into consideration factors such as the individual's diagnosis, the severity of their mental health condition, and their own health goals. Such a "matched" or "stepped" care approach is rooted in the belief that many individuals can be effectively treated with less intensive methods, and only those who do not respond to lower-intensity treatments require more extensive care. This concept aligns with both the principles of PHC and the deinstitutionalization of mental health services. In such care systems, diverse providers take on different but complementary roles, optimizing resource utilization and enhancing accessibility to care. This underscores the importance of ensuring that care providers at each tier, ranging from individuals and community providers to general and specialist health-care workers, possess and maintain competencies in mental health.

The successful implementation of these strategies is contingent upon education and training but also comprehensive policy support, with appropriate workforce, infrastructure, financial and governance levers.

As highlighted throughout this policy paper, the scaling up of mental health services in primary care faces many barriers, including inadequate education and training, insufficient human and financial resources, and a lack of political commitment. Addressing these barriers – including through the policy levers outlined below – is essential for successfully implementing the strategies detailed herein. While not explored in depth in this policy paper, initiatives aimed at raising awareness about mental health conditions and reducing stigmatizing attitudes among health-care workers and the general population (including those in positions of political decision-making) – such as public awareness campaigns – can play a pivotal enabling role in this process.

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- **Education and training.** Enhancing the mental health competencies of the primary care workforce necessitates the provision of appropriate education and training, commencing with pre-service education. In-service training (i.e. training that takes place during active employment) is in turn pivotal for reinforcing and updating existing mental health skills during active employment, as well as equipping those with a limited foundation in mental health care with basic skills. Involving input from diverse health workers and individuals with lived experiences of mental health conditions in the design of training programmes can ensure their adaptation to local contexts and help to break down professional silos and reduce stigma, while continuous supervision, mentoring and support are essential to reinforce mental health skills acquired through training. Various tools and programmes, such as WHO's Mental Health Gap Action Programme (mhGAP), offer guidance and resources to countries seeking to strengthen the provision of mental health services within primary care.

- **Human resources.** Education and training efforts should be complemented by strategies to encourage the generalist health workforce to assume and actively perform roles and tasks in mental health care, such as appropriate remuneration and opportunities for professional development. Particular attention should be paid to nurses who often encounter systemic inequities that hinder their engagement in mental health, despite constituting the majority of the health workforce. Finally, enhancing the stability of the implemented strategies necessitates strategies for recruitment, retention and promoting mental well-being among staff.

- **Physical resources.** Investments in health information systems and digital health technologies have the potential to enhance the provision of primary care services, including mental health interventions. While many mental health services can be delivered in existing primary care facilities, investments in facility development and upgrades can facilitate certain types of integration between primary care and specialist mental health services.

- **Financing.** Mental health strategies, plans, legislation and regulation are all pivotal in enhancing the provision of mental health services in primary care and reorienting mental health services towards the PHC approach. Multistakeholder collaboration and engagement can render policies more responsive to needs and contexts and facilitate effective implementation, while improving data collection and monitoring can support transparency and accountability in decision-making. Efforts to enhance mental health literacy can raise awareness about mental health conditions and reduce mental health stigma.

- **Governance.** Mental health strategies, plans, legislation, and regulation are all pivotal in enhancing the provision of mental health services in primary care and reorienting mental health services towards the PHC approach. Multistakeholder collaboration and engagement can render policies more responsive to needs and contexts and facilitate effective implementation, while improving data collection and monitoring can support transparency and accountability in decision-making. Efforts to enhance mental health literacy can raise awareness about mental health conditions and reduce mental health stigma.

Beyond these strategies, it is imperative to advance further the shift of mental health services to the community.

Historically, the first line of care for mental health conditions was nested within institutionalization, as community-based alternatives were scarce or nonexistent. The persistent shortage of these alternatives in many countries increases the likelihood of individuals being unnecessarily placed in institutions, which carries inherent risks. Institutions often provide limited therapeutic benefits and may exacerbate conditions. They are also associated with human rights violations, including inadequate living conditions, abuse, neglect and restrictions on personal freedom, which are often coupled with insufficient legal safeguards, perpetuating discrimination, stigma, and social isolation. In contrast, transitioning to community-based care offers more personalized and more effective treatment, promotes human rights, and creates environments that support recovery, well-being and social integration.

Primary care plays a significant role in delivering mental health services in the community and the argument for deinstitutionalization is rooted within the four key strategies described in this policy paper. However, achieving a comprehensive shift to community-based mental health care requires much more than this; it necessitates a robust network of both health and non-health settings within the community, going beyond primary care. Only through such an approach can the diverse needs of individuals with mental health conditions be met in a comprehensive and appropriate way, ensuring accessibility and equity, alignment with individuals' preferences regarding their care, and respect for their dignity and autonomy. The broader imperative to deinstitutionalize mental health services, extending beyond the four strategies outlined in this policy paper, is thus fundamental to ensuring compassionate, efficient and inclusive mental health-care systems.

A comprehensive assessment of mental health needs and the current provision of mental health services can empower countries to determine the optimal role of primary care in mental health.

Health expenditure largely reflects political choices, encompassing decisions about the allocation of government budgets to health and the design of coverage policies to reduce out-of-pocket spending. Strengthening the provision of mental health services and shifting health system's priorities towards primary care and the PHC approach necessitates political leadership, long-term commitment, and proactive, adaptable strategies to engage stakeholders at all levels while considering the social and economic contexts.

Looking ahead, countries within the Region are urged to renew their commitment to prioritizing mental health services. This entails conducting a thorough assessment of the mental health needs of their populations and identifying any gaps in service provision. It also requires evaluating mental health provisions across all settings, including within primary care. Embracing this holistic perspective on the demand and supply of mental health services can enable countries to design an optimal model of service delivery and determine the appropriate role of primary care within it.

1

Introduction

The profound health and broader socioeconomic impacts of mental health conditions are exacerbated by contemporary challenges, underscoring the urgent need for action.

Mental conditions, including substance use disorders, psychosocial disability and cognitive impairment, present a significant public health challenge in the Region. Their prevalence and associated burden in terms of disability and mortality affect over 125 million people in the Region, including children and young people *(1, 2)*. Among these, depression and anxiety are the most commonly reported, followed by drug and alcohol abuse disorders *(3)*. Dementia also emerges as a common issue, exacerbated by the aging population, affecting approximately 5% of individuals aged 65 and older, and as much as 20% of those aged 80 and above. Contemporary challenges, such as the recent COVID-19 pandemic *(4)*, climate events *(5)* and social and political changes, including the cost-of-living crisis *(6)* and conflicts, such as the war in Ukraine *(7)*, further contribute to heightened levels of mental distress among the population.

Addressing these multifaceted issues underscores the urgency of improving access to preventive and curative mental health services. Yet, due to various barriers, including insufficient provision, cost-related barriers and reduced care-seeking due to social stigma and discrimination *(8, 9)*, only a minority of those affected by mental health conditions are able to access needed services.

Most lifetime mental health conditions are initially present before adulthood, while adult mental disorders congregate in vulnerable population groups, offering obvious targets for focusing mental health interventions.

The recognition that most lifetime mental health conditions manifest during childhood and adolescence underscores the importance of early interventions. A substantial proportion of these conditions (excluding dementia) emerge before age 14, with a majority surfacing by age 25 *(2)*. Meanwhile, during adulthood, risk factors for mental health conditions tend to congregate in vulnerable groups, such as those in precarious socioeconomic circumstances, including minority ethnic groups, refugees and other displaced groups *(10, 11)*. Women during pregnancy and postpartum, young people leaving the care system, and people with chronic physical conditions are also disproportionately affected *(12)*. Additionally, older adults present a particularly vulnerable population and are susceptible to loneliness and isolation and often underserved *(13)*.

Many NCDs as well as communicable diseases that can be effectively managed in primary care are associated with comorbidities related to mental health.

Given the significant prevalence of comorbidities between mental health conditions and NCDs and their common underlying risk factors, introducing care approaches that attend to both the physical as well as mental health needs of individuals can potentially lead to improved health outcomes for both NCDs and mental health *(9)*.

For example, depression and anxiety are important comorbidities in patients with diabetes *(14)*, chronic obstructive pulmonary disease *(15)* and heart failure *(16)*, but they are often unrecognized and untreated. At the same time, depression is associated with nonadherence to diabetes self-care, including following dietary restrictions, medication compliance and blood glucose monitoring, resulting in worse overall clinical outcomes *(17)*. Since many chronic disease programmes are provided within primary care, integrating mental health care in this setting has the potential to improve health outcomes, quality of care, and adherence to medical and mental health interventions.

Similarly, mental health conditions play a critical role in the management of infectious diseases. For example, patients infected with hepatitis C or human immunodeficiency virus *(18)* frequently experience comorbid depression *(19–21)*. Evidence shows that managing these diseases in primary care is appropriate and effective *(22, 23)*.

As with chronic NCDs, comorbid mental health conditions can negatively impact treatment adherence and overall disease management *(24–26)*. Consequently, implementing an integrated approach that addresses the mental health needs of patients with chronic infectious diseases within primary care settings can significantly improve treatment outcomes and enhance overall health for these individuals *(26)*.

Primary care is well-positioned to provide preventive and treatment-based mental health interventions; however, this potential is often not fully utilized.

Against this backdrop, primary care emerges as a pivotal platform for delivering both preventive and treatment-based mental health interventions. Despite challenges in primary care provision in some countries, in many countries it is relatively accessible, affordable, and acceptable to individuals and families dealing with mental health issues. Given that many individuals with mental health problems seek help through primary care, enhancing the delivery of mental health services in these settings may contribute to faster detection and access to appropriate treatment *(27)*. Although some patients, particularly those with severe mental illness, report challenging relationships with their primary care providers, *(28)* many others indicate they would prefer to see a trusted and known primary care provider over an unfamiliar specialist *(29)*.

In fact, mental health issues make up a significant portion of the health problems encountered and managed within primary care settings *(30)*. In well-developed and comprehensive primary care systems, mental health concerns often represent a significant share of all presenting issues *(31)*. Primary care workers equipped to offer comprehensive care will thus naturally detect mental health issues during routine consultations.

Moreover, scaling up mental health services within primary care and aligning mental health services delivery with the broader PHC approach (see below), such as through better integration with other services and sectors, can facilitate the provision of comprehensive, coordinated and person-centred care for individuals with both physical and mental health conditions. This is especially true in contexts where primary care closely collaborates with other mental health care platforms, such as self-care, informal care and

specialized community-delivered mental health care. Indeed, there are many mental health interventions that can be effectively implemented within or signposted by primary care settings, including psychological interventions, such as cognitive behavioural therapy or screening for post-natal depression *(12, 32, 33)*.

Despite the international commitment to enhancing the integration of mental health and primary care services, more effort is required to scale up the provision of mental health services within the PHC approach.

WHO has long championed community-based mental health-care models, including the integration of mental health care and primary care. This shift to the community has been driven by the recognition that institutional environments do not provide the care that is expected today *(34)*, neglecting or violating human rights and often failing to provide therapeutic benefits, or even lead to worsening health outcomes *(35)*. In contrast, community-based care is generally associated with more health benefits compared to institutional care *(36, 37)*, promoting human rights, social inclusion and alignment with service users' preferences *(37, 38)*. As a result, deinstitutionalization has been a national policy in many countries and this transition has been supported internationally by bodies such as the European Commission and WHO *(34)*.

In 1975, an expert committee report on the *Organization of mental health services in developing countries* was published, recommending the decentralization of mental health care into the community and integration of mental health care into the general health service *(39)*. In 1978, the landmark *Alma-Ata Declaration* paved the way for a revolutionary comprehensive PHC approach with the aim of achieving "health for all", acknowledging the crucial role of social, economic, and environmental determinants in fostering health and well-being *(9)*. Although this declaration did not specifically highlight mental health, it did emphasize the need for comprehensive and holistic health care that addresses the health needs of individuals and communities in their entirety, suggesting that mental health could be considered within the broader framework of the PHC approach. The *Astana Declaration*, adopted in 2018, reaffirmed the continued relevance of the Alma-Ata principles, this time explicitly mentioning mental health as an integral component of overall health and well-being *(40)*. It identified PHC as the most "inclusive, effective and efficient approach to enhance people's physical and mental health, as well as social well-being" *(41)*. This approach rests on three pillars: (i) primary care and essential public health functions as the core of integrated health services across the life course; (ii) empowered people and communities; and (iii) multisectoral policy and action.

Since then, further initiatives promoted a stronger role of primary care in the provision of mental health services (Box 1). Yet, despite this dedication, the prioritization of mental health and progress towards scaling up mental health services within primary care service delivery platforms and within the broader PHC approach at the national level have been inadequate. Despite the general shift to community-based care over recent decades, progress has been inconsistent as evidenced by the varying numbers of psychiatric beds in different countries *(42, 43)*.

Community-based mental health care often remains underdeveloped, and the absence or shortage of community-based alternatives increases the risk of individuals being unnecessarily placed in institutions *(44)*.

This underdevelopment, coupled with the growing burden of mental health conditions, contributes to the widening gap between the demand for and supply of mental health services, insufficient mental health literacy, and enduring stigma surrounding mental health. These issues can lead to several adverse consequences, including a reduced willingness to undergo mental health training and lower rates of mental illness detection and treatment provision by health-care workers *(9, 45)*; diminished help-seeking behaviour *(46, 47)*; and poor adherence to treatment among individuals living with mental health conditions *(48, 49)*. They may also lead to limited advocacy for positioning mental health as a priority on the policy agenda, perpetuating a cycle of underinvestment in mental health. Consequently, the potential of primary care to deliver essential mental health interventions remains unrealized in many countries *(9)*.

In 2020, just 43% of countries in the Region estimated and allocated human and/or financial resources for the implementation of mental health policy, and only 29% of them used available indicators to monitor the implementation of most of their mental health policies *(43)*. Only 2% of health expenditure globally and 3.6% in the WHO European Region (ranging from 0.14% to 14.5% among countries) was allocated to mental health. However, it is important to recognize that funding for mental health, especially for prevention and promotion, also takes place outside of the health-care system (e.g. in education), including in the private sector (e.g. in workplaces).

Box 1. WHO has long supported the integration of mental health care into primary care

Over the years, a substantial body of evidence has emerged in support of the integration of mental health services into primary care. Key publications include a substantial international study published in 1995 by WHO on *Mental Illness in general health care* that demonstrated the significance (and treatability) of psychological disorders in primary care across various cultural and resource settings *(50)*. Additionally, the 2008 joint WHO/World Organization of Family Doctors *(51) report, Integrating mental health into primary care* – a global perspective, argued that integrating mental health services into primary care was the most viable way of closing the treatment gap and ensuring that people get the mental health care they need *(52)*.

In 2008, WHO launched the mhGAP *(53)* in response to the wide gap between the resources available and resources urgently needed to address the large burden of mental, neurological and substance use disorders globally. mhGAP aims to scale up services for mental, neurological and substance use disorders. The programme asserts that, with proper care, psychosocial assistance and medication, tens of millions could be treated for depression, schizophrenia and epilepsy, prevented from suicide, and begin to lead normal lives, even where resources are scarce.

Box 1. contd.

In the ensuing years, WHO Member States pledged to integrate mental health services into primary care. This commitment was evident through actions such as the adoption of the *Comprehensive Mental Health Action Plan 2013–2020*, which was later extended to 2030 at the 72nd World Health Assembly in 2021, whereby the Member States pledged to work towards achieving a global target of integrating mental health into primary care in 80% of countries by 2030. The four objectives of the Mental Health Action Plan 2013–2030 are to: (1) strengthen effective leadership and governance for mental health; (2) provide comprehensive, integrated, and responsive mental health and social care services in community-based settings; (3) implement strategies for promotion and prevention in mental health; and (4) strengthen information systems, evidence, and research for mental health *(54)*. Also in 2021, WHO issued guidance on community mental health services that provided a detailed description of person-centred and human rights-based approaches in mental health, complete with summary examples of good practice services around the world *(55)*. Those messages were reinforced by the World Mental Health Report published by WHO in 2022 *(9)*.

Within the WHO European Region, the *European Programme of Work 2020–2025 "United Action for Better Health in Europe" (56)* identified mental health as one of its four flagship initiatives *(57)*. The core strategic priorities of this flagship are laid out in the *WHO European Framework for Action on Mental Health 2021–2025 (58)* focusing on mental health service transformation; the integration of mental health into the preparedness for, response to, and recovery from crises and emergencies; and mental health promotion and protection over the life course, from children to adolescents and young people to older adults.

The EFAMH is in alignment with the *WHO Comprehensive Mental Health Action Plan 2013–2030 (54)* and considers all four globally agreed objectives for mental health. However, it focuses specifically on objectives, actions and initiatives tailored to address the unique needs, challenges, diversity and opportunities within the Region. To implement the EFAMH, the WHO Regional Director for Europe launched the Pan-European Mental Health Coalition on 30 September 2022 *(1)*. The Coalition's core priorities include the transformation of mental health services to integrate mental health care into emergency response and recovery efforts, and to promote mental health and prevent mental ill health across the life course.

