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REGIONAL OFFICE FOR Europe



INTEGRATING THE PREVENTION,
TREATMENT AND CARE OF
**MENTAL HEALTH CONDITIONS
AND OTHER NONCOMMUNICABLE
DISEASES WITHIN HEALTH SYSTEMS**

WHO EUROPEAN HIGH-LEVEL CONFERENCE
ON NONCOMMUNICABLE DISEASES

Time to Deliver: meeting NCD targets to achieve
Sustainable Development Goals in Europe
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→ ABSTRACT

Mental health conditions affect one in 10 people at any one time and account for a large proportion of non-fatal disease burden. There is a high degree of comorbidity between mental health conditions such as depression and other noncommunicable diseases (NCDs), including cardiovascular disease, diabetes and alcohol-use disorders. Mental disorders share common features with other NCDs, including many underlying causes and overarching consequences, their high interdependency and tendency to co-occur, and their predilection to being best managed using integrated approaches. Pathways to more integrated planning and programming include: population-wide policy measures that seek to enhance awareness about, and reduce demand for, risk factors for NCDs and mental health conditions (via legislation, regulation and information); community-based programmes carried out in schools, workplaces and communities to promote mental and physical well-being; and health-care services providing more person-centred, coordinated care to people with (often comorbid) mental and physical health conditions. The successful promotion, uptake and implementation of these actions or interventions depends on several factors, including effective advocacy, strong leadership, reconfigured financing measures and enhanced monitoring and evaluation of needs and impacts.

→ KEYWORDS

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→ CONTENTS

Acknowledgements **ii**

Summary **iii**

Context **iii**

Mental health and the global NCD agenda **iii**

Links between mental health, NCDs and their risk factors **iii**

Mental health within the NCD agenda: pathways to integration **iii**

Context **1**

Mental health and the global NCD agenda **2**

Links between mental health, NCDs and their risk factors **3**

Mental health within the NCD agenda: pathways to integration **5**

References **8**

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This document was prepared by Dan Chisholm, Programme Manager for Mental Health, Division of Noncommunicable Diseases and Promoting Health through the Life-course, WHO Regional Office for Europe.

A draft version was shared and commented on by Devora Kestel (WHO headquarters), Graham Thornicroft (King's College London, United Kingdom), Nino Makhashvili (GIP-Tbilisi, Georgia) and Alan Cohen (United Kingdom).



→ SUMMARY

Context

- A fundamental element of any individual's health and well-being, including their capacity to live a fulfilling life, is to enjoy good mental health. However, mental well-being is not assured and is put at risk by exposure to a range of determinants, including deprivation, unemployment and conflict.
- Mental health conditions affect one in 10 people at any one time and account for a large proportion of non-fatal disease burden owing to their frequency, chronicity and disabling effects.
- Mental disorders are treatable, many at primary care level through training of nonspecialized health workers, yet the treatment gap remains enormous due to low service availability, low detection levels and low prioritization (due in part to negative attitudes about mental illness).
- There is a high degree of comorbidity between mental health conditions such as depression and other noncommunicable diseases (NCDs), including cardiovascular disease (CVD), diabetes and alcohol use disorders.

Mental health and the global NCD agenda

- The inclusion of mental health in the United Nations Sustainable Development Goals (SDGs) and mental health conditions as the so-called fifth NCD at the third high-level meeting of the United Nations General Assembly provides new opportunities for a more holistic, collaborative and person-centred response to NCD prevention, treatment and care.

Links between mental health, NCDs and their risk factors

- Mental disorders share common features with other NCDs, such as heart disease, stroke and diabetes: they share many underlying causes and overarching consequences, are highly interdependent and tend to co-occur, and are best managed using integrated approaches.
- Mental health conditions affect, and are in turn affected by, major NCDs: they can be a precursor to, or a consequence of, chronic conditions such as CVD, diabetes or cancer. Risk factors for these NCDs, such as sedentary behaviour and harmful use of alcohol, are also risk factors for mental health conditions and strongly link the two.

Mental health within the NCD agenda: pathways to integration

- Pathways to more integrated planning and programming include: population-wide policy measures that seek to enhance awareness about, and reduce demand for, risk factors for NCDs and mental health conditions (via legislation, regulation and information); community-based programmes carried out in schools, workplaces and communities to promote mental and physical well-being; and health-care services capable of providing more person-centred, coordinated care to people with (often comorbid) mental and physical health conditions.
- The successful promotion, uptake and implementation of these actions or interventions depends on several factors, including effective advocacy, strong leadership, reconfigured financing measures and enhanced monitoring and evaluation of needs and impacts.





