DO YOU SPEAK POLITICIAN?

LESSONS FROM PRIME

Please access the video used in this presentation here:
https://youtu.be/TTW-6wejavQ

PRIME
programme for improving mental health care

Alan J. Flisher Centre for
Public Mental Health

University of Cape Town • iYunivesithi yaseKapa • Universiteit van Kaapstad

PRIME

programme for improving mental health care

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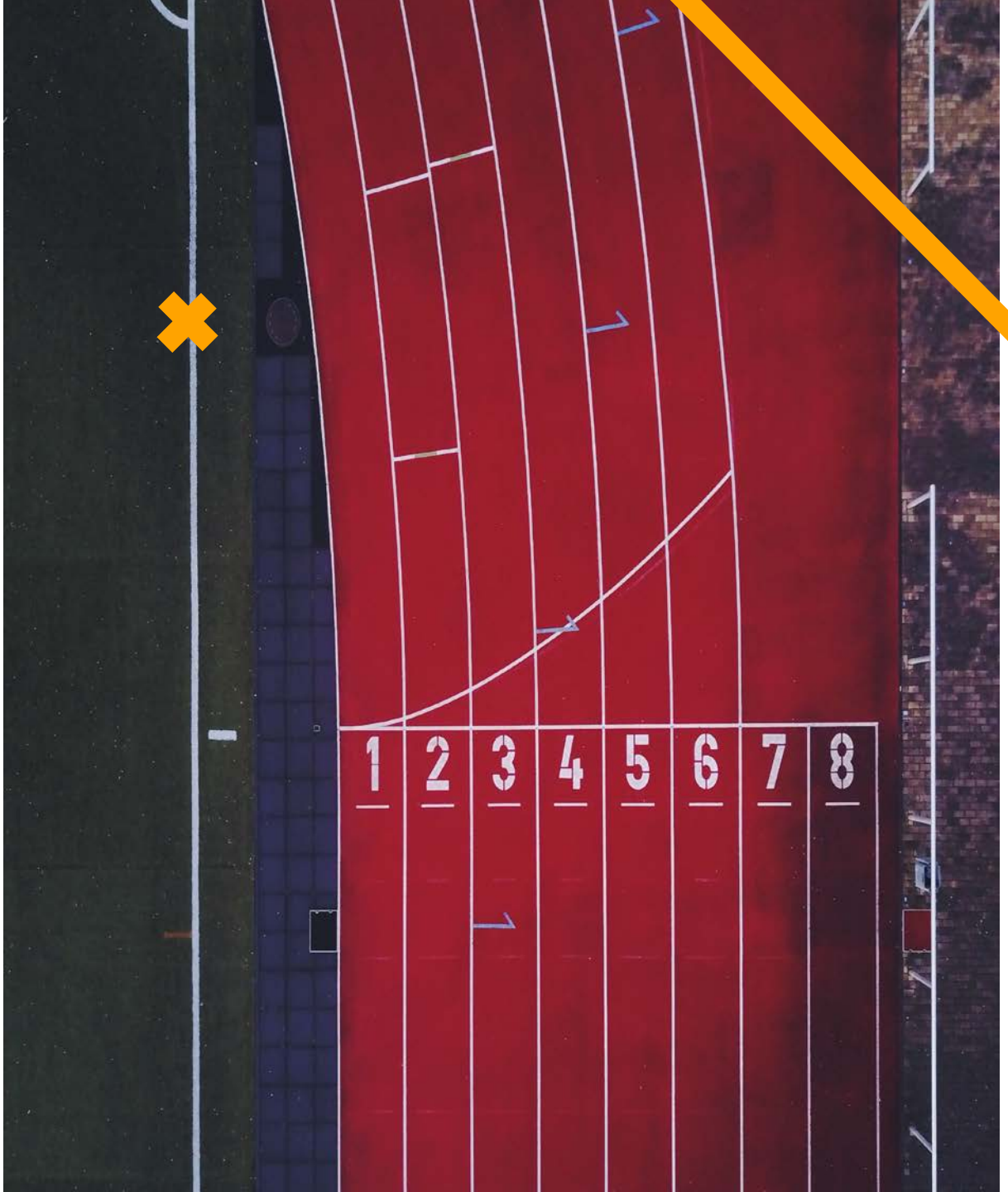
UKaid
from the British people