Finally, Goal 3 "Ensure healthy lives and promote well-being for all at all ages" of the United Nations 17 Sustainable Development Goals (SDGs), adopted in 2015, includes treatment of mental health conditions, their prevention and the promotion of mental well-being, and specifically highlights the need to prioritize investments in strong primary care. This implies the need to regularly assess the level of publicly funded provision of mental health care and services, including within primary care, and barriers to progress and actions to address them.

As the burden of mental health conditions is expected to grow – driven by factors and trends, such as the aftermath of the COVID-19 pandemic *(41)*, climate events *(59, 60)*, military conflicts, including the war in Ukraine *(61, 62)* population ageing *(62)*, exposure to an increasingly digitized society and the consequent increase of problematic use of social media among adolescents *(63)* the gap between the need for mental health care and access to timely and effective care is likely to widen. This underscores the urgent need to invest in the development of community-based mental health services across the Region.

This policy paper recognizes the need to revise national commitments to reevaluate the delivery of mental health services and offers strategies on how to scale up mental health services within primary care service delivery platforms and within the broader PHC approach.

Considering the substantial health and socioeconomic repercussions of mental disorders, many countries within the Region are currently faced with a compelling need to revisit their commitment to prioritize mental health services and reevaluate their delivery. Such actions could not only help to bridge the mental health service gap but also foster the reorientation of models of care towards the comprehensive PHC approach established in the Alma-Ata and Astana Declarations and further progress toward achieving the SDGs. While the term "primary care" in this policy paper primarily refers to the service delivery setting, it encompasses a broader conceptualization of health services aligned with the principles of the PHC approach. This broader understanding emphasizes first-contact accessibility, continuity, comprehensiveness (and thus the inclusion of mental health services), coordination and person-centredness as defining characteristics of primary care services *(64)*. By examining linkages between mental health services provided within primary care and other mental health services as well as linkages with other sectors, the strategies described in this policy paper comprehensively address all three pillars of the PHC approach.

In line with this view, this policy paper draws on available evidence and best practice examples to provide lessons on how to reorient mental health services towards the PHC approach. The remainder of this document is organized as follows. Section 2 describes four key strategies that have been identified as having much potential for scaling up publicly funded mental health services within primary care and promoting PHC orientation more broadly, outlining their components and offering examples of good practices from across the Region. Section 3 offers a detailed overview of health workforce education and training, given their roles as crucial policy levers in facilitating implementation of the identified strategies. Section 4 casts a spotlight on additional policy levers that are key to upscaling mental health services within primary care and the PHC approach. Finally, Section 5 summarizes the lessons learnt and discusses the way forward.

Beyond the strategies described in this policy paper, it is imperative to further advance the shift of mental health services to the community.

Scaling up mental health services within the PHC approach, such as through the four key strategies described in this policy paper, is pivotal for narrowing the gap in mental health care provision. However, while primary care plays a significant role in delivering mental health services within communities, it represents just one facet of a broader community-based mental health care network *(9)*. This shift entails developing and integrating diverse mental health-care settings, not only within general health care, such as primary care, but also encompassing mental health services in the community, such as peer support services and supportive housing, and services provided outside of the health sector, such as in workplaces and schools. This integration not only enhances the accessibility and equity of mental health care but also respects individuals' preferences for dignified and autonomous care. Such a holistic approach to advancing community-based mental health services beyond the strategies outlined in this policy paper is essential for fostering compassionate, efficient and inclusive mental health-care systems.

2

How to scale up mental health services within primary care

The foremost consideration when scaling up mental health services in primary care is to ensure their seamless integration into the broader organization of mental health services and their contextual tailoring.

Addressing mental health needs comprehensively in a population requires the provision of a wide spectrum of services, spanning from mental health promotion and mental illness prevention measures to treatment at various levels of specialization. Although the shift toward the deinstitutionalization of mental health services progresses at varying speeds across countries in the Region, it is widely recognized that the majority of mental health needs can be met within the community:

(1) in general health-care settings, at primary care facilities and general hospitals, which may offer treatment themselves or act as crucial links to specialized mental health services *(65)*, and within existing health programmes, such as for mothers and children or for specific diseases;

(2) through mostly specialist but also non-specialist community health services, which can include community mental health centres (CMHCs) or teams, as well as psychosocial rehabilitation programmes, peer support services, and, where feasible, supported housing that promotes independent living; and

(3) through services provided in other sectors, such as local housing, employment, education and welfare services *(9, 66)*.

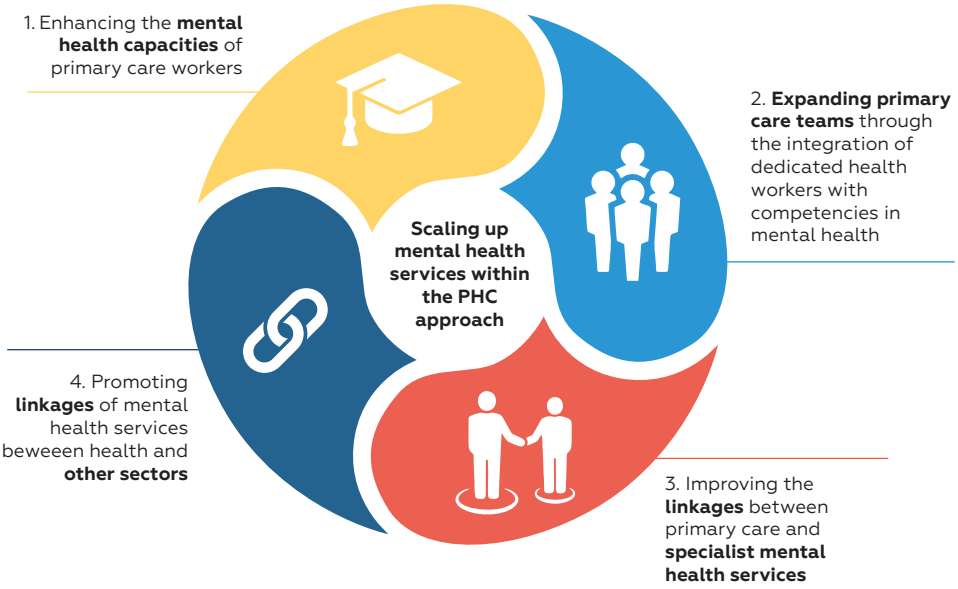
The PHC approach (Section 1) emphasizes comprehensive, accessible, community-based care that is integrated across different sectors and levels of the health system. This approach places significant importance on primary care as one of the pivotal entry points for addressing mental health needs and as a core component of a more comprehensive service delivery model that addresses not only illness but its biological, social, and psychological root causes. Varying country contexts, such as differences in institutional legacies, resources and needs, influence the configuration of services. This means that there is no single model for organizing this broader web of community-based mental health care and aligning it with the PHC orientation, and that tailoring to context is essential. This policy paper contributes to our collective understanding of which scale-up strategies work under which scenarios.

Key strategies for scaling up mental health interventions in primary care involve enhancing the capacity and associated competencies to provide mental health services within primary care and strengthening links with other types of care and sectors.

There is generally a lack of routinely collected comparable information about the provision of mental health interventions specifically within primary care and relatively little review evidence on potential implementation strategies in different contexts *(67, 68)*. This section attempts to address this knowledge gap by describing four key strategies that hold the potential to improve the provision of mental health

interventions within the PHC approach (Fig. 1), including their main components, practical implementation considerations, and highlighted examples of good practice from across the Region. The first and second strategies focus on enhancing the provision of mental health services within primary care settings by either amplifying the competencies of primary care workers in this area (Section 2.1) or by adding dedicated mental health workers into primary care teams (Section 2.2). The third strategy centres on improving the linkages between primary care and specialist mental health services, while allowing primary care and mental health professionals to continue working in their respective settings (Section 2.3). The fourth strategy focuses on promoting coordination with other sectors, including public health, schools and social care, as well as workplaces and community organizations (Section 2.4).

Fig. 1. The four strategies are interrelated and should be considered jointly



Source: Authors' compilation.

The four strategies have been identified by drawing upon established and emerging practices in mental health and primary care delivery within the Region. They align with the imperative for a major restructuring and scaling up of efforts that are outlined in the 2022 *World Mental Health Report*, *WHO Comprehensive Mental Health Action Plan 2013–2030*, WHO mhGAP, 2021-2025, *WHO European Programme of Work*, and with the PHC approach (see Box 1). These strategies have been chosen pragmatically to offer a framework for targeted action.

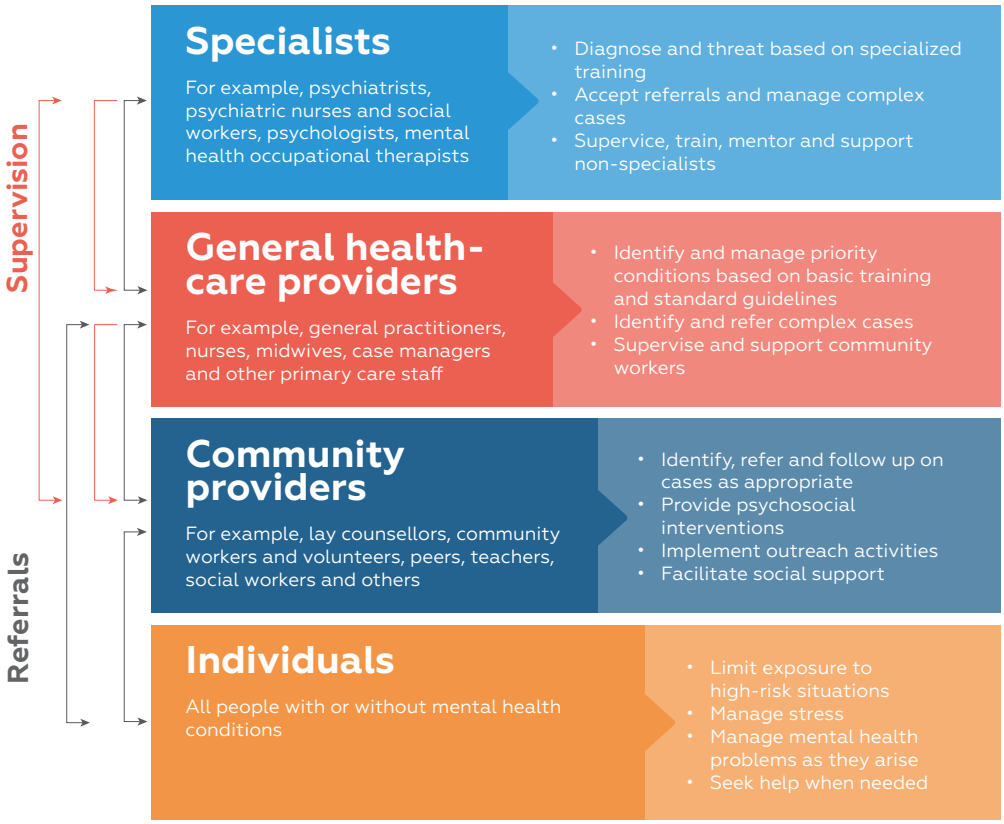
Nonetheless, it is important to note that this categorization is somewhat artificial because, in practice, many actions falling within these strategies are inherently interconnected and there is significant overlap among them. The strategies are ultimately different entry points to tackling a common aim and are interrelated; therefore, they should not be viewed in isolation from one another.

The choice of strategy should be guided by the imperative of ensuring that patients receive the most appropriate type and level of service.

Any form of care, including mental health care, should be personalized by aligning the intervention with the specific characteristics and needs of the individual seeking care. In the realm of mental health care, this approach is explicitly recognized as "matched", "stepped" or "tiered" care and considers factors such as the individual's diagnosis, the severity of their mental health condition and the patient's own goals around the level of health they wish to achieve *(69)*. According to this approach, the objective is to ensure that the individual receives the most suitable and effective treatment tailored to their unique circumstances. This is based on the idea that many individuals can be effectively treated with less intensive methods, and only those who do not respond to lower-intensity treatments receive more extensive care. For instance, someone with severe depression may require a different treatment approach compared to someone experiencing mild anxiety. The latter would thus typically start with low-intensity interventions, such as self-help resources or brief counseling, and only move to higher-intensity treatments, such as therapy or medication, if their condition does not improve with the initial intervention.

In such systems of care, diverse providers adopt different but complementary roles that use resources efficiently and make care more widely available (Fig. 2). This means that competencies in mental health need to be achieved and maintained by care providers at each tier, ranging from individuals and community providers to general and specialist health-care workers.

Fig. 2. Tiered care allocates different but complementary tasks to workers at different levels of the health system



Source: Adapted from the original, replacing primary healthcare staff with primary care staff *(9)*.

This tiered approach further underscores the importance of preventing the onset of mental health problems, which can be effectively achieved by integrating mental health care into primary care and community settings. For instance, the area of perinatal mental health has seen increased attention in the recent decade, and mental health services (including screening, prevention and promotion, as well as treatment for mental health problems, such as depression, substance use and postpartum psychosis) for new or future mothers have been launched and scaled up in many settings *(9)*. Examples include the perinatal mental health services in the United Kingdom of Great Britain and Northern Ireland *(28)*, which aim to identify and address mental health issues in pregnant women and new mothers within primary care settings; the Neuvola [maternity and child health clinics] in Finland, which provide comprehensive care and support, including mental health services, to expectant mothers, infants and young children; the Barnavårdscentral [child health care programme] in Sweden, which offers comprehensive services that include mental health support for children and parents; and the Helsestasjon [child health clinics] in Norway, which provide a range of services, including mental health support for mothers and children. The clinics offer regular assessments, counseling, and referrals to specialized care when needed, aiming to address mental health issues early on in a "stepped" fashion. Another example from Norway is the *Oslohjelpa*, a low threshold interdisciplinary service offered in each district within Oslo that does not require a referral and ensures parents and their children receive timely and appropriate support as needed *(70)*. In Denmark, nurses that visit the home of new mothers over the course of their child's first year screen for both postpartum depression in mothers and the mental health status of fathers *(71)*. The prioritization of perinatal mental health can also be seen through policy efforts, such as the Nordic Co-operation's, which refers to the collaboration between the Nordic countries, policy recommendations around a child's first 1000 days, which aims not only to comprehensively support parents across their child's early life, reduce risk factors for young children, and promote health equity, but also to strengthen cross-sectoral collaboration and advance research on children's first 1000 days of life *(72)*.

The successful implementation of the "stepped" approach hinges upon the availability of mental health competencies and resources across various levels of care, which unfortunately may not be universally accessible in every country. Across Europe and Central Asia, several countries have embraced such models of care to optimize mental health service delivery. In the United Kingdom *(28)*, this model is exemplified by the Peterborough Exemplar (Box 2), which systematically provides patients with the least resource-intensive mental health interventions first, escalating the intensity of treatment only as needed. This approach is aimed at efficiently using health-care resources, while ensuring patients receive the care intensity their condition requires. In Ukraine, non-specialist, community-based primary care providers were trained to deliver a simple mental health intervention to match the need for the treatment of symptoms of depression, anxiety, dysfunction and post-traumatic stress (PTS) experienced by veterans and other displaced peoples as a result of the ongoing war in Ukraine *(73)*. "Stepped" care approaches are also used in countries such as the Netherlands (Kingdom of the), starting with evidence-based self-help and progressing to more intensive psychological interventions and, finally, to specialized mental health-care services (Box 5

in Section 2.2); Germany, particularly in treating depression, where patients receive a range of services, from online interventions to specialized outpatient care, based on the severity of their symptoms; Finland, where triage systems ensure that individuals receive personalized treatment plans; and Sweden, where primary care plays a crucial role in facilitating access to appropriate care paths for patients based on comprehensive assessments of their mental health conditions (Box 3).

Box 2. The Peterborough Exemplar provides stepped mental health services to a highly deprived population

Despite significant progress in transitioning from institutionalized care to community-based mental health services in the United Kingdom (28), which included the creation of community mental health teams (CMHTs) and other services, the provision of mental health services is often fragmented and inefficient, with 90% of referrals to mental health services returned to primary care, and a high variation in waiting times (74).

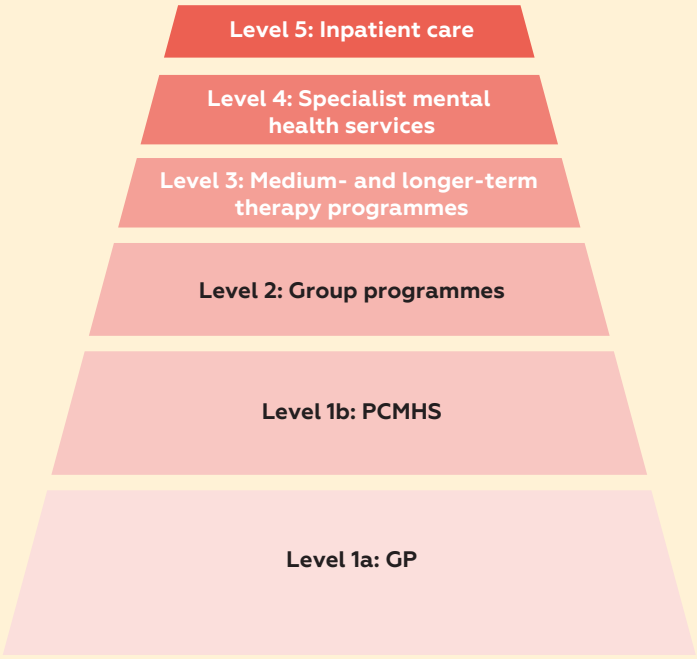
A model of community mental health care was developed in response to these challenges, and its implementation began in 2020. The city of Peterborough, with a population of approximately 200 000 people, was selected for the two-year pilot due to its high level of deprivation. The goal was to establish a multidisciplinary service that aligns health and social care specifically in targeted geographic areas by integrating CMHTs within primary care networks (PCNs), which are groups of general practitioners (GPs) operating within a geographic area and offering care tailored to the needs of local populations based on demographic characteristics and identified health and care needs.