→ CONTEXT

Mental health is an integral part of an individual's capacity to lead a fulfilling life, including the ability to form and maintain relationships, study, work or pursue leisure interests, and make day-to-day decisions about education, employment, housing or other choices. Good mental health is not assured, however, and is put at risk by a range of factors that include biological characteristics, social or economic circumstances and the broader environment in which individuals find themselves. Exposure to these risk factors or stressors can lead to a range of mental health problems. Increased exposure to these adverse determinants of mental health, as well as the ageing of populations in many parts of the world, has resulted in a 30% rise in the global prevalence of mental disorders since 1990 (1).

Psychosis, depression, dementia, alcohol dependence and other mental, neurological and substance use (MNS) disorders constitute a subgroup of noncommunicable diseases (NCDs) that together impose a heavy burden of disease in all regions of the world. According to latest Global Health Estimates for the WHO European Region in 2016, MNS disorders accounted for 29% of non-fatal disease burden (years lived with disability) and 14.5% of total disease burden (disability-adjusted life years) (2). Even these alarming statistics do not fully capture the fatal toll of these disorders, since they are the predominant cause behind the 141 000 deaths attributed to self-harm in the European Region in 2016. It also needs to be emphasized that people with severe mental disorders have a two-to-three times higher average mortality compared to the general population, which translates to a reduction in life expectancy of 10–20 years; these premature deaths are most commonly due to unrecognized and untreated physical health conditions (3).

A further concern for global public health and development is that mental health problems during childhood and adolescence are on the rise, emerging as prominent causes of morbidity and mortality. A total of 17 million young people aged 10–19 years in the WHO European Region are estimated to have an MNS disorder, equivalent to nearly one in five of the population in this age group. Depression and anxiety disorders are among the top five causes of disease burden, and suicide is the leading cause of death among 10–19-year-olds in low- and middle-income countries and the second leading cause in high-income countries of the WHO European Region (4).

The intrinsic value of good mental health, the wide-ranging consequences of MNS disorders, and the multisectoral nature of a comprehensive approach to its formation, preservation and restoration are among the key reasons for the inclusion of mental health and well-being in the United Nations Sustainable Development Goals (SDG) agenda. The main SDG targets associated with MNS disorders are shown in Box 1; a detailed exposition of the links between mental health and the SDGs is laid out in a recent Lancet Commission paper (5).

Box 1. Mental health, NCDs and the SDGs

Target 3.4. By 2030, reduce by one third premature mortality from non-communicable diseases through prevention and treatment and promote mental health and well-being.

Target 3.5. Strengthen the prevention and treatment of substance abuse, including narcotic drug abuse and harmful use of alcohol.