PRIME
programme for improving mental health care



PRIME
programme for improving mental health care

PRIME IN NUMBERS

- Implemented in 37 facilities with 20340 health visits conducted
- Scaled up to a total of 94 facilities
- Published 81 peer-reviewed papers
- Presented at 71 conferences
- 20 PhD students

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POLICY IMPACT

ETHIOPIA

- Ethiopian National Mental Health Strategy (2012) and current revision

INDIA

- New Pathways, New Hope: National Mental Health Policy of India (2014)
- Core Committee on Health for the National Human Rights Commission

NEPAL

- Third Nepal Health Sector Plan (in development)
- MHCP training officially adopted by National Training Institute
- Psychotropic medications for free drug list
- The Primary Healthcare Revitalisation Division of Community Mental Health Care Package, Nepal, 2074

POLICY IMPACT

UGANDA

- National Mental Health Strategic Plan (in development)

SOUTH AFRICA

- South African National Mental Health Policy Framework and Strategic Plan (2013)
- Mental Health Technical Advisory Committee to the Minister of Health
- Dr Kenneth Kaunda district mental health task team

POLICY IMPACT

CROSS COUNTRY

- 2014 UK Parliamentary Report – Mental Health for Sustainable Development
- 2015 WHO global strategy on people-ceentred and integrated health services: interim report
- 2016 ODI Report - Mental health funding and the SDGs: What now and who pays?
- 2016 Providing Sustainable Mental and Neurological Health Care in Ghana and Kenya: Workshop Summary
- 2016 WHO Handbook - Strategizing national health in the 21st century: a handbook
- 2016 World Bank/WHO meeting on "Out of the Shadows: Making mental health a global development priority", Washington DC
- 2017 PRIME has made a substantial contribution to the WHO mhGAP Operations Manual