The new model of support provides access to different levels of support, as depicted in Fig. 3. Level 1 support is provided by the GP and the Primary Care Mental Health Service (PCMHS), which is organized around the PCNs. PCMHS provides specialist mental health support for GP surgeries, so that patients with mental ill health can access prompt advice and support, receive help in a community setting, and experience a more coordinated approach to care *(75)*. This is complemented by a range of community-based options, including the Improving Access to Psychological Therapies *(76)* (IAPT) programme (detailed in Box 5). Moving up to Levels 2 and 3, the support becomes more intensive and includes access to specific group programmes, such as for personality disorders (Level 2) and medium- and longer-term therapy programmes (Level 3). At Level 4, specialist mental health services are available, while the highest level of intensity is represented by inpatient care (Level 5).

Several measures have been taken to promote systematic knowledge exchange and enhance relationships among local service providers. These include regular clinical meetings known as “virtual clinics” between primary and secondary care. In addition, mental health professionals have been integrated into the PCMHS to assess patients with complex needs (Level 1). A dedicated area consultant works across different levels of care, ensuring the smooth flow of patients through the system and addressing bottlenecks collaboratively with the involved teams.

Box 2. contd.

Fig. 3. GPs and PCMHS constitute the first level of mental health support in the Peterborough Exemplar



Source: Based on the Peterborough Exemplar *(76)*.

To bolster leadership in mental health within primary care, the model allocates sessions from primary care professionals to focus on enhancing outcomes for their PCN population. These PCN clinical mental health leads meet monthly with PCMHS team leads to address operational issues and review performance indicators.

New services with more accessible entry points (Levels 3 and 4) have also been developed within the Exemplar. These include services specializing in psychological skills, personality disorders (PDs) and peer support. The initiative also introduced dedicated services for individuals with a dual diagnosis, a team dedicated to facilitating engagement with social prescribing, a mental health pharmacist, and a social care pathway operating within the primary care setting. Notably, the implementation of these services involved establishing or improving collaboration among mental health services, third-sector organizations and social care, thereby exemplifying elements of integrated care and integration with other sectors. Of course, there are some caveats where therapies available do not necessarily represent the needs of the population, but rather the supply of the providers.

The model is currently being evaluated. Initial findings suggest that it has resulted in an increased availability of treatment for patients with mental health needs who previously fell into the gap between primary and secondary care (i.e. service users who need more intensive mental health treatment than primary care can provide, but do not reach the threshold for secondary care). Outcomes from the evaluation will inform the rollout of the Exemplar model across the county.

Source: Based on *(74)*. This box was co-authored by country experts; see acknowledgments.

2.1. Enhancing the mental health capacities of primary care workers

The provision of mental health care by primary care workers can significantly improve access to such services, but its implementation can vary widely across countries.

The first strategy of upscaling mental health services in primary care settings involves recognizing the roles that primary care workers, such as primary care doctors and nurses, and other primary care workers, such as health-care assistants and primary care community educators, can play in addressing mental health needs, and enhancing their mental health care competencies. Primary care workers frequently encounter individuals presenting with symptoms that are often the somatized manifestations of stress, depression and other mental health conditions and, in well-developed and comprehensive primary care systems, mental health concerns often represent a significant share of all presenting issues (see Section 1).

Primary care workers equipped to offer comprehensive care will thus naturally detect mental health issues during routine consultations. Additionally, primary care personnel are well-positioned to understand the community and social context, which can be contributing factors to mental health presentations. This can improve community access to mental health services, especially in areas with a shortage of specialized mental health professionals. Although many European countries have policies and frameworks that encourage the integration of mental health services into primary care, the extent of integration varies widely, with areas for improvement. Supporting primary care workers with capacity-building, role redefinition and appropriate environments can foster this approach where it is not yet customary.

However, when considering this approach, it is crucial to recognize that mental health care inherently demands more time and resources compared to many other forms of care provided at this level. This observation underscores that the challenge does not exclusively lie in managing an influx of new cases but also in enhancing the efficiency and effectiveness of care for the existing caseloads. Moreover, it prompts a critical "how" question, particularly in contexts where human resources and services are already strained. It is thus imperative to debate and address this question, such as by adopting a well-thought-out and phased implementation, to mitigate the risk of burnout among primary care professionals.

Primary care doctors, nurses and other primary care professionals can effectively address many common mental health concerns.

(1) Primary care doctors

The practice of primary care doctors can be extended to include a diverse range of mental health competencies to effectively address many common mental health concerns, particularly where such expertise is not available or well-developed. These skills can include the ability to assess, diagnose and manage mental health conditions, using a biopsychosocial approach (to ensure that any concomitant physical illness and social problems are also addressed), with referral if necessary for severe or complex cases *(77)*;

provision of basic and recovery-oriented care and support, including the administration of essential medications; facilitation of referrals to more specialized care, such as mental health care specialists, including community mental health providers skilled in psychological counselling, as necessary; and managing the transition and ongoing care of individuals returning from specialist mental health-care services. Efforts to enhance mental health skills among primary care doctors have been evident in countries such as Finland, Norway, Sweden and the United Kingdom, where generalist physicians receive mandatory training in mental health and serve as the first point of contact for individuals seeking mental health support (see Box 3). In Spain, the training of family doctors and nurses includes building a core set of mental health competencies, enabling primary care teams to manage most mental health problems, and preventing the overmedicalization of these issues (Box 4).

Box 3. Swedish primary care centres serve as the first point of contact for individuals seeking mental health care

Mental health care services in Sweden are provided in primary care centres (PCCs) and specialized care settings, such as psychiatric clinics and hospitals. However, over the years, there has been a shift towards providing specialized services in community-based settings, for example, residential care for older people. The governance of PCCs, and health care more generally in Sweden, is shared between regions and municipalities. Regions are responsible for primary care, specialized care, and psychiatric services, including child and adolescent care. Municipalities handle the care for older people, people with mental disabilities, and those with substance abuse issues. The National Board of Health and Welfare issues regulations and guidelines to standardize care across the country, ensuring that health services are accessible and meet the population's needs.

Sweden's mental health-care system puts a strong emphasis on a community-based approach, with GPs and psychologists working in PCCs serving as the first point of contact for individuals seeking mental health care. PCCs cater to a broad population, including children, adolescents, adults and the elderly, and around 70–80% of the population visits a primary care provider annually. Most adults suffering from conditions, such as depression or anxiety, receive care within PCCs, with only 20% being referred to specialists.

This approach is supported by mandatory training in mental health for GPs. All GPs complete six months of psychiatry training in their five-year residency. Their role includes the assessment, diagnosis and treatment of mild-to-moderate symptoms, for instance, through counseling, life-style interventions focusing on nutrition, substance use, physical activity and stress management, as well as issuing referrals to specialized mental health services.

In addition to having GPs with mental health training, PCCs in Sweden employ a multidisciplinary team to deliver comprehensive care. This team includes psychologists, registered nurses, specialist nurses, physiotherapists and occupational therapists, all of whom can provide mental health services. Nurses, and particularly specialist nurses in psychiatric care, play important roles delivering mental health services, such as counselling (for example, through problem management and cognitive behavioural therapy (CBT) techniques) and life-style interventions.

Box 3. contd.

However, it is important to note there are large shortages of such nurses, and shortages are expected to become worse following expected retirements. Additionally, there are resources available through Stockholm Health Care Services (the governing body responsible for health-care services in the Stockholm region which offers support for GPs, nurses, psychologists and speech therapists as well as for operations managers. These resources are aimed at patients of all ages in primary care but there are additional courses for extended interventions for children and young people.

Psychologists are typically employed as part of an attached care model (see Section 2.2). They assess, diagnose and treat patients with mild to moderate symptoms of mental illness and refer those with severe conditions to specialized mental health services. The psychologist collaborates with a GP and any other necessary health-care professionals, such as dietitians or physiotherapists. Appointments are made without referral. This collaboration may extend to social services provided by the municipality or schools for paediatric patients. The GP also oversees any pharmacological treatments; in the absence of such treatments, the psychologist will assume responsibility for the patient's care. It is important to note that several regions also report a shortage of psychologists.

GPs often collaborate with psychiatric services through a referral process. There is a 30-day maximum waiting time. This waiting time is stipulated by "the care guarantee", which says that a patient is entitled to receive a first psychiatric assessment within a maximum of 30 days of initial contact. The first assessment also helps for initial triage, ensuring priority for patients who require urgent help.

In some locations, psychiatrists provide in-house consultations at the request of doctors, nurses or psychologists. In these consultations, referrals, medications and the coordination of care for patients, who require both psychiatric as well as somatic care in primary care, are discussed. If a consultation for a youth is required, child and adolescent psychiatry is consulted. There are also opportunities to have meetings with the closest child and adolescent psychiatric units once per semester to discuss collaboration.

Over the past decade, Sweden has developed mental health strategies to enhance coordination and collaboration among authorities responsible for mental health care. The latest strategies (2016–2020) focused on strengthening collaboration with the Swedish Association of Local Authorities and Regions, with financial incentives for local and regional actors to improve promotion and prevention activities. Most regions have developed their own strategies and plans based on the national framework, with a particular focus on improving mental health care for children and young people.

Source: Based on *(53)*. This box was co-authored by country experts; see acknowledgments.

(2) Primary care nurses

The competencies and responsibilities of primary care nurses in mental health can also be augmented in many countries. This expansion may include the initial assessments of patients with mental health concerns; managing their medication, including monitoring adherence, providing medication education, and observing potential side effects; case identification and follow-up; and monitoring patients with mental health conditions.

The latter can include tracking their progress, ensuring adherence to treatment plans and monitoring for any warning signs or potential relapses *(78)*.

Primary care nurses already play central roles in the management of mental health conditions in several countries. For example, in the United Kingdom, primary care nurses working within the National Health Service (NHS) are often the first point of contact for individuals with mental health concerns. They conduct initial assessments and provide ongoing management, including medication monitoring and support for self-help interventions. However, they face challenges with training and development opportunities in mental health *(79)*. In the Netherlands (Kingdom of the), *Praktijkondersteuner Huisartsenzorg - Geestelijke Gezondheidszorg* [GPs and general practitioner mental health professionals (GP-MHPs)], *or* "POH-GGZ", play a crucial role in providing mental health care in primary care (see Box 6 in Section 2.2). In Spain, primary care doctors and nurses work in multidisciplinary primary care teams and address most mental health needs in the populations they serve (Box 4). Likewise, in Finland, primary care doctors and nurses play a central role in delivering mental health-care services, covering early intervention, treatment and the long-term management of mental health conditions. They collaborate with other professionals, including psychologists and social workers, to provide holistic care. Finally, in Sweden, district nurses in primary care play a vital role in mental health, providing counselling and follow-up care. Sweden's health-care system emphasizes continuous education, but there remains a need for more specialized mental health training for nurses (see Box 3 above).

Box 4. Multi-professional primary care teams in Spain play a key role in the provision of mental health services as part of mental health services networks, as exemplified by the Asturias model

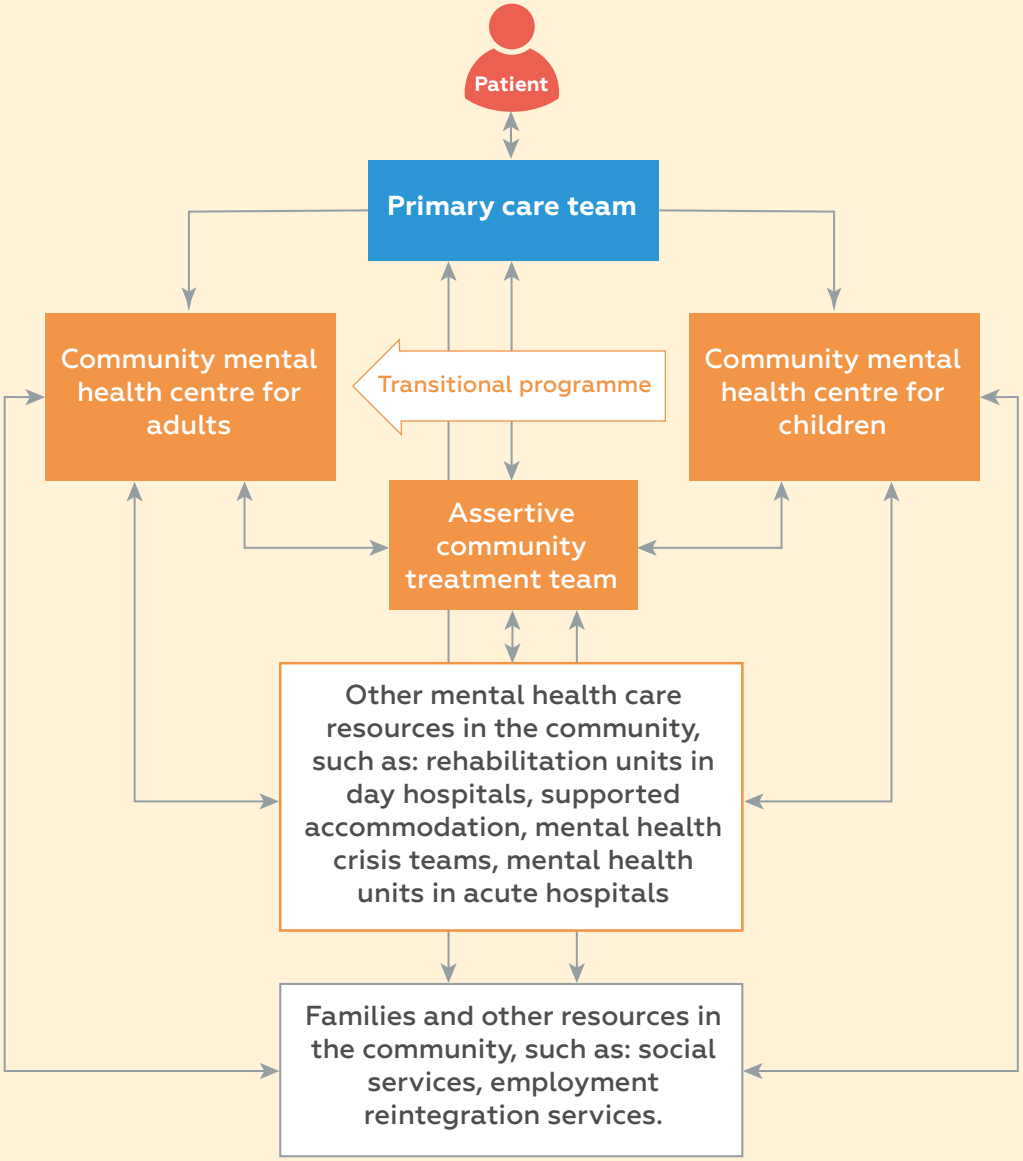
The provision of primary care in Asturias, Spain is based on multi-professional teams, with family medicine doctors and advanced practice nurses at their core, serving as the primary point of contact for the adult population. For children up to the age of 14, paediatricians and paediatric nurses perform such roles. These teams also include social workers, physiotherapists, midwives, odontologists, administrative staff and others. The teams also play a key role in the provision of mental health services and form part of community-based mental health services networks.

The composition of these networks can vary across the Spanish Autonomous Communities (regions) but always include separate CMHCs for adults and children. These centres provide outpatient services and are staffed by various professionals, including psychiatrists, psychiatric nurses, clinical psychologists, social workers and occupational therapists. Fig. 4 depicts such a network in the Principality of Asturias, which is used as an example hereafter.

Starting in 1983, Asturias pioneered a major psychiatric reform, gradually shifting from centralized care in the regional psychiatric hospital to a community-based model. The goal was to bring services closer to the population and reduce the need for hospitalizations. As a result of this reform, Asturias has one of the lowest numbers of psychiatric hospital beds by Spanish and European standards (9.6 beds per 100 000 inhabitants in Asturias compared to 36 in Spain and an average of 73 in the European Union) *(80, 81)*.

Box 4. contd.

Fig. 4. Primary care teams serve as the key entry point to the mental health network of Avilés in the Principality of Asturias, Spain



Patients presenting with mental health issues are first seen by their family doctor and/or nurse within their primary care team. In Spain, the pre-service training of family doctors and nurses includes clinical rotations in CMHCs and other mental health settings to build a set of core mental health competencies. Additionally, they have opportunities to participate in in-service trainings to acquire and maintain these competencies. This comprehensive training, along with the multi-professional composition of primary care teams and the availability of community resources and support networks, enables them to diagnose and manage the most common mental health problems at the primary care level.

One of the most important roles of the primary care team is to prevent the pathologizing and overmedicalizing of social problems and other life situations, thereby avoiding unnecessary referrals to specialized mental health services.

Box 4. contd.