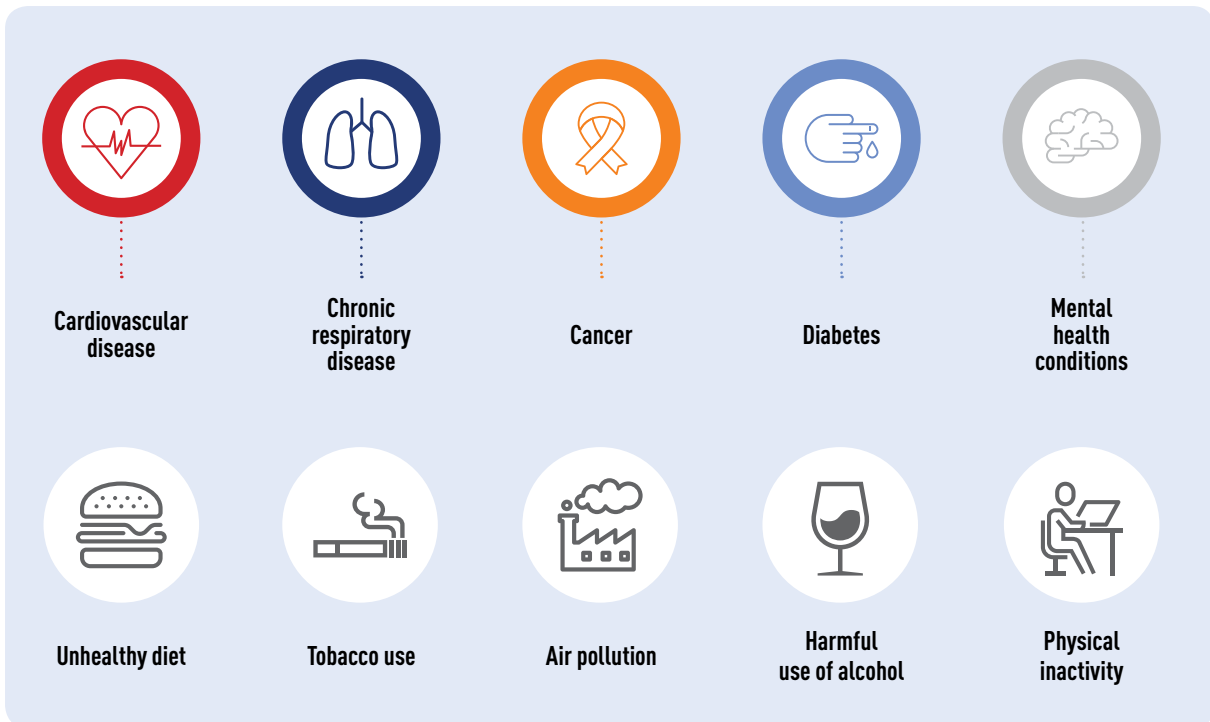
Target 3.8. Achieve universal health coverage, including financial risk protection, access to quality essential health-care services and access to safe, effective, quality and affordable essential medicines and vaccines for all.

A major implication of SDG target 3.4 for mental health policy and practice is the renewed emphasis on implementing a strong public health approach that addresses the known determinants of mental health and the needs of those already affected by mental disorders and psychosocial disabilities.

→ MENTAL HEALTH AND THE GLOBAL NCD AGENDA

The political declaration arising from the third high-level meeting of the United Nations General Assembly on the prevention and control of noncommunicable diseases, held in September 2018, provides the most recent, explicit and prominent articulation of national governments' desire and commitment to formally link and include mental health within the NCD agenda (7). MNS disorders are NCDs by definition but had not been prioritized for particular attention in earlier political declarations, such as that arising from the high-level meeting on NCDs in 2011. By moving from "4 by 4" to "5 by 5", Member States have now not only established greater parity between mental health conditions and other NCDs, but have also provided new opportunities for a more holistic, collaborative and person-centred response to NCD prevention and management (Fig. 1).