1

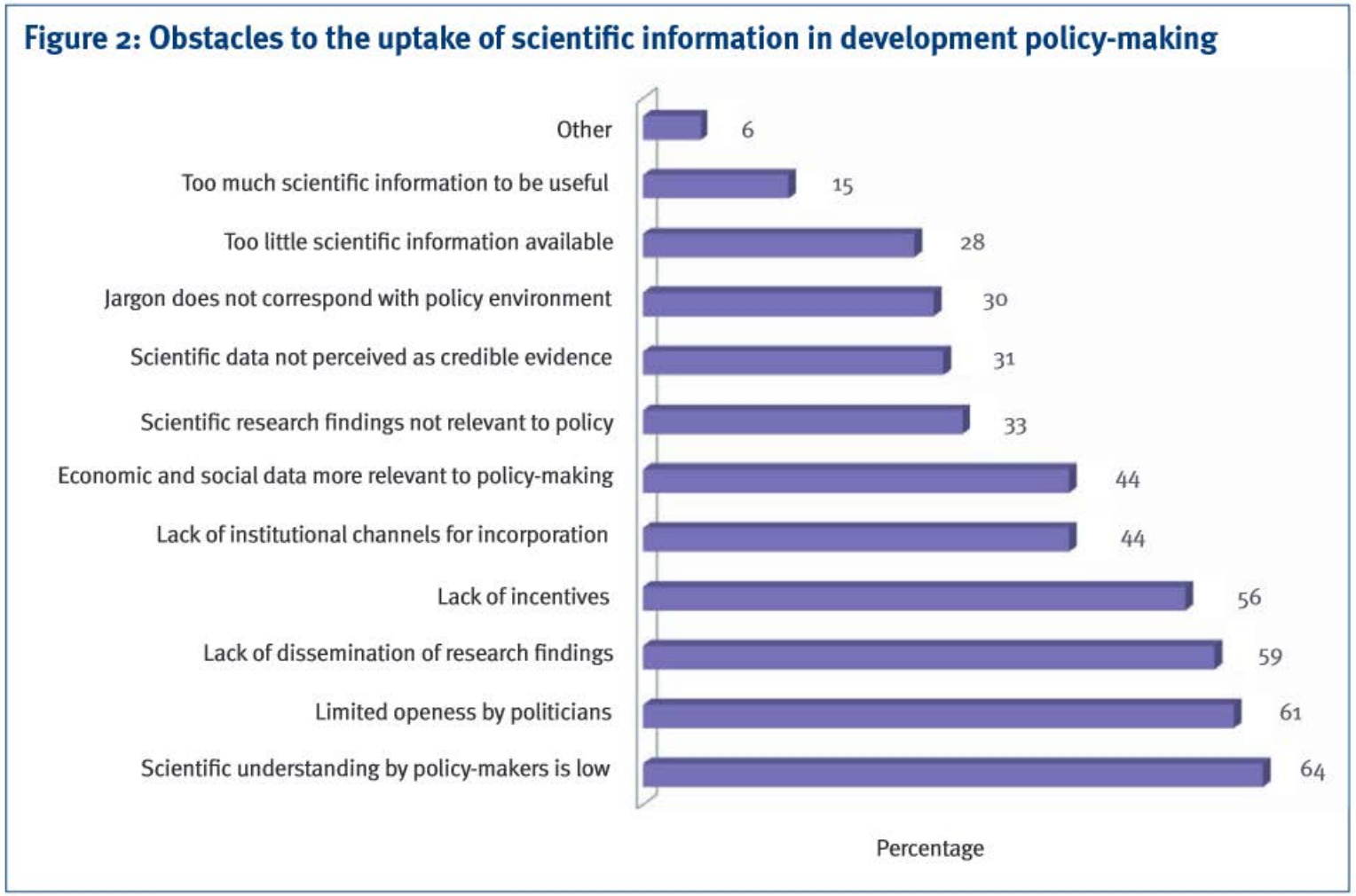
Involve policy makers in the research

- ✕ Memorandums of understanding
- ✕ Mutual responsibility
- ✕ Direct lines of communication
- ✕ Still proved challenging

2

Don’t try to speak politician … or academic

- ✕ Interviews done as part of evaluation
- ✕ Responses show low interest in consuming academic literature
- ✕ Participants indicated multi-media as more accessible



Jones, N. and Walsh, C., 2008. *Policy briefs as a communication tool for development research*. Overseas development institute (ODI).

POLICY PACK

Proactive community case-finding to facilitate treatment seeking for mental disorders, Nepal

Mark JD Jordans,[a] Brandon A Kohrt,[b] Nagendra P Luitel,[c] Crick Lund[d] & Ivan H Komproe[e]

Problem Underutilization of mental health services is a major barrier to reducing the burden of disease attributable to mental, neurological and substance-use disorders. Primary care-based screening to detect people with mental disorders misses people not frequently visiting health-care facilities or who lack access to services.

Approach In two districts in Nepal, we trained lay community informants to use a tool to detect people with mental, neurological and substance-use disorders during routine community service. The community informant detection tool consists of vignettes, which are sensitive to the context, and pictures that are easy to understand for low literacy populations. Informants referred people they identified using the tool to health-care facilities. Three weeks after detection, people were interviewed by trained research assistants to assess their help-seeking behaviour and whether they received any treatment.

Local setting Decentralized mental health services are scarce in Nepal and few people with mental disorders are seeking care.

Relevant changes Out of the 509 people identified through the community informant detection tool, two-thirds (67%; 341) accessed health services and 77% (264) of those individuals initiated mental health treatment. People in the rural Pyuthan district (208 out of 268) were more likely to access health care than those living in Chitwan district (133 out of 241).

Lessons learnt The introduction of the tool increased the utilization of mental health services in a low-income country with few health resources. The tool seems beneficial in rural settings, where communities are close-knit and community informants are familiar with those in need of mental health services.

Abstracts in عربي, 中文, Français, Русский and Español at the end of each article.