The continuity of care provided by the primary care team fosters a strong bond and trust with their patients. This relationship makes patients more open to discussing mental health issues, alongside or during consultations for other health concerns.

Family doctors manage various mental health conditions, including mild cases of anxiety, sleeping disorders, minor depression and self-esteem issues. They assess, diagnose and manage these conditions, using a biopsychosocial approach, ensuring that any accompanying physical illnesses and social problems are also addressed. Their responsibilities include providing basic and recovery-oriented care and support, including administering essential medications, making referrals to specialized care, when necessary, and managing the transition and ongoing care of individuals returning from specialist mental health services.

They also place significant emphasis on health promotion and disease prevention activities, which are supported by the Programme of Health Promotion and Disease Prevention Activities (PAPPS) *(82)*. This programme targets psychosocial issues as part of its broader focus on health promotion and disease prevention. The PAPPS also supports psychoeducation, which is aimed at helping patients understand and proactively manage their mental health issues, thereby reducing the need for pharmacological interventions or referrals to specialists. Family doctors and nurses support adults facing a range of challenges, such as bereavement, psychological distress due to illness, and adjusting to retirement. They also focus on suicide prevention and preventing the exacerbation of other mental health conditions. Additionally, they play a crucial role in identifying cases of gender-based violence and referring affected women to appropriate support services. For children, who are seen by paediatricians and paediatric nurses, promotion and prevention activities include early detection of mental health problems, identifying cases of neglect, and addressing school-related problems.

Family doctors and nurses collaborate with social workers to address not only clinical issues but also the underlying social causes that can exacerbate mental health problems. They facilitate connections with municipal social services and other relevant authorities to assist with issues such as housing, employment and substance dependency. In Asturias, members of primary care teams can link patients with health resources available in the community, including municipal sport and cultural services, and services provided by nongovernmental organizations (NGOs) *(83)* and civil society organisations, which can contribute to improving patients' health and well-being. This is supported by an online repository of community health resources that is regularly updated. These resources are identified and recommended by the community itself and validated by public health services, ensuring accessibility and relevance to the local population.

In Asturias, patients who could benefit from a limited, pre-defined number of counseling sessions for specific mental health issues can be referred by their family doctor to clinical psychologists working within primary care. These psychologists can either provide visiting support to multiple primary care teams within their designated area or be co-located and fully integrated into a single primary care team. When patients require more intensive or extended treatment, either the family doctor or the clinical psychologist refers them to a CMHC for specialized care.

Box 4. contd.

CMHCs for adults and children in Asturias offer a wide range of services, including evaluation and treatment through both psychotherapeutic and pharmacological approaches, community interventions, home care for people with serious mental disorders, and emergency care. They coordinate with other specialist mental health providers and collaborate closely with primary care teams by offering trainings, consultations and counter referrals. They also coordinate with education, social and justice services within their respective catchment areas. The mental health network in Asturias also includes Spain's first assertive community treatment team, established in 1999. This mobile team delivers proactive care, including home visits, to both adults and children, and operates in close collaboration with both primary care and social services.

Source: This box was co-authored by country experts; see acknowledgments.

(3) Health-care assistants

The roles of health-care assistants, or support workers, working in primary care settings can also include, or be enhanced by, mental health roles. For example, they can conduct initial screenings for common mental health conditions and use standardized assessment tools, thereby supporting the identification of mental health conditions. Several countries in western Europe, including the Netherlands (Kingdom of the), use health-care assistants to conduct mental health screening as part of their efforts to improve mental health care within primary care, while trained and supervised psychological well-being practitioners (PWPs) in the United Kingdom *(28)* deliver highly standardized, evidence-informed, low-intensity, guided self-help across individual and group formats (see Box 5 in Section 2.2) *(84)*. Likewise, in various countries in other parts of the Region, including Bulgaria, Kazakhstan, Romania and Serbia (see Box 8 in Section 2.2), health-care assistants working in primary care have adopted roles that encompass mental health screening.

(4) Dental care teams

Management of oral health is often challenging in individuals with mental health conditions *(85)* but because dentistry is often separated from other primary care services this important area can be completely overlooked (86). However, some countries have made efforts to address this issue more effectively through integrated care models and specific programmes and tools, including those targeted at enhancing the mental health-care competencies of dental professionals. For example, the United Kingdom's NHS has developed policies to encourage the collaboration of dental professionals with mental health services. One example is the Lester adaptation of the Positive Cardiometabolic Health Algorithm *(87)*, a tool designed for managing cardiovascular and metabolic health risk in patients with severe mental illnesses, which includes considerations for oral health. Furthermore, the NHS provides guidance for dental teams on managing patients with mental health conditions, emphasizing the importance of understanding these conditions and adapting dental treatment accordingly.

(5) Self-management and other support

Self-management support can also be delivered within primary care *(88)*, and primary care workers can encourage and guide individuals to utilize evidence-based self-help tools or digital self-help interventions, *(12)* such as group-based stress management courses *(89)*. Psychoeducation, counselling and evidence-based psychological interventions can also be delivered as part of depression and anxiety management. In addition, in some countries, primary care can direct patients to various organizations that offer assistance with issues such as debt, marital or relationship problems, or addictions.

2.2. Expanding primary care teams by integrating dedicated health workers with competencies in mental health

Health workers, with varying levels of competencies and training in mental health, can be useful additions to primary care teams.

The second strategy for upscaling mental health services in primary care relates to expanding primary care teams through the addition of dedicated health workers with competencies in mental health. These can have varying levels of expertise and training and can include psychiatrists, clinical and counselling psychologists, mental health nurses, clinical social workers, mental health therapists and counselors, and peer support workers with lived experience.

Similar to the first strategy, one advantage of this strategy is that it offers better coordination of holistic care for patients by addressing the mental health aspects which often coexist alongside physical ailments. This strategy also provides primary care workers with options when time does not permit for the more attention typically required by mental health services. However, it may pose challenges for mental health workers supporting primary care teams, particularly if they are expected to take on additional duties alongside their existing responsibilities, such as in areas with limited mental health resources. Furthermore, fostering effective collaboration between mental health and primary care workers may necessitate considerable time and effort from both sides, emphasizing the importance of investing in such collaborative relationships and limiting the potential overlap of care.

(1) Clinical psychologists and other mental health workers trained in psychological interventions

Clinical psychologists and other mental health workers trained in psychological interventions, such as counselling psychologists, mental health counselors, social workers and psychotherapists, can be particularly useful additions in primary care settings since they possess the expertise needed to deliver first-line treatments for common mental health conditions, such as anxiety and depression. However, despite their critical role, there is often a lack of sufficient financial and non-monetary incentives to attract them to primary care settings rather than private practice, although there are notable exceptions, such as the integration of assistant psychologists into primary care psychology services in Ireland *(90)*, and the IAPT programme in the United Kingdom *(28)* (see Box 5).

Box 5. CBT therapists and PWPs in the United Kingdom *(28)* deliver psychological therapies for common anxiety in primary care centres and GP surgeries

IAPT is the flagship initiative of the NHS in the United Kingdom *(28)*, focusing on providing care for individuals experiencing common anxiety and depression. IAPT delivers evidence-based psychological therapies recommended by the National Institute for Health and Care Excellence *(91)* through a stepped-care delivery system. The nationwide expansion of IAPT began in 2008, following successful pilots in the cities of Doncaster and Newham. In the 2018/2019 period, IAPT reached over one million individuals.

The service operates on a "hub and spoke" model. A central office serves as the base for the clinical director and administrator, offering facilities for supervision, training, record-keeping and telephone support for guided self-help. However, most of the face-to-face therapy is delivered in proximity to patients' residences, often within GP practices or other community settings.

People with mild to moderate depression or anxiety are typically offered a low-intensity intervention, which may include guided self-help, computerized CBT, or participation in psycho-education groups. These interventions are delivered by PWPs. Individuals entering PWP training courses often do not possess a core mental health profession background and may be recent graduates from psychology programmes with some subsequent experience working in mental health in junior roles. They are commonly stationed in GP surgeries, health centres and psychological treatment centres.

Those with more severe symptoms, or individuals who have not responded to initial low-intensity interventions, are provided with high-intensity treatment, administered by experienced mental health professionals. These sessions are usually conducted in person, lasting approximately one hour each week. Successful applicants for high-intensity CBT courses typically have several years of prior experience in mental health services and belong to core mental health professions, such as clinical psychologists, social workers or mental health nurses. They are commonly found in CMHTs, GP surgeries, health centres, hospitals and social services. Both the high-intensity CBT and PWP training programmes are conceived as joint university and in-service trainings (see Section 3).

Source: Based on *(92)* and *(93)*. This box was co-authored by country experts; see acknowledgments.

(2) Psychiatric nurse practitioners and psychiatric nurses

Psychiatric nurse practitioners and psychiatric nurses, also known as mental health nurses, are mental health professionals that are frequently included in primary care teams. The former are highly specialized and can diagnose and treat mental health disorders, prescribe medication, provide therapy and offer a wide range of mental health services, while the latter are typically more focused on general nursing care, depending on their scope of practice, and they may work under the guidance of more specialist mental health professionals. For example, in the Netherlands (Kingdom of the), most general practice facilities are equipped with mental health nurses (see Box 6).

Box 6. In the Netherlands (Kingdom of the), both GPs and mental health nurses provide mental health services and act as gatekeepers to advanced mental health services

In 2014, the Netherlands' (Kingdom of the) mental health-care system underwent a reform to introduce a stepped-care model for mental health services and encourage the transfer of care from specialized mental health care to primary care.

Under the new referral model, GPs serve as the initial point of contact for most patients, functioning as gatekeepers to advanced mental health services. They are trained for and expected to address uncomplicated mental health issues and will refer patients with suspected psychiatric disorders or with a high risk of harm (to themselves or others) to other health-care providers. All other patients with mental health concerns are to receive treatment within the GP practice.

The second step in the care process involves basic mental health services within primary care, delivered by professionals, such as psychologists, psychotherapists, social-psychiatric nurses and nurse specialists. The third level of specialist mental health care services consists of treatment by highly specialized professionals, often within a multidisciplinary team operating in CMHCs.

To facilitate GP practices in accommodating more patients with mental health issues, GPs can receive financial compensation for utilizing e-mental health resources or consulting with psychiatrists. Furthermore, they have the option to employ mental health practice support professionals, trained as psychiatric nurses, psychologists or social workers, who work under the GP's supervision. Their primary responsibilities include assessing mental health issues and offering short-term guidance to patients with such concerns. Initially, GPs could initially claim up to eight hours of mental health practice support per week per standard practice, which has since been expanded to the equivalent of one full-time position (FTE).

Most general practice facilities are equipped with mental health nurses who often fulfill the role of GP-MHPs (see Section 2.1). Introduced in 2008 *(94)*, this role involves conducting diagnostic assessments, providing short-term treatment, offering longer-term support, and delivering guidance and therapeutic counselling.

The share of general practices employing mental health nurses rose from 20% in 2010 to almost 90% in 2015, leading to a growing number of patients with mental health conditions receiving mental health services within primary care *(95)*. A prospective cohort study among 320 adults with anxiety or depressive symptoms seemed to imply that the care provided by GP-MHPs contributes to improving patients' functioning, while another report concluded patient satisfaction was high among those who received this care *(94, 96)*. GP-MHPs are an integral part of the Kingdom of the Netherlands' (Kingdom of the) mental health strategy, though continuous education is essential for maintaining their competencies.

Source: Based on *(94, 96,* 97). This box was co-authored by country experts; see acknowledgments.

(3) Non-specialist counsellors

Non-specialist counsellors for depression and anxiety are another example of mental health workers who may be included in primary care teams. They can include individuals with a wide range of backgrounds, ranging from community workers, volunteers, and peers, for instance, from the same

cultural or contextual background, as with some counsellors for brief psychological interventions for refugees. Depending on the country, they range from having as little as ten years of education to people with a university degree but without specialist mental health training, for example, nurses or first-degree psychology graduates. Non-specialist psychological counselling programmes can also be used to reach specific groups of people that may be particularly vulnerable to depression or anxiety, including new parents, refugees and displaced people or people living with HIV/AIDS.

Non-specialist counsellors in primary care can be found in several countries. For example, the IAPT programme in the United Kingdom *(28)* includes the use of non-specialist psychological counsellors, called PWPs, who deliver low-intensity psychological interventions, such as guided self-help and brief cognitive-behavioural therapy, to individuals with common mental health problems within primary care settings (see Box 5) *(84)*. The Stepped Care Model implemented in primary care in Norway involves the use of non-specialist psychological counsellors, in a programme called *Rask Psykisk Helsehjelp*, providing low-intensity interventions, including brief counseling, psychoeducation and self-help support, for individuals with mild to moderate mental health concerns. Mental health practice support professionals in the Netherlands (Kingdom of the) can also include non-specialist counsellors (Box 6). In some regions of Switzerland, non-specialist psychological counsellors are integrated into primary care teams to provide low-intensity mental health interventions. These counsellors, often known as *psychologische Beraterinnen/Berater* [psychological advisors], offer counseling, psychoeducation and support services for individuals within primary care settings.

(4) Peer support workers with lived experience

Primary care practices may also employ peer support workers with lived experience in mental health and delegate some responsibilities to them. These workers can lead support groups within the primary care context, providing individuals with mental health conditions with a sense of community and understanding as they navigate their challenges. Across the Region, primary care practices are increasingly recognizing the value of employing peer support workers with lived experience in mental health. These individuals bring their personal insights into the health-care environment, offering unique support and fostering a sense of community among those facing mental health challenges.

In the United Kingdom, the NHS has been at the forefront, integrating peer support workers into its primary care framework. These workers lead support groups and provide one-to-one support, creating spaces where empathy and shared experiences are key components of the healing process. The Netherlands (Kingdom of the) has also embraced this model, particularly within its CMHTs. Known as FACT teams *(98)*, they employ a multidisciplinary approach where peer support is a fundamental element, contributing to a more comprehensive mental health-care system. In the eastern part of the Region, Kazakhstan and Kyrgyzstan are collaborating with international bodies to reform their mental health systems. They are exploring community-based models which may include peer support as a significant feature in primary care, though these initiatives are in varying stages of evolution and practical application.

Addition of mental health workers into primary care usually takes either the form of attached care or co-location.

These various types of mental health workers can be involved in primary care teams in two predominant ways. The first is attached care, where specialists from a secondary care provider are linked to and operate within a local primary care setting alongside their usual role and where these professionals are considered integral members of the primary care team *(99)* co-location, which involves housing multiple services in the same physical location according to a defined model that outlines organizational characteristics, patient care responsibilities, coordination mechanisms, and data systems and policies *(100, 101)*. Irrespective of the mode of involvement, mental health workers working within primary care can offer consultation to individuals referred to them; advise or directly supervise primary care staff managing individuals with mental health conditions; train primary care staff on relevant aspects of mental health care (training might be better received if it is provided by mental health professionals who are attached to or directly embedded in primary care teams); and streamline links into specialist services (see Section 2.3).

(1) Attached care

The first option is for mental health workers to be "attached" or integrated into primary care teams. In this model, they remain predominantly employed in specialist mental health settings but work in primary care settings on a regular basis, accepting referrals, with the GP retaining the overall responsibility for the patient. In Sweden, for example, psychiatrists work as a part of the multidisciplinary teams in PCCs providing consultations for patients with severe symptoms (see Box 3 in Section 2.1).

(2) Co-located care

Mental health workers, such as counselors, mental health nurse specialists, and clinical psychologists, can work permanently in primary care settings alongside primary care providers in a shared physical space. For example, in the Netherlands (Kingdom of the)Kingdom of the Netherlands, most general practices employ mental health nurses (see Box 6 above). Similarly, CBT therapists and PWPs deliver psychological therapies for common anxiety in primary care centres and GP surgeries in the United Kingdom *(28)* (see Box 5). In the eastern part of the Region, Kazakhstan exemplifies this approach with GPs and psychologists working in primary care settings to provide comprehensive mental health services, with a strong emphasis on prevention and promotion (Box 7).

Primary care providers can also be integrated within a specialist mental health service.

Another option is to integrate a visiting primary care provider within a mental health service, sometimes referred to as reversed shared care *(103)*. This can be a family physician or a nurse whose role is to assess the physical health problems of individuals using that service, initiate treatment, monitor progress and refer on to more specialized care if required. For example, within the IAPT programme in the United Kingdom *(28)* (see Box 5), primary care professionals can also be members of specialist CMHTs. In Ireland, specialist early intervention teams for mental health also include primary care practitioners *(104)*.

Box 7. Primary mental health centres in Kazakhstan seek to ensure accessible and integrated mental health care for local populations

Since its independence, Kazakhstan's health system transformation has been centred around the provision of comprehensive, person-centred health services within primary care. This is in alignment with the PHC approach articulated in the Alma-Ata (1978) and Astana (2018) Declarations. This has been evident in the development of multidisciplinary primary care teams, incorporating a range of health-care professionals, including psychologists and social workers, and a strong focus on health promotion and disease prevention. This approach stands in stark contrast to the specialist-driven system inherited in the early years of independence, which had weak primary care capabilities and non-existent community-level mental health services.

