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Discharging Mental Health Patients in Aceh: A Preliminary Study

Marty Mawarpury, Arum Sulistyani, and Karjuniwati
Department of Psychology Faculty of Medicine
Universitas Syiah Kuala

Hasmila Sari and Rachmalia
Department of Nursery Faculty of Medicine
Universitas Syiah Kuala

Yulia Direzkia and Subhan Rio Pamungkas
Psychiatric Hospital Aceh

A high prevalence of mental health patients in Aceh has caused the number of referrals in mental health institutions to rise. An appropriate discharge planning could ensure that patients will be able to continue to treat themselves after they leave the mental health institutions. The objective of this study was to describe the existing discharge planning process of mental health patients in Aceh. Research data was obtained by interviews, observations, and focus group discussions with schizophrenic patients' family members, important figures in the society and in their faith communities, and various officials at Puskesmas (community health centers), RSUD (local hospitals), and RSJ (mental health institutions). Research results show that the process of discharge did not proceed systematically and optimally. Moreover, there is no optimal coordination between mental health institutions and the surrounding communities, resulting in gaps of health services in Aceh. A better and more systematic discharge system are discussed to get the best results.

Keywords: discharge, mental health patients, Aceh

Tingginya jumlah pasien gangguan jiwa menyebabkan rujukan pasien ke RSJ di Aceh meningkat. Suatu perencanaan pelepasan pasien (*discharge planning*) yang baik dapat menjamin pasien mampu melakukan tindakan perawatan diri sendiri/lanjutan setelah meninggalkan rumah sakit jiwa. Studi ini bertujuan untuk mendapatkan gambaran pelaksanaan pelepasan pasien gangguan jiwa di Aceh selama ini. Data diperoleh dengan metode wawancara, observasi dan FGD pada keluarga pasien skizofrenia, tokoh agama dan masyarakat, petugas kesehatan di Puskesmas, RSUD, dan RSJ. Hasil menunjukkan bahwa pelaksanaan pelepasan pasien tidak berjalan secara sistematis dan optimal. Selain itu koordinasi antara pelayanan kesehatan di RS dan komunitas juga tidak optimal, sehingga menimbulkan kesenjangan pelayanan kesehatan di Aceh. Didiskusikan perlunya pelaksanaan sistem pelepasan pasien yang sistematis dan optimal demi tercapainya hasil yang terbaik.

Kata kunci: pelepasan, pasien gangguan jiwa, Aceh

Aceh is one of the provinces in Indonesia that was hit hard by the tsunami and owns the longest history of conflicts, even compared to all countries in South-East Asia. The aftermath of all those conflicts and natural disasters left a high prevalence of mental health patients that are still rising in numbers to this day and various mental health problems including stress, anxiety, fear, and even severe mental health problems such as Schizophrenia. Basic Health Research of 2007 (Badan Penelitian dan Pengembangan Kesehatan Departemen Kesehatan, Republik Indonesia/ Balitbangkes Depkes RI, 2008) found that 18.5% of Aceh residents suffer from severe mental problems, while 14.1% suffer from mental emotional problems.

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Correspondence concerning this article should be addressed to Marty Mawarpury, Department of Psychology, Faculty of Medicine, Universitas Syiah Kuala, Jl. Tgk. Tanoh Abee , Darussalam Banda-Aceh. E-mail: marty.psi@gmail.com

Those numbers are well above the national average of 4.6% and 11.6%, respectively. The disparity between the Aceh and national numbers underlines how mental illnesses are a serious problem in Aceh that deserves special attention. The prolonged conflicts and various natural disasters such as earthquakes and tsunami contribute heavily to this condition.

The increasing number of mental health problems in Aceh has made the local mental health hospital (RSJ) overcrowded with patients referred to them. Ideally Aceh's mental health hospital (RSJ Aceh) accommodates only 300 patients, but the number right now stays at 600 patients each day. This condition has forced the patients to be squeezed into each room of the hospital. According to one of the psychiatrists at the RSJ, the overcrowded capacity of the hospital was not only caused by new patient referrals, but also by relapsed mental patients that need to be sent back to the hospital. Moreover, the success of the Indonesian government's program since 2010 in transferring mental health patients that formerly were kept and shackled at resident's houses under inhumane condition (pasung) to mental health institutions has also been judged as another factor contributing to the overcrowded mental hospitals (Workshop Inter-university partnership program, 2012).

The current discharge process at the mental hospital follows the procedure suggested by BLUD at Aceh's RSJ, but it has failed in slowing down the rising numbers of mental health patients every day. The treatment stages of mental health in-patients are shown in Figure 1.