Introduction

Globally, underutilization of mental health services is a major barrier to reducing the burden of disease attributable to mental, neurological and substance-use disorders.[1] Service underutilization has been attributable to lack of awareness of service availability; lack of recognition of mental, neurological and substance-use disorders in oneself or one's family; stigma against seeking mental health care; and perceived ineffectiveness of treatments.[2] Routine or indicated primary health-care screening has been proposed to tackle this challenge, but this approach misses people who rarely use primary health-care services. In areas with high poverty levels and/or long travel times to health facilities, large portions of the population access primary care infrequently. Moreover, many low- and middle-income countries lack resources for widespread screening, especially in populations with high illiteracy that require health staff to administer screening tools.

An alternative approach to increase utilization is community case detection, which employs a gate-keeper model where people with regular community engagement are taught to identify and refer people for assessment and treatment in primary health care. However, community case detection has received limited attention for mental health.

To address this challenge, we developed a community informant detection tool, which we piloted in Nepal.[3] The tool facilitates detection of people with depression, alcohol-use disorder, epilepsy and psychosis and helps identified people to seek care. The disorders were selected based on prevalence, burden of disease and responsiveness to evidence-based treatments, and have been confirmed for Nepal through an expert priority-setting study.[4] The tool is developed on the premise that people who are intimately connected within the community, such as community health workers (CHWs), are in a position to identify those in need of care, if they are provided with a tool for identification. The structured tool contains vignettes, which are sensitive to the context, rather than symptom checklists and uses pictures that are easy to understand for low literacy populations. Trained lay community informants (e.g. CHWs or civil society women's groups), use the tool during daily routine activities, where they check the extent to which people match paragraph-long vignettes using a four-point scale. The pictorial vignettes are designed to initiate help-seeking for mental health treatment in primary care settings. The community informants do the vignette matching based on their observation of people as part of their interactions during their regular responsibilities. If the person fits well with the description, they will ask additional questions on need for support or impairment in functioning. The questions are an integral part of the tool with yes/no responses, functioning as a decision flowchart. In the case of a positive reply to either of the two questions, the informant encourages the person (possibly through their family) to seek help in health-care facilities where mental health services are being offered and the person can be evaluated by trained health professionals. No stigmatizing psychiatric labels are used

POLICY PACK

✕ Journal paper

Proactive community case-finding to facilitate treatment seeking for mental disorders in Nepal

Policy Brief 12
November 2017

by Mark JD Jordans, Brandon A Kohrt, Nagendra P Luitel, Crick Lund & Ivan H Komproee.

INTRODUCTION

Globally, underutilization of mental health services is a major barrier to reducing the burden of disease attributable to mental, neurological and substance-use disorders.

Service underutilization has been attributable to lack of awareness of service availability; lack of recognition of mental, neurological and substance-use disorders in oneself or one's family; stigma against seeking mental health care; and perceived ineffectiveness of treatments.

Routine or indicated primary health-care screening has been proposed to tackle this challenge, but this approach misses people who rarely use primary health-care services.

Moreover, many low- and middle-income countries lack resources for widespread screening, especially in populations with high illiteracy that require health staff to administer screening tools.

An alternative approach to increase utilization is community case detection, which employs a gate-keeper model where health workers have been trained in mental health care and encourage people to seek help for assessment and treatment in primary health care.

However, community case detection has received limited attention for mental health.

METHOD

To address this challenge, we developed a Community Informant Detection tool (CIDT).

The tool facilitates detection of people with depression, alcohol-use disorder, epilepsy and psychosis and helps identified people to seek care.

In two districts in Nepal, we trained lay community informants to use a tool to detect people with mental, neurological and substance-use disorders during routine community service.

The CIDT consists of vignettes, which are sensitive to the context, and pictures that are easy to understand for low literacy populations. Trained informants encouraged people they identified using the tool to seek help at health-care facilities.

A previous PRIME study, focused on evaluating the accuracy of case detection by community informants using the CIDT, found that 64% of cases were accurately detected.[1]

Three weeks after detection, people were interviewed by trained research assistants to assess their help-seeking behaviour and whether they received any treatment.

The study took place in two Nepalese districts. Chitwan district in southern Nepal has been the implementing site for the Programme for Improving Mental Healthcare (PRIME) since 2011.

The district is densely populated, is relatively well resourced and at the time of the study had 12 health-care facilities with mental health services.