GPs in these multidisciplinary teams have been trained in mental health competencies, including diagnosing, treating and managing patients with mental disorders. They conduct assessments, develop personalized treatment plans, provide psychological interventions, manage medications, and facilitate referrals to specialized mental health services when needed. They receive training through the mhGAP (see Section 3) and regular support from psychiatrists, especially in complex cases. This support is delivered in different ways. For example, GPs can: 1) directly discuss specific cases with a psychiatrist without patient identification; 2) jointly consult with a shared patient if necessary; and 3) refer a patient for a consultation with a psychiatrist, if needed. Psychiatrists can provide outpatient consultations at the primary mental health centre, located in the same building where GPs see patients, based on the patient's residence. However, there are also psychiatrists who consult at specialized mental health centres. Many of these options are driven by patient preference, which aligns with the values of a person-centred approach.

GPs are also involved in promoting mental health and prevention in their respective areas (in Kazakhstan, there is a district principle, with around 1700 people assigned to each district), with first point of contact and accessibility acting as key drivers for prevention and promotion strategies. Anecdotally reported, there was a high level of mental health stigma among GPs, but now they are among those who promote mental health issues. Other professionals in the primary care team have also had their roles updated to include proactive identification of potential mental health conditions, providing mobile responses, and making referrals.

Using a co-located care approach, psychologists in multidisciplinary primary care teams conduct psychological evaluations, diagnose and counsel on mental health conditions and behavioural disorders, and engage in suicide prevention. They also support the self-management of patients with chronic conditions: patients enrolled in NCD management programmes are referred to psychologists when their behavioural risk factors are psychosocial. The need for referral is typically identified either during appointments or through home visits, which can be conducted by any member of the multidisciplinary team. Mental health issues are determined using various widely accepted tools, such as interviews, algorithms and scales. If any mental health problems are detected, the entire multidisciplinary team works together, with the GP taking the lead, and involving a psychiatrist if necessary.

Source: Based on *(102)*. This box was co-authored by country experts, see acknowledgments.

2.3. Improving the linkages between primary care and specialist mental health services

The collaboration between primary care and mental health workers can be enhanced while allowing these professionals to continue working within their respective settings.

The third strategy for advancing mental health services in primary care revolves around enhancing collaboration between primary care and mental health workers while allowing them to remain in their respective settings. One of the key advantages of this strategy is that it allows patients to access a wider range of services and benefit from smoother transitions between primary care and mental health services without the need for significant restructuring or reallocation of resources.

However, implementing effective collaboration between primary care and mental health workers may present challenges. It requires clear communication channels, mutual respect for each other's practice, and a coordinated approach to patient care. Additionally, ensuring seamless coordination and information sharing between primary care and mental health settings may require investment in technological infrastructure, such as electronic health records (EHRs) that are compatible across systems. Additionally, training programmes may be needed to equip primary care providers with the skills and knowledge necessary to recognize and address mental health issues effectively, as well as to facilitate interdisciplinary teamwork.

Mental health specialists can be linked with primary care through consultation liaison services or collaborative care.

Mental health specialists can be effectively connected with primary care settings through consultation-liaison or collaborative care models. In the consultation-liaison model, the primary care provider remains central in delivering mental health care, with a mental health specialist offering consultative support *(105)*. This approach ensures that primary care workers maintain their primary role in patient care while benefiting from the expertise of mental health specialists. On the other hand, the collaborative care model involves the integration of specialist mental health workers who take the leading role in patient care to deliver comprehensive and coordinated management of behavioural health conditions in primary care settings.

(1) Consultation liaison

Consultation liaison, sometimes also called shared care (103), involves members of primary care and secondary mental health care working together in both formal and informal ways (106). In consultation liaison, there is ongoing communication between specialists and the primary care team, which can range from informal discussions in passing to more structured meetings (107). Some cases are managed within primary care and referrals of new cases are only possible after a discussion between the specialist and primary care team. Some countries, such as Italy, have combined consultation-liaison services with brief therapeutic interactions involving mental health specialists.

In remote rural areas, teleconferencing, video conferencing and virtual consultation platforms can enable real-time communication between primary care and mental health providers. They can be an effective means of providing consultation-liaison services, by allowing for virtual meetings, case discussions and collaborative consultations, enabling quick access to specialized expertise and enhancing coordination.

Specialist mental health crisis teams can also closely collaborate with primary care providers to offer rapid assessment, support and intervention for individuals experiencing acute mental health crises, ensuring continuity of care and facilitating access to specialized services.

(2) Collaborative care

Mental health workers can also engage in collaborative care with primary care providers, which involves dividing care responsibilities, with a dedicated care manager taking on a central position to coordinate the overall medical and psychological care, such as in Bosnia and Herzegovina (Box 8), and with a mental health specialist providing regular guidance and oversight to the care manager and the primary care provider. For every mental health service user, a structured management and follow-up plan, which is customized to meet the individual's specific requirements and preferences, is put in place. There is enhanced inter-professional communication between primary care and specialist mental health care, *(108)* which can leverage digital health tools, such as teleconferencing.

Box 8. Case managers act as the link between primary care and community mental health services in Bosnia and Herzegovina

Bosnia and Herzegovina *(109)* initiated mental health reform in 1996 to address the mental health impacts of exposure to traumatic events during the war. A key element of the reform was making mental health care more accessible through the establishment of CMHCs as part of primary care facilities.

Prior to the 1996 reforms, family medicine teams (FMTs), which consisted of family doctors and nurses, offered pharmacotherapy, counseling, and psychoeducation to service users. However, due to stigma towards individuals with mental health conditions, most FMTs preferred to refer them to psychiatric or outpatient clinics.

To try to address this, Bosnia and Herzegovina established CMHCs with strong links to FMTs, creating a network that allows for the treatment of common mental health conditions within primary care as well as more complex or severe conditions through specialist services in the CMHCs. Most CMHCs consist of a single, multidisciplinary team, including a psychiatrist, a psychologist, a nurse, a social worker, an occupational therapist for mental health, a speech therapist and a child psychiatrist (in selected centres). In larger cities, several teams may operate in a CMHC (e.g. a substance abuse team, a team for children, a team for adults, a team for the elderly). There are currently 74 CMHCs in Bosnia and Herzegovina. Service users can access either service directly without a referral, but they can also be referred by any health point contact to either service to begin their care.

Much focus has been devoted to equipping primary care professionals with the necessary skills to manage common mental health conditions, supported by a well-defined referral pathway that allows patients to transition seamlessly between the two services based on their specific needs.

Box 8. contd.

Modules on mental health are included in the family medicine specialization curricula. In addition, clinical guides for the most common mental disorders were developed for use by FMTs. The nurse training curriculum also contains elements for the management of mental health conditions. Likewise, the competencies of CMHTs were strengthened through additional education and trainings.

Efforts to enhance primary care competencies in mental health include the "Strengthening Nursing in Bosnia and Herzegovina Project" (ProSes), initiated by the Swiss Agency for Development and Cooperation in 2012, and the "Mental Health Project in Bosnia and Herzegovina," part of the Swiss Cooperation Programme for 2021–2024 *(110)*. These projects aim to train nurses and other primary care workers in family medicine to detect and manage depression and anxiety in adults in a timely manner. In 2024, the fourth canton in the Federation of Bosnia and Herzegovina planned a comprehensive programme for nurse training in leadership, new care guidelines and community nursing.

CMHC staff organize regular joint meetings with FMTs to define responsibilities, plan care for the somatic health of CMHC service users, exchange opinions and information about service users and conditions in which they live, plan for joint education sessions, solve technical communication issues, provide feedback, and engage in the collaborative creation of protocols and guides. These efforts have contributed to the provision of better treatment, rehabilitation and resocialization and have improved the monitoring of service users with mental disorders.

The role of a case manager, based in the CMHC, has been introduced to facilitate effective coordination and communication between CMHCs and FMTs and other services to ensure that service users have a dedicated focal point for their transition among various sectors within and beyond health care, including family medicine, social services, hospitals and CMHCs. Case managers, also called care coordinators, are designated members of the multidisciplinary mental health professionals' team who are assigned to patients with severe mental health problems and complex needs to coordinate the provision of health and social services for these patients. They also serve as a point of connection between acute care and rehabilitation programmes.

FMTs in turn work with services beyond the health sector (as discussed in Section 2.4), such as advocacy groups and media, to reduce the stigma of seeking help and improve other forms of mental health support. This has resulted in a shift away from the traditional paternalistic, predominantly medical model whereby individuals with mental health conditions were mainly treated in hospitals, towards a more person-centred, biopsychosocial model that addresses people's needs more holistically.

Source: This box was co-authored by country experts; see acknowledgments.

In Türkiye, psychiatrists working in the CMHCs bear the responsibility of developing the care plan for the patient, but they do so in close collaboration with family and family doctors (Box 9).

Box 9. Integration of CMHCs and healthy life centres (HLCs) with primary care in Türkiye has reshaped the roles and responsibilities of primary care doctors

The mental health policy in Türkiye has been undergoing a staged transformation process since 2006. In 2011, the establishment of CMHCs was a significant milestone as part of the National Mental Health Action Plan 2011–2023. Despite CMHCs and primary care group practices being accountable to different departments, the National Mental Health Action Plan outlines the goal of full integration of CMHCs with primary care services. These CMHCs are designed as community-based specialized health institutions, providing treatment and support at a local level to individuals with severe mental health problems and their families. They serve as versatile one-stop-shop centres for multidisciplinary assessment and care. In general, CMHC teams are typically comprised of various mental health professionals, including a psychiatrist, a psychologist, several mental health nurses (usually 5–6), a social worker, an ergotherapist and other support staff.

CMHCs, family physicians and social workers collaborate to ensure timely access to primary care and mental health services through patient referrals and counter-referrals. Psychiatrists are instrumental in providing essential support to primary care professionals in managing patients with mental health issues. While psychiatrists bear the responsibility of developing the care plan for the patient, this is achieved through close collaboration with other team members and in cooperation with the patient and their family and family doctor. This collaborative approach encourages shared responsibilities between family doctors and psychiatrists in the treatment of mental health conditions and associated physical comorbidities.

Additionally, all CMHC team members have the potential to serve as the "case manager" for the patient. In this role, they play a significant part in identifying patients in need of psychosocial support, initiating contact with patients or their relatives, inviting them to the centre, ensuring patients' smooth transition to the centre and their treatment, and designing an intervention plan based on a comprehensive assessment of the patients in their own environment.

Furthermore, in an effort to emphasize the prevention of mental health issues and other chronic conditions, HLCs were established in 2018. Their mission is to promote a healthy lifestyle and fortify primary care services, including mental health support. The psychosocial units within HLCs aim to address mental health risk factors through psychosocial counseling, screening and education services. They also provide smoking cessation counseling and support for drug users and their families, adopting a holistic approach. Currently, there are 185 CMHCs operating in at least 79 provinces and 223 HLCs in 77 out of 81 provinces across Türkiye. Primary care workers working within HLCs offer a broad spectrum of services aimed at preventing hospitalization and minimizing disability among individuals with mental health issues. Moreover, the primary care workforce has assumed new and crucial responsibilities, particularly in providing support to families caring for individuals with severe mental health problems.

The integration of CMHCs and HLCs into primary care has played a pivotal role in reshaping and reinforcing the roles and responsibilities of the primary care workforce in the field of mental health. Türkiye has proactively participated in various training initiatives to enhance the mental health competencies and skills of its primary care health workforce, which links to the strategy of enhancing mental health competencies of primary care workers, as discussed in Section 2.1. For example, the Ministry of Health expanded the mhGAP trainings to encompass all family doctors in the country, with the objective of improving their competencies in early diagnosis and prevention of mental health disorders.

Source: This box was co-authored by country experts; see acknowledgments.

In Czechia, mental health care centre teams collaborate closely with general practices, local government authorities, social services, law enforcement and other relevant stakeholders to both identify and deliver care to service users *(111)*.

Comprehensive joint action plans are established nationwide, facilitating a strong partnership between mental health care centres and general practices. These plans aim to ensure that the centres can offer support to general practices whenever necessary, particularly in cases where assistance is required to prevent hospital admissions or to provide care to service users upon their discharge. Additionally, and when this is necessary, the mental health care centre team can deliver crisis intervention. This may entail enhanced support, the engagement of additional team members, including psychiatrists, the initiation of intensive home care support plans, providing access to crisis beds, or the development of care strategies aimed at averting further crises.

2.4. Promoting the linkages between mental health services in the health care and other sectors

Partnerships between mental health services provided in the health and other sectors foster a holistic approach to addressing mental health needs.

Collaborating with sectors, such as public health, education, housing, social protection, police, criminal justice, employment services as well as public and private sector workplaces, allows for a holistic approach to mental health, recognizing that social determinants, environmental factors and societal contexts have an impact on mental well-being (66). The higher prevalence of risk factors in vulnerable population groups (see Section 1) further highlights the need for strengthening collaboration beyond health care. By collaborating with other sectors, primary care mental health services can access additional resources, expertise and support networks to better meet the diverse needs of their patients.

However, promoting partnerships between mental health services provided across various sectors may require overcoming various challenges, such as differences in organizational cultures, funding mechanisms, and communication barriers between different sectors.

Partnerships between mental health services provided in the health and other sectors are emerging and can be promoted by a range of initiatives.

One example of a partnership between primary care and other sectors in the area of mental health is the Street Triage service in the United Kingdom *(112)*, which offers teams of mental health nurses and police officers on certain emergency calls. Similarly, in some Scandinavian countries, there are specialized emergency co-response teams that include mental health professionals. These integrated responses can offer immediate assistance, help in crisis resolution, and connect individuals to ongoing mental health services; however, there is still further research needed to understand the impact of these teams *(113)*.

Workplaces serve as an example of a crucial setting for the delivery of mental health services, given that so many people can be reached at work. Primary care plays a pivotal role in connecting people with mental health

conditions to supported employment programmes, for instance, to the Individual Placement and Support (IPS) model – an evidence-based approach to supported employment for people with mental health conditions that can be highly effective and cost-effective in a variety of settings.

Successful IPS programmes have been established in various Nordic countries, with Norway serving as an example of widespread IPS implementation, and in the United Kingdom. Although supported employment and IPS programmes primarily fall under the purview of community mental health interventions rather than primary care *(83)*, they rely heavily on establishing strong connections with primary care services (e.g. for referrals) *(114)*.

A variety of approaches can be implemented to support the development of cross-sectoral partnerships in mental health care, such as the promotion of cross-sector training and education that brings together professionals from different sectors to enhance their understanding of mental health issues and develop a shared language and knowledge base (see Section 3); implementation of joint initiatives and programmes that address shared goals and challenges (e.g. promotion of mental health literacy in schools, provision of supportive housing for individuals with mental health needs, promotion of sport and physical activity, or implementation of diversion programmes in the criminal justice system); and establishing effective communication channels to promote common goals, such as in Belgium (Box 10), or in the Peterborough Exemplar in the United Kingdom (see Box 2), where investment has been made into a "super local" website, supported by a face-to-face digital and community engagement team, which facilitates the dissemination of information and promotes an understanding of local mental well-being and support resources that are available in the community *(115)*. Other approaches to foster partnerships include encouraging the sharing of data and research findings between sectors to inform policy development, programme planning, and service improvement efforts; and advocating for policy alignment across sectors to ensure mental health is addressed as a cross-cutting issue.

Despite these examples, such solutions remain rare in most countries. Partnership in itself will not enhance the scale-up of mental health services in primary care or the coverage of relevant interventions by different sectors. Determining the most effective setup requires careful consideration. In the Netherlands (Kingdom of the), the introduction of the *Integraal ZorgAkkoord* [Integral Care Agreement] set out an aim to increase collaboration between GPs and social care workers to better tackle rising mental health concerns in the population *(120)*, and research is ongoing to determine how best to restructure the mental health care system to be community-centred and move away from siloed, specialist care *(121)*. There also needs to be concerted efforts to address barriers in different sectors, including insufficient resources and training. This, however, falls outside the scope of this report.

Box 10. Mental health networks facilitate intersectoral collaboration in Belgium

Belgium has opted for a nationwide reform of the mental health sector from 2009 with the goal of improving people-centred approaches for people with mental health conditions *(116)*. Initially, the focus of the reform was on reducing the number of psychiatric hospital beds, which prior to the reform was among the highest in Europe, and the development of mobile care in the community, centred on the needs of individuals and their context. The second part of the reform, pursued since the end of the COVID-19 pandemic, focuses on prevention, early detection and care for mild to moderate problems, in particular by developing psychological care in the first line of care, with a view to improving care integration. There is also investment in specialist care, such as in the highly intensive care units.

Central to the reform are the regional mental health care networks offering outreach services, prevention, in- and out-patient mental health services, primary care, day care, and vocational, housing and social care services. The regional mental health networks facilitate collaboration and coordination among various stakeholders involved in mental health care and related domains/sectors. This includes health-care providers, mental health professionals, social services, patient organizations and other relevant actors. The networks aim to ensure a multistakeholder and coordinated approach to mental health services. The regional mental health networks play a key role in organizing and optimizing the provision of mental health services within their regions. They aim to ensure that individuals have access to appropriate care and support services at different levels, including prevention, early intervention, treatment and rehabilitation. The networks facilitate referral pathways and collaboration between primary care providers, specialized mental health services, and other relevant community resources.