Fig. 1. Moving from "4 by 4" to "5 by 5" NCDs and risk factors



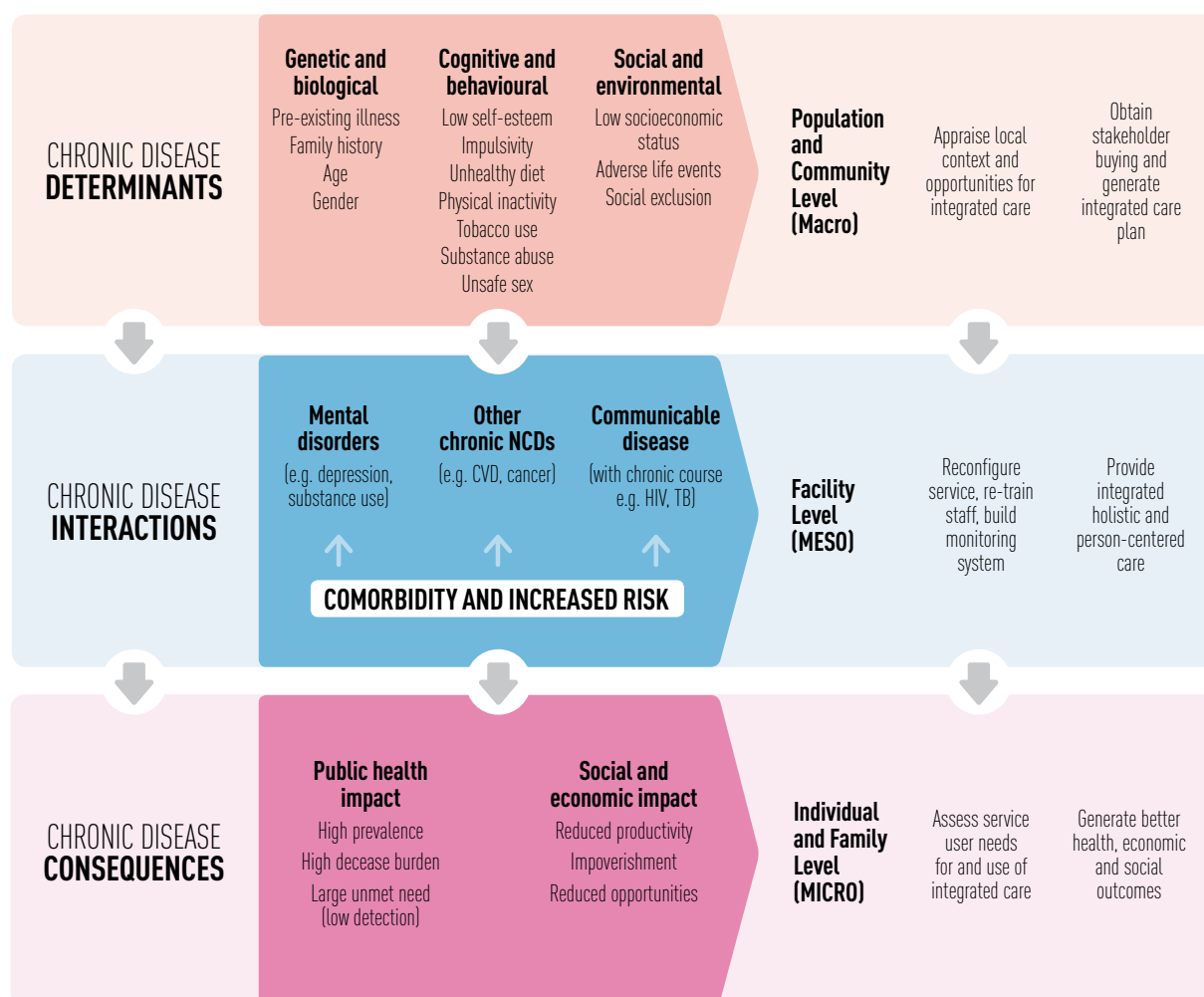
A similar strategic shift in thinking is recommended in the report of the WHO independent high-level commission on NCDs, published in 2018 (7). Mental health has also been explicitly included in earlier policy guidance documents governing the response to NCDs, such as the *Action plan for the prevention and control of noncommunicable diseases in the WHO European Region 2015–2025*, which includes a goal to promote mental health to reduce the onset or exacerbation of NCDs (8). The first Global Ministerial Mental Health Summit was held in 2018, the declaration from which included a conclusion that "mental health cannot be separated from physical health; treating the two as linked and equal is critical for progress towards Universal Health Coverage" (9). The Lancet's Commission on Global Mental Health and Sustainable Development was launched during the summit, with calls for a reframing and broadening of the mental health agenda to include the scaled-up application of collaborative care models for integrated chronic disease management of mental disorders and other NCDs.

→ LINKS BETWEEN MENTAL HEALTH, NCDs AND THEIR RISK FACTORS

What is the thinking behind these new political declarations and commitments? Why should mental health be included in what is already a substantial agenda of disease prevention and management? From the public health perspective, a key reason is that mental disorders, NCDs and other chronic conditions (such as HIV and tuberculosis) share common features (Fig. 2):

- they are chronic, in that they persist over time and require ongoing monitoring and management, frequently over the life-course;
- they share common determinants, in that they arise from a combination of biological, behavioural and environmental factors;
- substantial commonalities exist in their consequences, with all leading to significant levels of disability, which in turn diminish socioeconomic opportunities; and
- mental disorders and other chronic diseases often co-occur.

Fig. 2. Shared determinants, interactions and consequences of chronic conditions



Source: WHO and the Calouste Gulbenkian Foundation (10).

Mental health conditions affect, and are in turn affected by, major NCDs (Table 1). They can be a precursor to, or a consequence of, chronic conditions such as cardiovascular disease (CVD), diabetes or cancer (11). Risk factors for these major NCDs, such as sedentary behaviour and harmful use of alcohol, are also risk factors for mental disorders and strongly link the two.