Anticipating the problem of rising number of patients at mental hospitals, one important factor that may potentially bring down the number is discharge planning. Discharge planning is a process where patients start to receive health services that are given in continuous treatment, both in the healing process and in maintaining the mental health level until the patients feel ready to return to their communities (Shepperd et al., 2013). Shepperd also added that the goals of discharge planning are to reduce the length of stay at the hospital, to decrease the number of patients who need to be sent back to the hospital, and to improve the coordination of different services after patients are discharged from the hospital.

According to Baron et al. (2008), the benefits of discharge planning are: (1) patients get connected to the right resources that they need, (2) patients' propensity to relapse after a successful treatment is minimized, (3) it prevents patients from becoming homeless people or even criminals, and (4) it helps prepare patients to return to their communities. Furthermore, other benefits of a well-planned discharge planning process are an increase in the number of patients discharged from the hospital and a lower number of rapid relapse among patients (Backus, Weinkove, Lucas & Jespersen, 2008).

Various different formats of discharge planning have been designed over the years in Indonesia. However, in reality discharging patients is done only by documenting patients resume, which means that discharged patients are simply given some information as they leave the hospital (information such as the list medical and non-medical interventions that were given to the patients at the hospital, schedule of visits, the amount of nutrition that patients have to keep consuming at home). This format of discharge planning consists of simply giving patients and their families information for them to know and to remind themselves, but there is no certainty that the patients and their families are aware of all the risk factors that may trigger a relapse and what to do in case of an emergency (Pemila, 2009). A successful discharge planning process guarantees that patients are capable of realistically and safely administering follow up

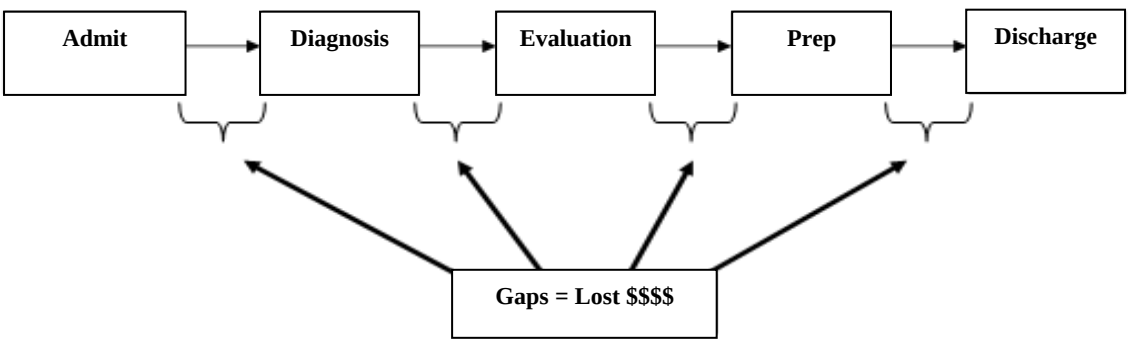

Figure 1. Treatment stages of in-patients (Birjanda & Bragg, 2009).

treatment after they are discharged from the hospitals. In contrast, discharge planning that is not done properly may potentially become one of the factors that slow down the recovery process at home.

According to Baron et al. (2008), discharge planning needs to involve multiple parties, including patients, their families, psychiatrists, psychologists, social workers, case managers, vocational specialists, and the communities where patients live. Thomas and Bond showed in their 1996 study that there needs to be a coordinated approach in discharge planning to ensure that relevant and appropriate information is given to everybody (Cleary, Horsfall & Hunt, 2003). Discharging mental health patients into their communities is an important stage in therapy, therefore their needs should be anticipated and pre-planned as early as possible. Discharging is part of a continuous process of therapy, starting from preadmission until aftercare (Fischer in Durgahee, 1996). Discharge management is a multi-agency issue. Community mental health service will not succeed without inter-agency collaboration. This collaboration is needed in developing social and health service system in order to optimize the function of professionals in the area (Durgahee, 1996).

Since 2005 the province of Aceh has been employing a mental health system that attempts to integrate hospital-based services with community-based services. WHO (in WHO and WONCA, 2008) developed a model of primary service organization that consists of multiple levels of services, starting from self service, informal service in the community, mental health primary service, community-based health service, psychiatric service at the hospital, long-term facilitation and special psychiatric service. Patient treatment after being released from the hospital is obviously related to all those levels. All those components, starting from patient self-care and help from family members, puskesmas junior staff (?), independent doctors, general hospitals and mental health hospitals, are important in achieving the ultimate goal of patient's mental health. Therefore patients' discharge process should be integrated among all those components. Without integration each level will operate on its own, resulting in a disjointed patient care.