The regional networks assess the mental health needs and resources within their respective regions. They identify gaps, challenges and priorities for mental health care. Based on this assessment, they develop strategic plans, including budget stratification and integration of care and other interventions to address the specific mental health needs of the population in their region. They collaborate with local authorities and policy-makers to influence mental health policies and resource allocation at the regional level.

Sources: Based on *(117–119)*. This box was co-authored by country experts; see acknowledgments.

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3

Health workforce education and training as crucial tools and resources for integrating mental health care into primary care

Enhancing the mental health roles and responsibilities of the primary care workforce requires the provision of appropriate education and training, starting with pre-service education.

The four strategies for upscaling mental health services in primary care described in this policy paper call for adjustments to the roles and tasks of the health workforce, and an increase in mental health competency, especially for those working in primary care. This entails a capacity-building reconfiguration in education and training for mental health care in contexts where mental health competencies are not sufficiently developed in primary care. For instance, while many primary care doctors may feel more at ease employing medical approaches to mental health, it is important to note the shift away from prescribing psychotropic medication as the first line of treatment for many mental health conditions. It is therefore important to build the confidence of general health-care providers in engaging in care which uses complementary psychosocial approaches. Providing education and training in mental health, and mentorship and support from mental health specialists, can help to build this confidence and reduce the stigma against mental health among the generalist health workforces.

Unfortunately, in numerous countries, mental health training offered during medical or allied health sciences schooling remains primarily theoretical in nature and offered over a brief period of time, with clinical internships frequently consisting of rotations in psychiatric hospitals, which do not adequately reflect the practical realities of health care in general or community health-care settings *(9)*. Further, many countries do not have training programmes for adult and child psychiatry, clinical psychology and mental health nursing developed with a focus on primary or community care.

What do desirable mental health competencies (i.e. skills, knowledge and attitudes) in primary care workers look like? In general, these providers traditionally focus on physical health problems, with limited exposure to mental, neurological and substance use conditions. To effectively provide mental health services to the populations they serve, they need to be equipped with the competencies required to identify mental health conditions, deliver basic mental health care, communicate effectively with mental health workers, and make referrals to specialized services. At the very least, relevant providers need a level of awareness of the available mental health services and referral options for individuals, whether these are specialist or community providers skilled in psychological counselling. Primary care workers should also be able to encourage and guide individuals to use evidence-based self-help books or digital self-help interventions as part of depression and anxiety management. In practice, enhancing the competencies of primary care workers in these areas entails a combination of education, training, ongoing supervision, mentorship and support *(9)*.

Ideally, the training of primary care providers in mental health care should be integrated into their pre-service education. Unlike in-service training (discussed below), pre-service training is considered more sustainable since it is an integral component of their educational curriculum and is typically more cost-effective per trainee *(122)*. Trainees tend to be highly motivated as pre-service training, unlike most in-service training, is assessed through examinations that must be successfully completed *(9)*.

The United Kingdom, where mental health training has been included in the pre- and in-service education of primary care doctors and nurses, can serve as a valuable learning source for other countries (Box 11). Indeed, a growing number of countries are expanding the number of training hours for generalist health professionals that is dedicated to mental health. For example, in Kazakhstan, students in all medical universities take mandatory courses on mental health issues and every medical intern is required to take courses in psychiatry *(102)*. In addition, GPs, paediatricians and other primary care doctors who work as interns at the Asfendiyarov Kazakh National Medical University in Almaty must work for a minimum number of credit hours with the *WHO mhGAP Intervention Guide* (mhGAP-IG) on providing care to patients with mental, neurological and substance use disorders in non-specialist health settings.

Box 11. Mental health training has been included in the pre- and in-service education of primary care doctors and nurses in the United Kingdom

Primary care doctors and nurses in the United Kingdom receive comprehensive training in various aspects of mental health care as part of their pre-service education. Mental health education is incorporated into the curriculum of undergraduate medical and nursing programmes, with students receiving foundational knowledge and skills related to mental health, including understanding mental health conditions, assessment techniques, treatment approaches and communication skills for interacting with individuals experiencing mental health challenges.

After completing their undergraduate education, doctors pursuing a career in primary care undergo specialty training, known as GP training. This training includes mental health components and rotations, providing practical experience in diagnosing and managing mental health conditions in primary care settings. Trainees learn about the integration of mental health care into their practice and work closely with mental health professionals.

Primary care doctors and nurses engage in continuous learning and development throughout their careers through continuing professional development activities. These activities include workshops, conferences, seminars and courses focused on mental health, where these professionals can update their knowledge and skills, and stay informed about advances in mental health care. They also have the opportunity to pursue specialized courses and qualifications in mental health. These programmes offer in-depth training in specific areas of mental health, such as child and adolescent mental health, addiction psychiatry or psychological therapies. These courses enable professionals to develop advanced skills and expertise in providing mental health care in primary care settings.

Box 11. contd.

Nurses enter into mental health care first with comprehensive foundational training during their undergraduate education, where they learn about a variety of mental health conditions, assessment techniques, treatment options and communication skills for engaging with patients facing mental health challenges. Following general nursing qualifications, nurses can opt to specialize in mental health nursing, which involves deeper training focused on understanding and managing a wide spectrum of mental disorders, providing patient care and designing effective treatment plans. For those looking to further enhance their expertise, postgraduate degrees and certifications in mental health nursing are available, offering specialized knowledge in areas, such as psychotherapy, crisis intervention and specific conditions like schizophrenia. This robust educational framework supports nurses in pursuing diverse career paths within health-care settings, ranging from hospitals to private practices, and advancing to significant roles, such as senior mental health nurse or nurse consultant, thereby playing a critical role in the integrated mental health approach within primary care settings.

National bodies, such as the National Institute for Health and Care Excellence *(91)*, Royal College of General Practitioners and Royal College of Nurses, provide guidelines and resources to support primary care professionals in delivering evidence-based mental health care. These guidelines inform professionals about best practices, treatment protocols and emerging research in mental health *(124)*.

Clinical internship and/or residencies, which are mandatory in many countries following basic medical education, offer valuable opportunities to augment the knowledge gained during pre-service education. For example, these experiences can serve to expand and reinforce diagnostic and communication skills and deepen the understanding of various treatment modalities, provided that appropriate training and support are made available *(125)*. Specifically, interns and residents can be trained in primary and secondary prevention methods, psycho-education techniques and brief psychological interventions. For example, in psychotherapy, there are many therapies, such as behavioural activation, that are adapted to be delivered by non-specialists, including by text message. Interns and residents can also enhance their cognitive-behavioural skills by learning reattribution and other techniques for medically unexplained symptoms, develop problem-solving skills, and learn to conduct anxiety management and simple exposure and response prevention interventions.

In-service training is crucial for reinforcing and updating existing mental health skills, as well as providing basic skills to those with a limited foundation in mental health care.

In-service training (i.e. training that takes place during active employment) serves as an essential tool in primary care, particularly when it comes to mental health. It plays a dual role: firstly, it strengthens and updates the mental health skills of existing health-care workers, ensuring their practices are aligned with the latest research and clinical guidelines; secondly, it provides fundamental mental health-care education to those primary care workers who may not have had extensive training in this field.

Looking at an example from the United Kingdom, the NHS has a comprehensive framework for mental health training that includes Health Education England's (a public body responsible for the education, training, and development of the health workforce in England) initiatives to provide in-service training for a range of professionals, including primary care nurses, to bolster their mental health care capabilities.

Incorporating input from diverse professionals and individuals with lived experiences of mental health conditions in the design of training programmes can help to break down professional silos and reduce stigma.

Training programmes can be designed to accommodate multiple professionals, including doctors, nurses, public health experts, social workers and various other workers who contribute to the delivery of mental health care within their respective community roles. The benefits of multiprofessional training are manifold; it leverages diverse experiences and insights from different perspectives, and it can play a pivotal role in breaking down professional silos *(126)*.

Giving people with mental health conditions co-facilitation roles during mental health training can help to reduce mental health stigma among those receiving such training *(9)*. For example, in the "Recovery College" model in the Netherlands (Kingdom of the), people with lived experience co-design and co-deliver training sessions *(127)*. The strategy behind this approach is that firsthand testimonies and insights can challenge preconceived notions, humanize psychiatric conditions and foster empathy and understanding among clinicians.

Ongoing supervision, mentoring and support can reinforce the practical application of training in mental health skills.

Despite their potential to achieve positive outcomes, the effects of training programmes are likely to be short-lived if health workers do not practice newly learnt skills and receive specialist supervision and feedback over time *(125)*. Supervision can be performed by, for example, mental health specialists for primary care doctors, or by primary care doctors for other primary care staff. It can include action planning; reflection on clinical situations; role development and training; indirect and direct supervision; and supervision from both internal and external organizations *(128)*.

For instance, some countries enable mental health professionals from specialist hospitals to regularly work in community-based settings to support primary care providers (see Section 2.2). In this setup, specialist hospitals establish specific responsibilities for training, support and the supervision of task sharing, ideally mirroring their clinical care responsibilities. A designated lead, for example, a community psychiatrist, can be appointed to oversee this task, with specialist nurses or junior psychiatrists participating in a supervision rota. This approach ensures that suitably qualified individuals, who maintain their specialist hospital roles and have the necessary human resources, are responsible for supervision.

WHO's mhGAP offers guidance and resources to countries to scale up services for mental, neurological and substance use disorders.

The WHO's mhGAP serves as a resource and guide for countries to develop, expand and improve their mental health services, especially in low- and middle-income countries where mental health resources are often limited (Box 12). Indeed, many countries with less capacity to provide mental health training, for example in eastern Europe, the Balkans and Central Asia, collaborate with WHO to implement the mhGAP. The programme promotes the idea of task-sharing, where non-specialized health-care providers can play a significant role in delivering mental health services, thus expanding access to care.

Box 12. WHO's mhGAP has developed a set of task-sharing training packages and implementation tools to help countries implement training, supervision and support for general health-care workers

The WHO's mhGAP was introduced in 2008 with the aim of bridging the implementation gap between the demand for mental health care and its availability by developing task-sharing training packages and implementation tools (e.g. training and operations manuals, community toolkits) for general health workers.

These are designed to teach 12 core competencies relevant to assessing, managing and following up on people with eight priority mental, neurological and substance use conditions: (1) depression; (2) psychosis, including schizophrenia and bipolar disorder; (3) epilepsy; (4) dementia; (5) disorders due to alcohol or drug use; (6) child and adolescent mental and behavioural disorders; (7) conditions related to stress, such as post-traumatic stress disorder; and (8) self-harm/suicide (Fig. 5). Such training also provides important opportunities to familiarize trainees with the clinical assessment and management of priority mental health conditions.

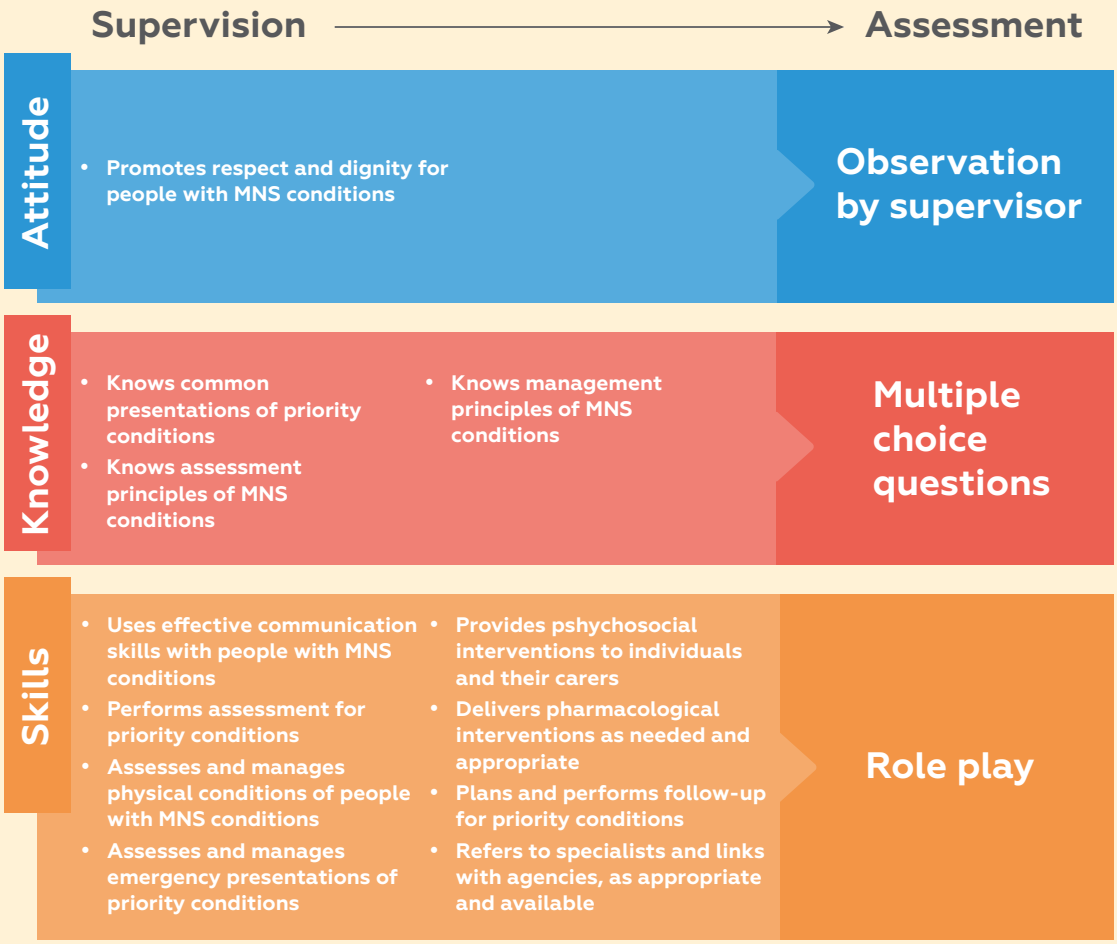
Despite potential challenges encountered by PMC providers in delivering psychosocial interventions, it remains vital for them to acknowledge the significance of such care. In this regard, the mhGAP also imparts the skill of facilitating referrals to specialists and establishing connections with various available resources, including beyond the health-care sector (see Section 2.4).

The WHO has developed, and continues to update, recommendations for managing these eight conditions using the well-established Grading of Recommendations Assessment, Development and Evaluation (GRADE) method. The recommendations cover both psychosocial and pharmacological interventions. The mhGAP-IG and app (e-mhGAP) turn these evidence-based guidelines for the eight priority conditions into simple clinical protocols that can support decision-making on the ground in non-specialized health-care settings. A humanitarian version of the mhGAP-IG (mhGAP Humanitarian Intervention Guide) also exists and has been used widely by international NGOs responding to humanitarian emergencies (130). A broader programme of action builds partnerships across all stakeholders to adapt and adopt the protocols at scale.

Sources: (47, 53, 122).

Box 12. contd.

Fig. 5. mhGAP training targets 12 core competencies



Note: MNS: mental health, neurological and substance use. *Source: (129).*

It features a comprehensive set of task-sharing training packages and implementation tools, developed to aid countries in establishing training, supervision and support for general health-care workers, that can be implemented as both pre-service and in-service training.

While mhGAP is most often used to scale up mental health care for the general population, it can also be used for specific contexts and groups, such as youth or refugees. For example, Türkiye has been using mhGAP since 2016 to train Syrian and Turkish primary care providers to deliver essential mental health care through refugee health centres and community mental health services *(131)*. mhGAP tools have also been used in Ukraine to help build capacity during armed conflicts since 2017 (Box 13).

Various tools, such as treatment guidelines, can support the development and strengthening of mental health skills within primary care.

The development and strengthening of mental health skills within primary care can be supported by using mental health assessment and diagnosis tools and treatment guidelines.

Box 13. mhGAP-IG and other mhGAP resources have been effectively used in Ukraine to facilitate access to mental health services during times of conflict

The conflict in eastern Ukraine since 2014 had led to a significant increase in the mental health needs of the population, putting much strain on already scarce mental health resources. In response, the Ministry of Health of Ukraine launched a health reform in 2015, with an initial focus on strengthening primary care. In 2017, the Government passed a concept for the development of mental health care in Ukraine for the period up to 2030, with the goal of improving mental health services, including at the primary care level.

These efforts were supported by collaborative initiatives between the Ministry of Health and WHO to implement the mhGAP. Thus, in 2017, capacity-building initiatives for the humanitarian version of mhGAP-IG were initiated in the east of the country. Subsequently, in 2019, the programme was extended, and family doctors, therapists and nurses working in primary care in the Donetsk region were trained on Version 2.0 of the mhGAP-IG. However, these efforts have been confined to specific regions and may face challenges in terms of sustainability due to the lack of government funding *(132)*. Since 2018, Ukraine has also worked towards strengthening mental health education by integrating the mhGAP-IG into education settings, which included graduate and post-graduate education of medical workers in medical universities, within the framework of the Ukraine-Norway-Armenia Partnership *(132)*.

Following the Russian invasion of Ukraine in February 2022, the Government initiated a national mental health programme. This programme reinforced efforts to integrate mental health services into primary care and prioritized mhGAP for short- and long-term responses to the war and recovery period. As part of this initiative, an online self-paced course based on mhGAP materials was launched in November 2022, made available for all primary care staff in Ukraine, complementing existing services and funded by the global health-care budget, and face-to-face training was rapidly expanded. Around 5200 primary care workers were trained in WHO's mhGAP initiative by the end of 2023 and over 62 000 participants completed an online mhGAP course since its availability was extended to all primary care staff in December 2022.