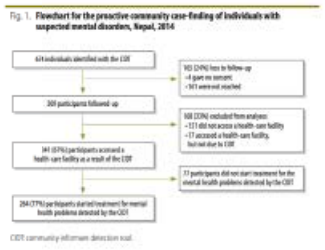
Pyuthan is a more remote and poorer hill district, and was the site for the Mental Health Beyond Facilities (mhBeF) initiative from 2013 to 2015.

Both mental health programmes were implemented by the nongovernmental Transcultural Psychosocial Organization (TPO) Nepal.

RESULTS

Out of the 509 people identified through the CIDT, two-thirds (67%; 341) accessed health services and 77% (264) of those individuals initiated mental health treatment.

People in the rural Pyuthan district (208 out of 268) were more likely to access health care than those living in Chitwan district (133 out of 241).



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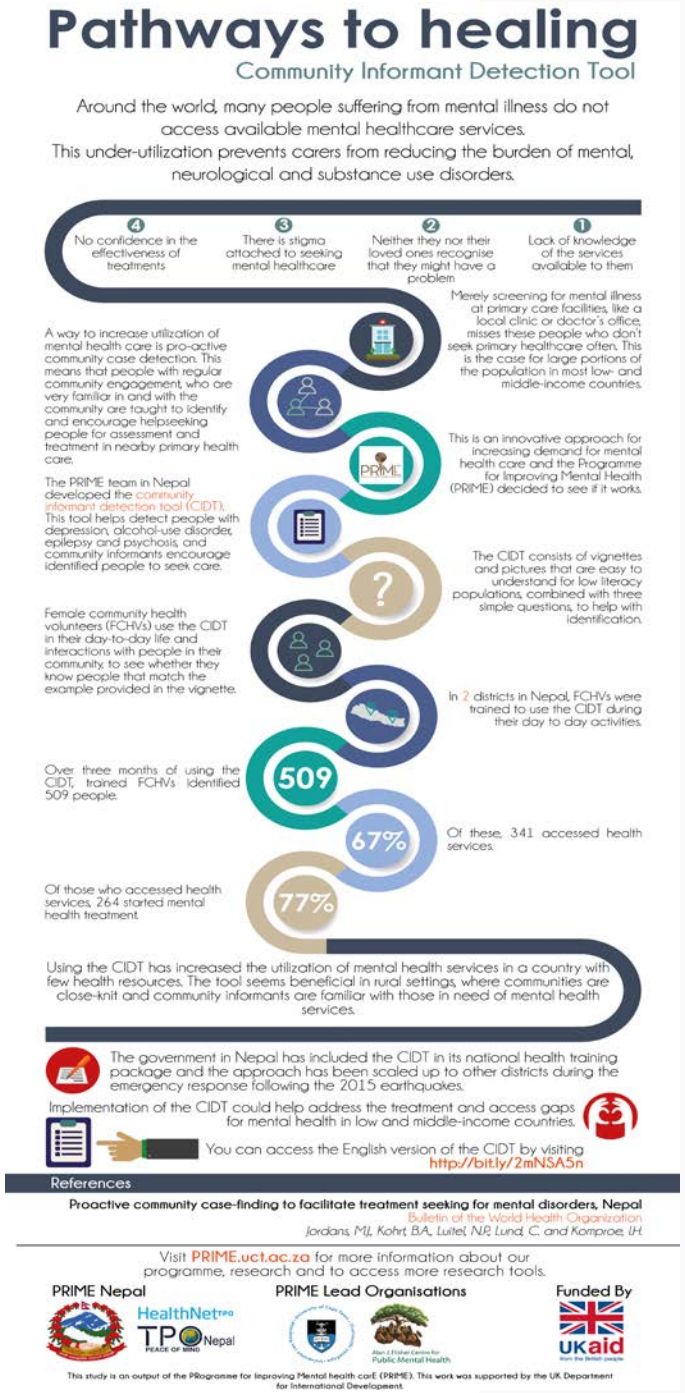
- ✕ Journal paper
- ✕ Policy brief



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- ✕ Journal paper
- ✕ Policy brief
- ✕ Infographic

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SPES BONA