Currently each level operates on its own with little integration, resulting in treatment gaps, which are one of the main causes of relapses in patients. A similar problem is taking place in the execution of discharge planning on the mental health patients. Ideally discharged patients and their families at home ought to know where they should go if they need help, for example GP+ (General Practitioner plus) at the local community health center (Puskesmas), CMHN (Community Mental Health Nurse) at Puskesmas, and junior staff. In addition, patients need to be adequately informed about their mental problem, how to treat the problem at home and some effective coping strategies. Obviously the hospital is incapable of supervising patients' progress at home, therefore an excellent coordination with the local CMHN is necessary to monitor them. In reality, however, this coordination is often not working well.

On the community level, families of the patients complain about the hospital services for them, including the absence of instructions for the families before the patients are sent home. However, one of the psychologists at Aceh mental hospital reported in an interview that head nurses of some of the rooms at the hospital, as well as some doctors and psychologists, do educate families of the patients when they visit the hospital. However, facts indeed show that not all families of mental health patients are willing to be involved actively in preparing the discharge planning of their family members that are in the hospital. Further evidence of this lack of participation is the low number of visits from family members while patients are in the hospital. Unfortunately hospital staffs are unable to educate family members unless they visit the hospital.

The community health centers (Puskesmas) have their own problem regarding medicines for mental health patients. Currently the available medicines at Puskesmas are different from the ones given to the patients at the hospital. This is resulting in either patients choosing to get their medicines at the hospital or Puskesmas referring the patients back to the hospital because they do not have the medicines that patients need. On the society level it was found that the common people in the Aceh society understand mental problems only at the minimal level, and currently it is lacking efforts at educating the Aceh people on this topic.

Problems at multiple levels as described above are the ones that the government's Health Department (Dinas Kesehatan) has to take into account in making decisions. Information on how discharge planning is currently applied in Aceh is only available verbally through interviews/discussion with related parties such as the mental hospital (RSJ), Health Department (Dinas Kesehatan), community health centers (Puskesmas) and families of patients. Printed literature on this topic is very rare, which might have

caused by the dearth of scientific research and publications on the discharge process. This scarcity is the reason behind the authors' decision to study the discharge process in its application in Aceh.

Research Objectives

To understand how discharge system of mental health patients is applied at Aceh mental hospital (BLUD RSJ Aceh) with the specific objectives to: (1) understand the roles of medical staff at Aceh's general hospital (RSUD) in treating mental health patients as part of the referral system, (2) understand the roles of medical staff at the community health centers (Puskesmas) in treating mental health patients as the basic provider of health services and referral agents to the mental health hospital, (3) understand the attitudes and behaviors of public and religious figures in Aceh towards mental health patients, and (4) understand the experience of families with mental health patients as family members.

Research Questions

In general the authors were trying to understand how mental health patient discharge system was applied by medical staff at Aceh mental hospital (RSJ Aceh).

More specifically, the study is trying to understand:

1. What are the roles of medical staff in treating mental health patients?
2. What are the roles of medical staff at the community health centers (Puskesmas) in treating mental health patients as the basic provider of health services and referral agents to the mental health hospital?
3. What are the attitudes and behaviors of public and religious figures in Aceh towards mental health patients?
4. What is the experience of families with mental health patients as family members?

Methods

This study employs a qualitative paradigm with interviews, observation and group discussion targeted at specific participants as research methods. All subjects in this study were chosen by referring to all levels in the Aceh mental health service model. Those levels are families, society (religious and public figures), puskesmas, RSUD and RSJ. On the family level five participants were chosen as research participants because one or more of their family members is schizophrenic and have been hospitalized more than twice. More specifically, these participants are the caregivers, people who attend to and watch the family members with mental illness while they stay at home. In this study the five participants consist of a father, two mothers, a wife, and a nephew (or niece). These family members are expected to share their perspectives on the patients' condition after they are discharged from the hospital.

On the society level, participants were chosen based on their proximity to where the patients live. A Muslim religious figure, two village secretaries and one geuchik (village leader) were chosen as participants; four participants instead of five because two patients actually live in the same village. These religious and public figures are expected to share their perspectives on how the society accepts and perceives mental health patients, especially after they are discharged from the hospital.