Following on this, a new package of mental health services in primary care was launched as a part of the State Programme of Medical Guarantees *(133)*. It includes clinical assessments for those screened positive for mental disorders; physical and mental status examinations; referrals for further diagnostic tests; psychiatric evaluations; the development of personalized treatment plans incorporating psychosocial, pharmacological, and behavioural interventions; support for treatment adherence and social rehabilitation; the continuous monitoring and adjustment of treatment plans; emergency care provisions; and psychological support and education for patients' families and caregivers, all aimed at addressing mental and neurological disorders and ensuring the patient's overall well-being. Thanks to these efforts, the availability of mental health services in primary care has culminated in more than 20 million people gaining access to primary level mental health services through over 3000 trained doctors and approximately 16 000 online course completions, acknowledging some overlap due to dual training avenues, significantly improving access to mental health care for the population.

Source: This box was co-authored by country experts; see acknowledgments.

General assessment tools include the General Health Questionnaire *(134)*, the WHO Mental Disorders Checklist *(135)*, and the Hopkins Symptom Checklist *(136)*, which are freely available and validated in multiple contexts. Other assessment tools focus on specific mental health issues.

For example, the AUDIT screens for hazardous and harmful use of alcohol and the ASSIST screens for use of a range of psychoactive substances, including illicit drugs, alcohol and tobacco *(53)*. Tools are also available to support the diagnosis of various conditions, such as depression *(137)*, behavioural conditions *(138)*, youth mental health conditions *(139)* and dementia *(140)*. Decision aids, such as for depression treatment, can also be implemented but there is limited evidence on their effectiveness *(141)*. Finally, treatment guidelines, such as those developed within the mhGAP (see Box 12 above), can also be used to support the provision of mental health care within primary care, although evidence suggests that uncertainty remains about clinically meaningful and sustainable effects of treatment guidelines on patient outcomes and how best to implement such guidelines for maximal benefit *(142)*.

WHO-developed and freely available tools, detailed in Box 14, can be used to further enhance psychosocial skills in the non-specialist general workforce, as exemplified by programmes such as Self Help Plus (SH+) implemented in the HLCs and refugee health centres in Türkiye (see Box 9). SH+ employs audio recordings to impart stress management skills to participants, exemplifying a nuanced approach to skill enhancement within diverse primary care settings.

Box 14. WHO has developed a range of products to increase psychosocial skills in the non-specialist general workforce

- WHO has developed several tools and programmes that can be used by health professionals, community workers, and individuals seeking guidance and support for their mental well-being. These tools and programmes include the following.

- **PM+ (Problem Management Plus).** PM+ is a brief, evidence-based psychological intervention designed to provide basic support to people experiencing common mental health conditions, particularly in the aftermath of adversity and humanitarian crises. It is intended to be delivered by trained lay health workers or non-specialists and focuses on reducing symptoms of distress, improving functioning and enhancing coping skills. PM+ consists of five sessions and includes various strategies for managing stress, including stress reduction and problem-solving techniques.

- **Doing What Matters in Times of Stress.** This is a guide developed by WHO to help individuals cope with stress and emotional challenges during crises, such as the COVID-19 pandemic. It offers practical guidance on managing stress, maintaining well-being and supporting others during difficult times. The guide includes a variety of strategies and coping mechanisms to help people navigate stress and adversity effectively.

Box 14. contd.

- **Thinking Healthy.** Thinking Healthy is a psychosocial intervention programme developed for perinatal depression, which is depression occurring during pregnancy or within one year after childbirth. It provides support for pregnant women and new mothers to help manage and alleviate symptoms of depression. The programme emphasizes enhancing emotional well-being, reducing symptoms of depression and building strong maternal-infant bonds.

- **Self-help.** Self-help tools provided by WHO include a range of resources, from written materials and online guides to mobile apps and digital platforms. These resources are designed to empower individuals to take steps to improve their mental health and well-being independently. Self-help tools often cover topics like stress management, emotional resilience and strategies for improving mental health *(54)*.

Source:: (143–145).

Various tools are also available to enable providers implementing mental health interventions to design and monitor their training and supervision in a systematic, locally specific and pragmatic way. These efforts involve the utilization of tools, such as the Enhancing Assessment of Common Therapeutic factors tool (ENACT) *(146)*, which enables the assessment of therapist competence, and more recent initiatives, such as WHO's Ensuring Quality in Psychosocial Support (EQUIP). The goal of EQUIP is to develop and compile comprehensive sets of high-quality resources for psychological and psychosocial support interventions on a global scale *(146)*.

4

What other policy levers can support scaling up mental health interventions within primary care?

A spectrum of levers across the domains of workforce, infrastructure, financing and governance policies can facilitate the upscaling of mental health interventions in primary care. This section delves into some of the levers that are particularly crucial for implementing the four strategies detailed in this policy paper, while acknowledging that broader challenges, such as deficiencies in both the number and geographic distribution of workers within the primary care and mental health care workforce (or health workforce in general), or inadequacies in financing, while important, fall outside the scope of this document.

4.1. Human resources

Education and training should be complemented by strategies to encourage the generalist health workforce to take on and actively perform roles and tasks in mental health care.

Upscaling the provision of mental health services in primary care requires not only changes to education and training, as detailed in the previous section, including sufficient support to perform the new or expanded roles and tasks; it also has major implications for other aspects of human resources policy. For instance, primary care providers should be provided with adequate time and space to effectively fulfill mental health responsibilities, such as administering multi-session psychological treatments for conditions, such as depression and anxiety.

Improving the uptake of mental health roles and tasks among primary care workers also requires making these roles and tasks attractive. This can include similar strategies as those aimed at drawing health professionals to primary care, such as attractive salaries and remuneration for the provision of mental health interventions in primary care *(147)*, ensuring opportunities for professional development, interprofessional collaboration and professional autonomy. Actions are also required to reduce the stigmatizing attitudes towards individuals with mental health conditions. However, education and training in mental health can in themselves be seen as opportunities for professional growth for primary care workers, especially if marketed as a challenging and rewarding area of work, as well as contribute to reducing mental health stigma.

At the same time, there may be some hesitation among psychologists and psychiatrists regarding the involvement of non-specialists, which could pose challenges to scaling up mental health interventions in primary care *(148)*. It is therefore important to engage mental health specialists and foster their support to facilitate the implementation of mental health services in non-specialist settings.

Although nurses account for the majority of those in the health workforce, they experience systemic inequities that hinder their engagement in mental health.

Despite being the backbone of patient care, the nursing profession is marked by a startling deficit in regulatory frameworks, educational advancement and career progression. With several exceptions, including the United Kingdom (see Box 11), the standards of nursing education remain arrestingly low across vast stretches of the Region, a status quo stubbornly resistant to the burgeoning evidence that correlates higher education levels with superior patient outcomes. Nurses, predominantly women, face the precariousness of employment exacerbated by gender-biased career constraints, lesser salaries, unstable contracts devoid of pension security and a disproportionate burden of care responsibilities. WHO's Global Strategic Directions for Nurses and Midwives and the associated roadmap *(149)* offer a lens into the complexities of these challenges, underscoring the necessity for holistic interventions. The advancement of nursing roles cannot merely be a matter of expanding duties but must be underpinned by transformative education and strategic, supportive policies that afford nurses fuller integration into multidisciplinary teams, improving the working environment and granting them access to information technologies and pivotal decision-making arenas *(150–153)*.

Enhancing primary care workforce stability requires strategies for the recruitment, retention, and mental well-being of staff.

The recruitment and retention of primary care staff is critical, particularly against the backdrop of escalating mental health conditions and burnout rates among these essential workers. Ensuring the mental health of primary care staff is not another facet of workforce management, but rather a cornerstone for retention *(154)*. Moreover, safeguarding the mental well-being and resilience of primary care staff transcends individual benefits, extending to the broader implementation of health services to the population. A focus on creating safe working environments can preempt staff stress and mental health conditions, as evidenced by interventions among physicians that have shown a tangible decrease in burnout by 10% and a 14% reduction in high emotional exhaustion *(155)*. Moreover, a blend of cognitive, behavioural and mindfulness interventions has yielded a notable dip in anxiety symptoms among physicians and medical students, while strategies that combine psychoeducation, interpersonal communication and mindfulness meditation have been linked to diminished physician burnout.

4.2. Physical resources

Investments in health information systems and digital health technologies have the potential to improve the provision of primary care services, including primary care mental health interventions.

The integration of technology and health information systems is pivotal in improving mental health services in primary care. For instance, it can facilitate the seamless exchange of patient data among health-care providers, with appropriate consent, ensuring coordinated care that encompasses GPs, psychiatrists, nurses, psychologists and more. Many countries have recognized the potential of EHRs that include comprehensive mental health assessment tools, treatment plans and patient history. In

countries like Finland, the national EHR system allows health-care providers, including those in primary care, to access and share essential patient information, including mental health histories.

This facilitates better care coordination and ensures that mental health information is readily available to those providing primary care services. In Kazakhstan, information systems are being used for the dynamic monitoring of patients, including those being treated for mental health conditions and substance use disorders *(102)*. These systems, which include the EHRs of patients with mental- health and substance use conditions, are integrated with other health-care information systems, including electronic systems used in primary care.

In the evolving landscape of health-care delivery, teleconsultations via telephone or videoconference have emerged as a potent alternative to traditional face-to-face consultations (156). This modality has proven effective not only in general primary care but also within mental health services, offering a versatile option for patient care. The scope of online interventions is vast, ranging from parenting programmes addressing child mental health concerns and promoting positive behavioural changes *(12, 33)* to digital CBT for depression, which has shown effectiveness on par with its in-person counterpart *(157)*. The COVID-19 pandemic served as a catalyst for the rapid adoption of remote consultations *(12, 158)* across Europe, with some regions, such as one in the United Kingdom (28), reporting a remarkable transition where 90% of GP consultations were conducted remotely *(159)*. Today, teleconsultations, involving direct, real-time communication between health-care providers and patients, or among different providers via information and communication technology, stand out as one of the most widely adopted telemedicine interventions in primary care. Complementing this approach, digital e-screening for mental health conditions has been embraced, particularly by the youth demographic *(160)*, demonstrating both feasibility and acceptability. These innovations represent a significant shift toward more accessible and integrated health-care systems, leveraging technology to meet patients' needs effectively.

The development and integration of digital health tools have become a valuable asset in expanding mental health services within primary care in many countries, contributing to improved access, especially for individuals residing in underserved areas *(161)*, not only in terms of saving time and travel costs but also by addressing the stigma associated with in-person consultations. In Sweden, the expansion of telehealth services has enabled primary care providers to offer remote mental health consultations, thereby improving access to care, even in remote and underserved areas. Numerous countries have also shown support for mental health apps and online portals that offer self-help resources and appointment scheduling for patients. In countries like the Netherlands (Kingdom of the), digital platforms provide online CBT programmes, which can be used with or without the guidance of a professional, making it easier for patients to engage with mental health services.

Furthermore, there is a growing trend in promoting remote monitoring devices and wearables to collect mental health data for timely interventions. Denmark, for instance, has introduced a number of regionally based digital or hybrid treatments for persons with psychiatric conditions that include remote monitoring, which enables proactive interventions when necessary, ensuring a more comprehensive approach to mental health care.

While many mental health services can be provided in existing primary care facilities, investments in facility development and upgradation can facilitate certain types of integration between primary care and specialist mental health services.

While many mental health interventions can be provided within existing primary care facilities, some approaches described in this policy paper may require the redevelopment of existing facilities to ensure appropriate physical space. For example, some countries have established dedicated mental health clinics within primary care practice centres to foster closer cooperation between primary care and specialist mental health services. For example, the United Kingdom *(28)* has initiated a programme to integrate mental health services within primary care, resulting in the establishment of mental health clinics in many GP practices (discussed above in Box 5). These clinics offer a range of mental health services, from counseling to access to psychiatric specialists. Similarly, Germany introduced a funding programme to modernize health-care infrastructure, which included upgrading existing primary care facilities to accommodate separate mental health consultation rooms.

4.3. Financing

Investing in scaling up mental health services within a PHC approach has the potential to yield significant health, social and economic dividends, but requires political choices and a strong commitment from policy-makers.

Shifting mental health care from specialist-based and hospital-based services towards primary and community care can yield many benefits. By shifting resources towards community-based mental health services, including within primary care, mental health challenges can be addressed at their root. This helps to proactively support individuals before their conditions escalate to crisis levels. Community-based services offer personalized, culturally sensitive care that is accessible and inclusive, reaching marginalized populations who may otherwise face barriers to accessing traditional mental health-care settings *(162)*. Moreover, investing in community-based mental health services can yield significant cost savings in the long run by reducing the burden on emergency rooms, hospitals and the criminal justice system *(163)*. Investing in community-based mental health services is a strategic necessity for fostering resilient and thriving communities, empowering them to more actively engage in their health, promoting social inclusion of all community members, and thereby cultivating trust, solidarity and social cohesion.

WHO supports increased and better public spending on PHC as it is the most cost-effective way to enhance people's physical and mental health as well as social well-being and make progress towards universal health coverage *(164)*, recommending that all countries increase their public spending on PHC by an additional 1% of Gross Domestic Product (GDP) *(165)*. Yet, like any other public decision, public funding for mental health services involves political choices by governments or health-care authorities. These decisions are influenced by many factors, including political priorities, economic conditions and the need to balance competing demands on public funds. For instance, despite the difficult fiscal context resulting from the Russian invasion, Ukraine prioritized access to medicines needed for mental health disorders starting in 2021 by expanding their additional medicines programme, recognizing that investing in mental health is crucial for the overall resilience and well-being of the population

(166). Outside of emergenices, advocating for greater investment in mental health requires comprehensive data, compelling evidence of cost-effectiveness and strong public and political will, often driven by advocacy from mental health professionals, NGOs and the broader community.

While some countries have increased public funding for primary care or mental health services, many still struggle with insufficient financial resources to meet the growing demand *(167)*. In such cases, adopting a comprehensive approach to health system financing is essential to identify areas where funding can be improved and savings can be made to free up existing resources. For example, prior to 2018, Kazakhstan grappled with significant regional disparities in the availability of funds for mental health services within primary care, with multifold differences in mental health tariffs across the regions *(102)*. In 2018, the funding model for mental health services was restructured, transitioning from local budgets to a national budget framework and ensuring a more equitable funding distribution across regions. Simultaneously, the payment system for round-the-clock hospital services was amended, adopting a comprehensive tariff-based approach. This shift allowed the country to focus more on cost-effective mental health services, such as preventive care, outpatient services, in-hospital replacement care and rehabilitation services. These deliberate efforts to boost funding for mental health services resulted in a 1.7-fold increase in overall funds for mental health services in Kazakhstan between 2017 and 2022 *(102)*.

Expanding the publicly financed benefits package to include mental health services in primary care can enhance their accessibility but needs to be aligned with redefining the roles for those involved in delivering these services.

In order to promote primary care as the first point of access to routine services for the population, countries often try to protect people from having to pay out of pocket for consultations and diagnosis at this level of care by including services in the public benefits package. Yet, this often excludes mental health services, where care pathways are less standardized and many countries limit access to treatment in primary care settings, particularly prescription medicines, causing significant financial hardship for people with mental health conditions *(168)*.

Examining and adjusting the benefits package for mental health services alone may not sufficiently support mental health service delivery at the primary care level if role definitions do not align with this aim. For instance, family physicians may not be able to prescribe medicines for mental health conditions if it falls outside their defined scope of work. Clearly defined, evidence-based care guidelines can further support the provision of mental health services in primary care. Estonia, for example, has developed primary care-specific guidelines for managing generalized anxiety disorder and panic disorder in family practice, effectively shifting patient management to primary care settings *(169)*.

Ensuring the provision of mental health services in primary care necessitates a carefully tailored mix of payment mechanisms and incentives.

Payment mechanisms and financial incentives play a pivotal role in ensuring the provision of mental health services in primary care. Adequate financial support can motivate primary care providers to actively engage in mental health care, for example by offering higher or additional capitation payments, bonuses or other financial rewards tied to the delivery of mental health services or successful mental health outcomes (Table 1). Financial incentives can also attract mental health specialists and those working in other sectors to collaborate with primary care teams, bridging the gap between specialized and general health-care services and fostering multisectoral partnerships.

In Sweden, health-care regions may offer financial incentives to primary care centres that achieve set targets related to the provision of mental health services, thereby encouraging high-quality and accessible care *(170)*. In Ukraine, health financing reforms have been implemented that support the integration of mental health services into primary care, including funding for mental health training and infrastructure in primary care and creating financial incentives for the provision of mental health services in primary care settings *(171)*. Similarly, in Ukraine, the integration of mental health services into primary care has been supported through financial incentives, including a system of top-up capitation payments for all primary care providers; namely, 4.63 euros per month for each served patient in 2023. Further, primary care doctors and nurses are required to successfully complete the mhGAP training as a prerequisite for becoming eligible to receive funding from the national health insurance system *(166, 172)*. Starting from 2025, Ukraine plans to fully integrate mental health services into the primary care benefit package. Some countries also use lump-sum payments to cover the cost of additional labour to deliver mental health services. For instance, in Estonia, primary care providers can apply for additional lump-sum payments to cover the salary for a mental health nurse or psychologist to work in a primary care team *(173)*.