Table 1. Comorbidity between mental disorders and major NCDs

	Common mental disorders	Severe mental disorders
Mental disorders and diabetes	The relation between diabetes and depression is bidirectional: people with diabetes are more likely to develop depression, and depression is a risk factor for diabetes. It is therefore important that health-care staff who provide diabetic care should be able to identify people who are depressed and know how to manage depression or to refer patients to appropriately trained health-care professionals.	Diabetes is more common among people with severe mental disorders. Health-care staff who provide care to people with severe mental disorders should therefore understand the clinical features of diabetes and be able to identify potential life-threatening episodes. Models of integrated care for people with severe mental disorders and diabetes need to be further developed and evaluated.
Mental disorders and CVD	Depression and anxiety predict the development of CVD and worsen its prognosis. There is no evidence, however, that screening for or treating depression and anxiety improves cardiovascular outcomes: for example, screening for and treating depression will not prevent a heart attack. The combination of several NCDs, such as diabetes, hypertension and depression, points to the vital need for a more integrated approach to health service planning, delivery and liaison between specialists in mental and physical health.	The most common cause of death among people with severe mental disorders is CVD. Identifying and managing modifiable risk factors for CVD (such as alcohol and tobacco use) in people with a severe mental disorder will reduce their risk for premature mortality. Discrimination against people with severe mental disorder prevents them from accessing services and increases their risk for premature death and disability from CVD. Addressing discrimination will help to improve access to care for the physical health needs of people with severe mental disorders.
Mental disorders and chronic respiratory diseases	Anxiety and depression are more common among people with respiratory diseases such as chronic obstructive pulmonary disease (COPD) and asthma, partly because these diseases occur in unpredictable, life-threatening episodes. The relationship between common mental disorders and chronic respiratory conditions is bidirectional, complex and poorly understood. Pulmonary rehabilitation, consisting of physical training, occupational therapy, and smoking-cessation and psychosocial advice, provides one approach for people with chronic respiratory disorders.	Smoking is much more common among people with severe mental disorder than the general population. Smoking is a major cause of COPD and exacerbates asthma. As COPD and asthma are more common among people with severe mental disorder, smoking is a significant factor in their increased rates of mortality and morbidity. The promotion and availability of appropriately tailored tobacco-cessation programmes to people with a mental disorder will reduce the rate of smoking-related disease and related health outcomes.
Mental disorders and cancer	A substantial proportion of people with cancer have a common mental disorder such as anxiety or depression. Evidence-based approaches are available to identify people receiving palliative care who will benefit from treatment for depression and anxiety.	Cancer among people with psychosis is driven by lifestyle choices (such as smoking). People with a severe mental disorder are less likely to access health-care services; if they have cancer, they are likely to present at a later stage and have a poorer survival rate.

→ MENTAL HEALTH WITHIN THE NCD AGENDA: PATHWAYS TO INTEGRATION

Opportunities for conjoined action arise from recognizing and acting upon the commonalities that exist between mental health conditions and NCDs, not only in terms of their shared determinants and public health characteristics, but also in terms of common strategies for their promotion, prevention and management (12). For example, since most chronic diseases place similar demands on health workers and health systems, an integrated approach to organizing care and managing these conditions can reduce fragmentation and improve efficiency. Integrated, coordinated care can enhance access to services that are provided in a way that is configured around people's needs, respects their preferences, and is safe, effective, timely, affordable and of acceptable quality.

Pathways to more integrated planning, programming and evaluation range from overall governance mechanisms to shared service delivery modalities that better target an individual's overall (and often complex or multiple) needs for care. Collaborative care, for example, is an evidence-based approach that has been used successfully for the management of common mental disorders such as depression, and for people with multimorbidities, to improve their management in primary care settings. Like disease management models, collaborative care involves a case manager but with enhanced responsibilities for integration of care across comorbid conditions; it also involves regular caseload reviews and consultation with a specialist regarding patients who do not show clinical improvement, plus close involvement of patients in joint decision-making regarding their care. Beyond enhanced care arrangements, there are multiple opportunities for better linking of otherwise vertical health promotion and prevention efforts such as health awareness or literacy programmes in schools or the workplace.

Accordingly, potential actions or interventions can be identified and implemented across three distinct delivery platforms (13):

- 1. population-wide policy measures** that seek to enhance awareness about, and reduce demand for, risk factors for NCDs and mental health conditions (via legislation, regulation and information);
- 2. community-based programmes** carried out in schools, workplaces and communities to promote mental and physical well-being in targeted subpopulations (such as adolescents); and
- 3. health-care services** that are capable of providing more person-centred, coordinated care to people with (often comorbid) mental and physical health conditions.