On the level of Puskesmas, RSUD and RSJ the research participants consist of psychiatrists, general doctors, psychologists, nurses, pharmacists, and administrative staff. The participants were chosen purposely because they are the ones whose daily work relates to patient discharge process. These participants are expected to share their perspectives on how the discharge process is executed. Table 1 depicts the number of participants and the list of data collection activities in this study:

In this study data were obtained by employing semi-structured interviews and focus group discussion as data collection methods. Results from the interview sessions and discussions were noted and recorded. Interviewers and facilitators were the research team members

Samples of some interview questions and their goals are presented in Table 2.

Results and Discussion

The Implementation of the Process of Discharging Mental Health Patients at BLUD RSJ Aceh

On the level of RSJ, it was found that psychiatrists have the authority for discharging patients. Psychiatrists have the right to make the decision to send a patient home after getting the clinical recommendation that the patient is well enough. The clinical recommendation is based on the patients' medical notes and their clinical

condition at examination. The discharge plan as it is currently applied places more emphasis on the clinical condition and not enough on post-discharge planning. Ideally discharge plan should be drawn up as soon as the patient is admitted into the hospital based on data from the preliminary examination. Afterwards periodic examination that involves multi-disciplinary team should be performed routinely (Caffrey A dan Todd M, 2002). Hedges et al. (1999) in Caffrey A and Todd M. (2002) specified four levels that are often left out in a hospital's discharge plan: (1) Analysis of discharge needs, (2) formulation of discharge plan, (3) execution of discharge plan, (4) final evaluation. Discharge plan is the bridge that

Tabel 1
The Number of Participants and the Data Collection Activities

No	Activities	Participants	Place	Number (of people)
1	Interviewing RSJ staff	Psychiatrists(2), medical doctors (2), psychologists (2), nurse, assistant at rehabilitation unit , farmacists, administrative assistant	Aceh's RSJ	10
2	Interviewing RSU staff	Psychiatrist	BLUD RSUZA	4
3	Interviewing Puskesmas staff	Medical doctor, nurse, administrative assistant, farmacist	PUSKESMAS	4
4	Interviewing family members	caregivers	Community	5
5	Interviewing society	Neighbours, religious figures, public figures	Community	4
6	Focus Group Discussion	Aceh's RSJ, RSUZA, Puskesmas	Aceh's RSJ	20

Table 2
Samples of Target Participants and Interview Questions

Target Participants	Questions
RSJ (psychiatrist, doctor, nurse, psychologist, administrative assistant)	Is there a standard procedure for discharging patients?
	What is the procedure?
	Do patients and their families understand the procedure?
RSU	Has any patient ever come here for health services after being discharged from RSJ?
	What is the standard treatment for mental health patients, both those who were not treated at RSJ previously and those who were discharged from RSJ?
Family	Is there a routine schedule for patient to visit medical institutions for consultation (Puskesmas, RSUD, or RSJ)?
	Where and to whom would you seek help if the patient has a relapse?
Religious and Public Figures	Do you know of anybody in your village who is having mental-emotional problems?
	Do you know if there are any RSJ patients that were just discharged from the hospital? How did you find out?
Puskesmas	Is mental health service available here?
	Who provides the service?
	What is the mechanism of the service?
	Do you monitor patients that were discharged from RSJ?

connects inpatient institutions with community health services, and as a result the ideal continuum of care becomes a reality (Backer TE, Howard TE, Moran GE, 2007).

Discharge plan needs to put emphasis on the needs of patient care after the patient leaves the inpatient institution, such as medicine availability, locations of community health services, patient needs for clothing, money and housing. Planning for all these items require data of all the available resources in the communities where the patients live (Backer TE, Howard TE, Moran GE, 2007). Currently the patient discharge process at Aceh's RSJ is not ideal because those factors are not emphasized enough. Communication is still lacking between Aceh's RSJ and RSUD/Puskesmas as the closest health service providers to the patients, potentially causing disruption in patient care after they leave the inpatient institutions.

The Roles of RSUD and Puskesmas in Treating Mental Illness

On the RSU/RSUD level it was found that some of the RSUDs currently do not have psychiatric wards, and some of the RSU/RSUD' s that have psychiatric wards do not accept in-patients. The majority of mental health patients who visit RSU/RSUD for consultation are outpatients. Should general doctors/ psychiatrists come upon a severe case of mental problem that requires hospitalization they normally will refer the patient to RSJ. This referral mechanism is currently working well. However, patients that were discharged from RSJ often encounter a problem of the unavailability or shortage of medicines whenever they visit RSU/RSUD for regular checkups.