However, incentives can also work against integration where there are exclusions for mental health, as happened with some of the measures in the Quality and Outcomes Framework for primary care in the United Kingdom *(28)*.

Table 1. A range of mechanisms can be used to pay for mental health services in primary care

Payment type	Examples
Fee-for-service (FFS)	In an FFS model, primary care providers are reimbursed for each specific mental health service they deliver, such as GPs in the United Kingdom *(28)* working in the IAPT programme (see Box 5). This can include mental health assessments, therapy sessions, or medication management. The reimbursement is typically based on a set fee schedule. Mental health specialists, such as psychologists or psychiatrists, can also be paid on an FFS basis when they provide services in a primary care setting. They bill for their time or specific services rendered, and the reimbursement is based on established fee schedules. For example, psychologists in Germany may charge fees for individual therapy sessions, and the cost is covered by statutory health insurance.

Table 1. contd.

Payment type	Examples
Capitation	Under a capitation model, primary care providers receive a fixed payment per patient enrolled in their practice, regardless of the number of services provided, such as in the Netherlands (Kingdom of the). This payment method encourages providers to manage the overall health and well-being of their patients, including their mental health needs. Mental health specialists may also receive capitated payments when working within a primary care practice, for example, in the Netherlands (Kingdom of the). Additional or top-up payments can be defined for practices that offer mental health services.
Salary (or salary with performance-based bonuses)	Some primary care providers, particularly in tax-based public health systems, receive a fixed salary as employees of health-care organizations. They may also receive performance-based bonuses or incentives tied to meeting specific goals. In Estonia, primary care providers can apply for funding to cover the cost of a mental health nurse or psychologist.
Payment per episode of care	In this model, providers are paid a predetermined amount for an episode of care, which can include a series of mental health services. This approach promotes care coordination within the same level of care or between levels of care and can encompass mental health care services received in primary care as well as specialist mental health services provided during a specific period or for a particular condition. For example, in Denmark, an episode-of-care payment model is used for various health-care services, including mental health care, with providers receiving a predefined amount for a specific episode of care. Similarly, bundled payments is a model that combines payments for related services within a treatment plan, which may or may not cover the entire episode of care.
Payment for performance (P4P)	P4P models can link reimbursement to quality metrics, such as adherence to clinical guidelines, thereby promoting the delivery of evidence-based care that enhances patient outcomes.

Appropriate or revised financial protection policies are needed to reduce the risk of financial hardship for primary care users with mental health needs.

A further important financing concern relates to high out-of-pocket *(174)* spending on health care services and products, which may lead to financial hardship and unmet need for households with low incomes. OOP spending on health care remains at a high level in many countries of the Region *(168)*, and ensuring affordable access to mental health care can be particularly challenging. Affordability and access to mental health services and thus effective coverage are underpinned by entitlement rules. To minimize financial hardship or unmet need, entitlement to publicly financed mental health services should not be contingent on contributions, but rather on residence *(168)*, particularly for services provided in primary care and in other community settings.

In addition, evidence shows that covering higher cost specialist care is not enough to secure financial protection, as unmet need and financial hardship are primarily driven by the use of lower cost primary care. Outpatient medicines, an essential part of primary care services, are a key driver of OOP spending, particularly among individuals and households living with chronic diseases, including mental health conditions *(168)*. The accessibility of affordable medicines is of particular importance for certain mental health conditions, especially those requiring long-term treatment. In order to improve affordable access to mental health care at the primary care level, countries should reconsider their policies on user charges, potentially by limiting or capping co-payments, particularly for those affected by chronic and mental health conditions. For instance, the United Kingdom (Northern Ireland, Scotland and Wales) abolished user charges for outpatient prescribed medicines over a decade ago *(168)*. Other countries that apply user charges for outpatient prescribed medicines have protection mechanisms in place. In 2018, Estonia increased protection from user charges applied to outpatient medicines by strengthening an existing protection mechanism and automating it. The reform significantly contributed to reducing OOP payments for outpatient medicines covered by the Estonian Health Insurance Fund *(175)*.

4.4. Governance

Mental health strategies and plans, legislation and regulation are all crucial to enhancing the provision of mental health services in primary care and enhancing the PHC orientation of mental health services.

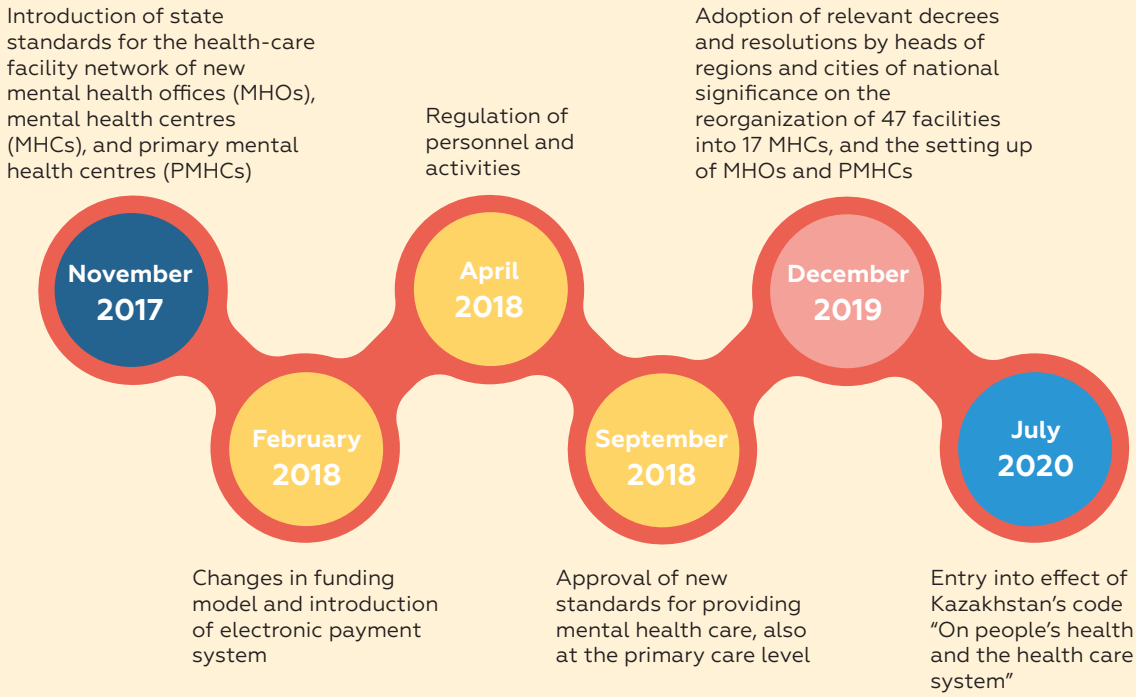
Mental health strategies and plans, legislation and regulation collectively form the bedrock for enhancing the provision of mental health services in primary care and enhancing the PHC orientation of mental health services. Thoughtfully crafted strategies and plans can serve as roadmaps, delineating the objectives and steps needed to integrate mental health into primary care. Such strategies can be developed at subnational (e.g. in devolved or federal countries) or national levels. However, the actual implementation of these strategies may be poor if they are not translated into legal and regulatory frameworks, as has been done in Kazakhstan (Box 15), or if these frameworks lack cohesion.

Across numerous countries, the fragmentation of government structures and policy-making processes presents barriers to achieving policy coherence. For example, policies aimed at elevating mental health services in primary care can be embodied in a diverse array of policy documents that are developed and implemented in different sectors and at various levels of authority. These documents span national mental health action plans, disability laws, policies strengthening primary care, targeted initiatives, such as depression and suicide prevention programmes, as well as various localized policies. The lack of or insufficient coordination among these diverse documents can hinder the effective implementation of policies. Fostering policy coherence requires a concerted effort across the government, ideally underpinned by a robust policy discourse and a shared political vision with concrete goals and targets.

Box 15. A robust governance framework has contributed to the success of mental health reforms in Kazakhstan

Serving as a foundation for reform, the political commitment of the Ministry of Health-care in Kazakhstan made it possible to launch a cascade of legislative amendments towards a paradigm shift in mental health services. Changes were introduced in accordance with roadmaps for developing mental health services, which were updated biennially. The principal approaches to and timeline for amending legislation on mental health are presented in Fig. 6.

Fig. 6. Governance-specified standards, financing, human resources and organization of mental health services



Source: This box was co-authored by country experts; see acknowledgments.

Multistakeholder collaboration and engagement can make policies more responsive to needs and contexts and facilitate effective implementation.

Fostering multistakeholder collaboration and engagement is an important mechanism for ensuring effective governance and policy coherence. This approach allows for the integration of diverse areas of expertise and viewpoints, ensuring that mental health and primary care legislation is not only thorough and comprehensive but also reflective of the priorities and perspectives of various stakeholders. The ability to govern a multistakeholder process is of paramount importance, as responsible officers must navigate multiple policy layers and engage a spectrum of stakeholders, including organizations representing individuals with lived experiences, recognizing their interests and concerns.

Countries such as Finland and Belgium (see Box 10) have set commendable examples by establishing joint authorities and multisectoral task forces that extend beyond the health sector. These task forces include officials from diverse ministries, such as social welfare, justice and home affairs.

Recognizing that recovery for many individuals with mental health conditions requires access to a broader programme of support, these initiatives encompass various activities, including those related to supported housing, work or education. Türkiye is another example of a country that embraced an inclusive approach to governing mental health reforms (Box 16).

Box 16. Türkiye has embraced an inclusive approach to governing mental health reforms

Türkiye has undertaken significant strides to enhance the provision of community-based mental health services (see Box 9). The establishment of a dedicated Mental Health Department under the Ministry of Health has played a pivotal role in catalyzing mental health reforms in the country. This has enabled the formulation and execution of a National Mental Health Action Plan, introduction of measures to combat stigmatization, and monitoring chronic mental disorders within primary care.

Numerous ministries, professional associations and entities actively contribute to designing and implementing mental health reforms, ensuring the engagement of all stakeholders deemed essential for the uptake and sustainability of these transformative initiatives. Key stakeholders include the General Directorate of Primary Health Care, municipalities, Provincial Directorate of the Ministry of Family and Social Services, Ministry of National Education, Turkish Employment Agency (İŞKUR), Psychiatric Association of Türkiye, Turkish Medical Association, Turkish Psychologists Association, psychiatry departments of major universities and various NGOs, among others.

Source: This box was co-authored by country experts; see acknowledgments.

In some instances, countries have formed coordination groups to address specific goals, such as incorporating mental health into humanitarian responses to conflicts, disasters, and disease outbreaks. The COVID-19 pandemic has further underscored the importance of intersectoral approaches to mental health, exemplified by initiatives such as the intersectoral mental health recovery strategy in the United Kingdom *(28)*.

Improving data collection and monitoring in primary care can support the transparency and accountability of decision-making.

While countries, such as Spain, have established robust data collection systems to evaluate the quality and effectiveness of mental health services in primary care, such systems are lacking in many nations, particularly in lower resource settings *(176)*. Even basic information, such as funds available to primary care and mental health, workforce distribution, and service coverage, may be unavailable in some cases. The absence of this crucial data hampers a thorough assessment of unmet mental health needs, rendering decision-making processes less transparent and accountable. Improving data collection and analysis in primary care, including performance metrics, is paramount for guiding decision-making and resource allocation, ensuring that health-care resources are distributed optimally, aligning with the specific needs of the population served.

Reduction of mental health stigma in the population requires a comprehensive approach.

Discriminatory views towards people with mental health conditions are prevalent in the populations of many countries *(91, 177)*. Additionally, stigmatizing attitudes towards individuals with mental health conditions may also be common among primary care workers, acting as a barrier to accessing appropriate support *(45)*. Stigma can affect every aspect of a health professional's practice, including their willingness to pursue additional education and training in mental health care, their ability to detect mental health problems in patients, and their capacity to make effective referrals to specialized mental health-care services.

Reducing mental health stigma requires more than just improving mental health literacy; it must be supported by creating an environment that actively challenges stigma and fosters open, supportive conversations about mental health *(109, 178)*. Such efforts are crucial for fostering understanding and raising awareness of mental health challenges. This holds particular significance for children *(179)* and teachers *(180)*, given that the majority of lifetime mental health conditions emerge before adulthood. Public awareness campaigns, education programmes in schools, workplace and community-based programmes, and other initiatives can play a pivotal role in achieving this goal, ensuring a more supportive community for individuals seeking help. The media can contribute to reducing mental health stigma by adhering to guidelines on responsible reporting *(47)*.

WHO can provide essential support to countries by assisting them in building the necessary capacity to formulate and implement policies.

Developing and adapting policies outlined in this policy paper, while aligning policy levers to facilitate their implementation, is a challenging task that demands substantial policy capacity. Such capacity is insufficient in many countries in the Region. The WHO Mental Health Flagship, the WHO European Centre for Primary Health Care and other WHO programmes and teams can serve as invaluable resources for countries seeking to develop, implement and sustain policies that scale up mental health interventions in primary care. Their expertise and technical support can help countries navigate the complexities of health-care policy, offer evidence-based guidelines and best practices for countries to follow when formulating their policies, facilitate training and capacity-building, and help to review and evaluate the impact of policies over time.

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Conclusions and the way forward

Scaling up of mental health services in primary care has the potential to support the visions of PHC ; 1 on 70 and deinstitutionalization of mental health care, but it is often unrealized.

In conclusion, the integration of mental health services into primary care represents a significant and necessary paradigm shift in the provision of health care services. This aligns with the vision of PHC outlined in the Alma-Ata and Astana Declarations, which position primary care as the first point of contact and a crucial gateway to accessible and comprehensive health services, where the biopsychosocial aspects of well-being are addressed holistically. Furthermore, it is also consistent with the movement to deinstitutionalize and destigmatize the provision of mental health services and bring them closer to the community and familiar settings.

The growing prevalence of mental health conditions will only strengthen the demand for mental health services, including within primary care. However, as highlighted in this paper, various barriers – such as inadequate funding, insufficient training and education, pervasive mental health stigma, and a lack of political prioritization – often limit access to community mental health services. This issue is particularly pronounced (although not limited to) primary care settings, where mental health services are frequently delivered informally and without adequate support.

The four strategies described in this policy paper offer universal yet pragmatic solutions that can be tailored to any setting.

The four strategies described in this policy paper offer universal but also pragmatic solutions for scaling up mental health services in primary care and fostering the PHC approach more broadly within the realm of mental health. These strategies are adaptable to various settings, regardless of their progress in realizing the visions of PHC and mental health service deinstitutionalization. The first strategy emphasizes enhancing the delivery of mental health services within existing primary care teams. The second strategy underscores the potential of integrating trained mental health workers into primary care teams, thereby augmenting primary care's capacity to provide even more comprehensive mental health services. The third strategy advocates for improved coordination between mental health and primary care services, allowing either mental health or primary care workers to take leading roles in managing the patient. The fourth strategy underscores the value of forging collaborations between primary care and other societal sectors – education, social services and community organizations – to strengthen the support network for individuals grappling with mental health conditions. A key consideration underlying all these strategies is the importance of tailoring, or matching, mental health services to the specific characteristics and needs of the individual seeking care.

Political commitment and prioritization are required to implement these strategies and to support the strengthening of both primary care and mental health.

Health expenditure is in large part a political choice reflecting political decisions about how much of the government budget to allocate to health and decisions about the design of public coverage policy and the extent of out-of-pocket spending *(181)*. Shifting a health system's priorities from specialist-based and hospital-based services towards primary care involves political choices and creates numerous political challenges *(182)*. Successfully reorienting a system towards primary care requires political leadership and long-term commitment, as well as proactive, adaptable strategies to engage with stakeholders at all levels that account for social and economic contexts.

Political commitment is insufficient if not backed up by appropriate workforce, infrastructure, financial and governance levers to implement the chosen strategies.

Critical to realizing these strategies is empowering the health workforce through targeted education and training programmes, ensuring that they possess the necessary competencies to fulfill their new or enhanced roles and tasks. It is important that these programmes are designed in a way that also fosters interdisciplinary collaboration and the adoption of person-centred care practices.

To effectively apply these competencies, the health workforce requires conducive conditions, including adequate time, space, infrastructure and equipment. Additionally, they need to be appropriately incentivized and rewarded through a host of financial levers. Finally, legislative, regulatory and other governance measures are essential to enable the effective reorientation of service provision toward the new models. In tandem, there is a need for robust data collection and research to both monitor progress and to better understand the effectiveness of the implemented measures.

A thorough assessment of mental health needs and the current provision of mental health services can empower countries to ascertain the optimal role of primary care in mental health.

Moving forward, countries within the Region are called upon to reinvigorate their commitment to prioritizing mental health services. This involves critically assessing the mental health needs of their populations and identifying any gaps in service provision. It also requires an evaluation of mental health provisions across all settings, including within primary care. Primary care is an important setting for delivering mental health services, but it is only one part of the wider ecosystem of community-based mental health care. Adopting this holistic perspective on the demand and supply of mental health services can enable countries to design an optimal model of service delivery and an appropriate role of primary care within it.

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