Illustrative examples of such potential actions across these different delivery platforms are shown in Table 2.



Table 2. Pathways to integration across delivery platforms

Platform	Function	Delivery channels	Pathways to integration (examples)
Population-wide	Universal prevention and health promotion	Legislation/ regulation	Policy measures addressing NCD risk factors (such as alcohol and tobacco demand reduction)
		Information/ awareness	Health literacy/awareness campaigns (such as physical activity for reducing depression)
		Intersectoral collaboration	Mapping/attribution of shared risk factors (such as deprivation, exclusion, education)
Community	Selective prevention and health promotion	Workplace	Wellness at work programmes (such as well-being, stress, NCD risk factors)
		School	Health promotion and early identification (such as physical activity, life skills, substance use)
		Community	Self-help and support groups (such as alcohol use, self-harm, overweight)
Health care	Targeted prevention, care and treatment	Self-care	Self-management of NCD risk factors (for reduced depression and dementia risk, for instance)
		Primary care	Linked training in use of treatment guidelines (in areas such as WHO mhGAP and PEN packages)
		Hospital care	Management of physical health conditions (such as adults with severe mental disorders)

The successful promotion, uptake and implementation of these actions or interventions depends on several factors, including effective advocacy, strong leadership, reconfigured financing arrangements and enhanced monitoring and evaluation of needs and impacts. Further details of the intended benefits and means of delivering integrated mental health care, this time through a health system strengthening lens, are shown in Table 3 (14).



Table 3. Intended benefits of delivering integrated mental health care

Domain	Intended benefit	Means of delivery
Governance	<ul style="list-style-type: none"> • Improve decision-making by policy-makers and planners • Improve accountability of senior and middle managers 	<ul style="list-style-type: none"> • Provide feasible methods to assess health policy objectives related to coordination, implementation, capability of managerial staff, and extent of cross-ministerial working
Financing	<ul style="list-style-type: none"> • Dedicated resources for mental health services • Better integrated funding • Enhanced financial protection for people with mental health conditions 	<ul style="list-style-type: none"> • Better coordinate funding, with recognition of comorbidity implications for, for example, tuberculosis and HIV/AIDS treatment • Increase provision of social insurance • Include mental health treatment in universal health care
Human resources	<ul style="list-style-type: none"> • More staff trained to identify and offer first-line treatment • Reduced mental health treatment gap • Training in line with best evidence • Increase effective coverage 	<ul style="list-style-type: none"> • Train generic primary care and community services staff in evidence-based treatment (such as the WHO mhGAP Intervention Guide) • Train senior staff to provide ongoing supervision and support • Provide change management support to middle managers
Service delivery	<ul style="list-style-type: none"> • Better quality continuing care for people with mental health conditions • Better informed patients and family members • More active participation of patients and family members in treatment decisions 	<ul style="list-style-type: none"> • Create primary care teams dedicated to continuing care for people with chronic conditions with case manager roles • Ensure an organized approach to offering information to patients and families about mental health conditions • Introduce self-management methods • Use continuous quality improvement
Stigma and discrimination	<ul style="list-style-type: none"> • Recognition by primary/community care staff that mental health treatment and care is part of core business • Increased staff willingness to receive and put into use mental health training 	<ul style="list-style-type: none"> • Adapt interpersonal contact methods to reduce stigma among health-care providers • Provide supervision and support related to individual clinical cases to improve staff familiarity and confidence for mental health tasks
Information systems	<ul style="list-style-type: none"> • Staff better supported with relevant information at point of contact with patients • Allow service monitoring and quality improvement 	<ul style="list-style-type: none"> • Make essential clinical information available to health-care providers at point of contact • Make these data available to health service managers and planners to allow appraisal of system performance

Finally, since the promotion and protection of physical and mental health requires a multisectoral response, a whole-of-government approach is very much required. Articulation and implementation of a strategic vision for integration of mental and physical health care and prevention needs to include links to, and engagement with, a range of constituencies in and beyond government, and in and beyond the health sector, including social care, education and the environment.

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World Health Organization Regional Office for Europe

UN City, Marmorvej 51,
DK-2100, Copenhagen Ø, Denmark
Tel.: +45 45 33 70 00
Fax: +45 45 33 70 01
Email: eurocontact@who.int
Web site: www.euro.who.int