On the level of Puskesmas it was found that some patients make use of the mental health services at Puskesmas. CMHN is currently having an important role in monitoring mental health patients. CMHN normally performs home visitation at the houses of mental health patients twice a month. Puskesmas can help these nurses monitoring medicine consumption in their patients by setting up some standard procedures. For example, after given their prescriptions patients can be directed to obtain their medicines at CMHN. This procedure helps these nurses (CMHN) in educating the patients on how they should consume their medicines. General doctors and CMHN work together in giving health services to the mental health patients. These mechanisms help in coordinating services given to patients in their communities (King and Nazareth, 1996).

The Society's Attitude Towards Mental Health Patients

On the society level, the study found that support and coordination of the key persons are severely lacking due to a few factors, namely the lack of information about patient's conditions and the lack of cooperation from patient's families in reporting the mental health patient's conditions before and after hospitalization. Typically public figures and the patient's community will offer their assistance whenever there are reports of an emergency situation by the patient's family, situations such as a sudden relapse of the patient or the need for transportation to take the patient to health institutions. Still another form of assistance from the community is by donating some money to the family to alleviate their daily needs.

The Caregiver's Experience

Patient's caregivers reported that they did not get enough information regarding the treatment plan of the patients. Currently the caregivers are provided information about patient treatment only when the patient is about to leave the hospital. Here are some excerpts from the interviews:

> "It was only administrative procedure, we used JKA for that, so we only gave administrative papers, there was no money, after that the doctor gave us the prescription and the doctor asked us a few questions." (CG 1)
>
> "What they asked us was how the patient became ill in the first place, the patient's progress here, that kind of stuff, nothing too detailed. Sometimes we come here many times but there was no doctor, we had to deal only with the nurse." (CG 1)
>
> "We took our kid home, the service was not clear. When we came here the first time the doctor or nurse explained us what was important. Maybe because we have come here so many times ever since, there was no more explanation." (CG 1)
>
> "Mmm there was no long explanation. I was simply dealing with the gentleman who will give me the letter of referral" (CG 2)
>
> “I don't know about the details, the doctor told me that we can go home but the patient still needs to take the medication. If the patient has eee.... a relapse, we were told to come back to the hospital." (CG 3)

"I go by my initiative to the mental hospital, nobody called me because I often go many times there (to visit). As soon as we show up we were told here's the patient, you can take the patient with you, the patient is okay now and calmed down. Nothing else was shared with me." (CG 4)

"When I was ready to go home the nurse helped me, but maybe the doctor signed. There has to be permission from the doctor I mean. They give us medicine routinely. But the problem is when the patient feels well already the patient doesn't want to take the medicine anymore. That's the problem." (CG 4)

Based on the previous discussion, it can be summarized that the process of patient discharge needs collaboration from the patients and their families as early as possible after treatment. Some of the information that needs to be shared is the justification for hospitalization, the nature of mental problem the patient is currently having, and the plans for treatment both before and after patient discharge. This analysis corresponds to Hanson's (1995) depiction of some barriers in the relationship between caregivers and psychiatrists/general doctors, especially when caregivers are seldom involved in the discharge process (Perreault M et.al, 2005). Another problem that families often experience at home is patient's refusal to take the medicine because they feel well enough, even after persuasion from the family members. This predicament forces patient's families to mix the medicine into patient's food or drinks. Patient's refusal to take medicines might be one of the symptoms of schizophrenia.

Taking into consideration Aceh's tiered mental health system, ensuring collaboration among those different levels, including the society, is of prime importance. The study confirms that in order to have an ideal discharge process there needs to be an implementation of a continuous well-run system with different parts that collaborate together.

Conclusion

This preliminary study found that the current mechanism of discharging patients at RSJ is not functioning as well as it should be because coordination among various levels involved is found wanting. The high number of patients and lack of resources are two other causal factors that make this problem even more complicated. Observation of the current discharge process further confirms this poor level of coordination between RSJ, RSUD, Puskesmas and the society in treating mental health patients. Currently RSUD and Puskesmas are assisting in treating the outpatients and sending patient referrals to RSJ when the case is outside of their capabilities. Family members serving as the caregivers are also playing an important role in patient treatment by ensuring that the patients take the medicine and visit health providers regularly. Unfortunately these caregivers are not instructed adequately in coping with potential problems that may arise when treating the patients after discharge.

This preliminary study provides us with the general description of how the discharge process of mental health patients needs systematic planning and execution with excellent coordination among all health service providers including RSJ, RSUD, Puskesmas, families of patients, and the society. This further underlines that discharge planning is seriously needed as one solution to the problems Aceh's BLUD RSJ is presently facing. Discharge planning deserves to have more research studies devoted to the issue, especially those focusing on the needs of the discharge plan of mental health patients.

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