Quick Mental Health Screens and Triaged Public Health Approach: Lessons From Mozambique

Ken Duckworth, M.D.

The article in this issue by Lovero et al. (1) represents a creative and paradigm-shifting way to think about identification and triage of a large swath of mental disorders. In Mozambique health care offices, the authors used three questions to test the ability to accurately assess people who may have mental disorders; respondents with a positive response were asked another nine questions. The authors' Mental Wellness tool looks at multiple psychiatric diagnoses and is not limited to one diagnosis, such as depression. The broad screening offers a way to triage the more severely affected population to receive scarce mental health resources. If replicated, this screen has applicability for low- to middle-income countries and gives higher-income countries something to actively assess. The increasing prevalence of mental health conditions in the ongoing COVID-19 pandemic make this article even more relevant.

This goal of easy and early identification of mental disorders is an urgent public health need across the globe. Given the global burden of mental disorders and workforce shortage in the mental health field, this is a topic well worth studying. Assessing creative approaches such as this identification-and-triage framework is important for the field. Primary care offices already burdened with many demands need an elegant way to identify mental health conditions.

The intent in Mozambique to triage more severely ill individuals to scarce mental health resources and offer community support for the less severely ill population is an elegant example of public health in mental health. The need to better understand the best ways of using nonprofessional resources is also highlighted.

Mozambique is a country I have never visited, and I do not speak Portuguese. I do not know the local culture, the populace's mental health literacy, or social attitudes toward help seeking. The authors acknowledge that they did not have a baseline for prevalence of mental disorders in Mozambique, so their prevalence numbers are understandably hard to assess. This is a problem that can be solved in other nations. With these important caveats, the initial lessons in the article may be worth assessing in other well-developed countries replete with mental illness underidentification and disparities in access to care, such as in the United States.

We need to be smarter about how we deploy resources in this country if we hope to stem the tide of underidentification, undertreatment, and misaligned resources. The collaborative care model, in which a psychiatrist or psychiatric nurse helps primary care physicians increase their mental health impact and a case manager makes sure no one in the group "falls through the cracks," is one well-studied public health model. It has been shown to be clinically effective and cost-effective in randomized controlled trials (2). But collaborative care is not common practice. Reducing primary care provider burden of screening for mental disorders is a much-needed outcome, and this article offers hope that this might be achievable.

The U.S. mental health field is very far from a public health model. About half of all psychiatrists take no insurance, and most counties have no psychiatrists. When the field was able to grow the child psychiatry workforce, we did not solve for public health goals. A review published in *Pediatrics* in 2016 noted, "We find evidence that the supply of child psychiatrists in the United States has improved over the past 10 years but that a shortage is still profound in large segments of the country" (3). The criminalization of people with mental health conditions is another shameful example of the failure to attend to a public health framework for people living with mental disorders.

In U.S. systems, we do not triage resource access only by severity. Rather, people get care through some combination of resources (private pay and insurance payment status), zip code, the luck of proximity or lack of proximity to better models (e.g., jail diversion or early psychosis programs), and many other variables. Disparities are common in our field. Telehealth has recently helped to reduce some of these disparities—a silver lining to the pandemic. Lawsuits are slowly bringing private payers to more equitable payment. This may offer incremental relief but is also not a public health approach. The disparities in payment between mental health and general medical providers are in fact worsening, and that affects access to care (4). The misalignment of triaging scarce resources is not only an outpatient phenomenon. The problems of who gets help on the outpatient side affect who is waiting in emergency departments for a psychiatric bed.

Not the least impaired but rather the most impaired are waiting for days or even weeks.

The increase in peer specialists is another opportunity to move the supply side forward. Peer family (5) and peer (6) resources can make a difference for people but are not a substitute for licensed care. Peer specialists are essential resources in a field with a shortage of licensed mental health professionals. Using the National Alliance on Mental Illness (NAMI) and other peer resources will help supplement the near static supply of licensed clinicians amid exploding demand. I run into families and peers who tell me, "If only I had known about NAMI a decade ago." It is our responsibility as professionals to share these free resources to people who cannot access the help they need. In addition to extending professional resources, both peer training and education empower and create meaning for many people who live with mental conditions. Giving to others is a key element of recovery for many.

Lovero et al.'s article should provoke reassessment of how we identify mental conditions and deploy our mental health resources here in the United States. Finding a short and elegant screening tool would be one key piece of a larger public health puzzle. Lovero et al.'s study needs replication in other settings and languages; it represents a potential sea change in identification and triage in a field that needs major improvement in both areas. Those of us in Manhattan, Montana, and Massachusetts could learn a lot from this creative work in Mozambique.

AUTHOR AND ARTICLE INFORMATION

National Alliance on Mental Illness, Arlington, Virginia; Department of Psychiatry, Massachusetts Mental Health Center of Beth Israel Deaconess, Division of Harvard Medical School, Boston. Send correspondence to Dr. Duckworth (ken@nami.org).

The author reports no financial relationships with commercial interests.

Received May 24, 2021; accepted May 27, 2021.

Psychiatric Services 2021; 72:961–962; doi: 10.1176/appi.ps.202100308

REFERENCES

1. Lovero KL, Basaraba C, Khan S, et al: Brief screening tool for stepped-care management of mental and substance use disorders. Psychiatr Serv 2021; 72:891–897
2. Katon W, Russo J, Lin EH, et al: Cost-effectiveness of a multicondition collaborative care intervention: a randomized controlled trial. Arch Gen Psychiatry 2012; 69:506–514
3. McBain R, Kofner A, Stein B, et al: Growth and distribution of child psychiatrists in the United States: 2007–2016. Pediatrics 2019; 144: 1576
4. Melek S, Davenport S, Gray TJ: Addiction and Mental Health Versus Physical Health: Widening Disparities in Network Use and Provider Reimbursement. Milliman Research Report, Nov 19, 2019. https://hcpf.colorado.gov/sites/hcpf/files/ACC%20Phase%20II%20PIAC%20Milliman%20Research%20Report%20February%202020.pdf
5. Dixon LB, Lucksted A, Medoff DR, et al: Outcomes of a randomized study of a peer-taught Family-to-Family Education Program for mental illness. Psychiatr Serv 2011; 62:591–597
6. Chinman M, George P, Dougherty RH, et al: Peer support services for individuals with serious mental illnesses: assessing the evidence. Psychiatr Serv 2014; 65:429–441