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Scaling up mental health services at district level

Lessons from district care systems in Ghana, South Africa and Uganda

The purpose of the Mental Health and Poverty Project is to develop, implement and evaluate mental health policy in poor countries, in order to provide new knowledge regarding comprehensive multi-sectoral approaches to breaking the negative cycle of poverty and mental ill-health.

Improving mental health, Reducing poverty

Scaling up mental health services at district level: Lessons from district care systems in Ghana, South Africa and Uganda

What do we know about district mental health service delivery in African countries?

Decentralization and integration of mental health into primary health care at a district level forms the core of many mental health policies in LMICs. A situational analysis conducted by MHaPP in Ghana, South Africa, Uganda and Zambia, however, indicates such processes are at different stages with varying degrees of success. The following was observed:

- Mental health is under-prioritized with none of the districts having a mental health plan in place.
- South Africa provides a greater degree of decentralized care with respect to dedicated psychiatric beds and availability of psychotropic medication at district level, while limited resources in Ghana, Uganda and Zambia mitigated decentralized care. These limitations included few mental health specialists in Uganda and none in Ghana and Zambia, insufficient supervision, training and support of primary health care (PHC) personnel and limited and inconsistent access to psycho-tropic medication.

The Mental Health and Poverty Project (MHaPP) is a five year study of mental health policy, legislation and services in 4 African countries: Ghana, South Africa, Uganda and Zambia.

Following broad situation analyses in each of the four countries involved in the MHaPP study, three areas of intervention were identified. These included improving policies, plans and legislation for mental health, mental health information systems and developing district-based models of service delivery. These interventions were undertaken during the second phase of the project.

In Ghana, South Africa and Uganda, mental health services were integrated into primary health care systems in typical resource-poor districts using a task shifting approach which refers to capacitating non-specialists to provide mental health care.

- Community-based rehabilitation programmes were limited or non-existent in all of the study districts suggesting that, even in middle-income countries like South Africa, effective services for de-institutionalized care of patients with chronic and serious psychiatric disorders are not in place.
- There is an almost exclusive emphasis on the treatment of less common psychotic and bipolar mental disorders. There is a large treatment gap for common mental health disorders such as depression and anxiety.
- There is limited evidence of mental health promotion and prevention, or involvement of other sectors in mental health care.
- Traditional explanatory models of illness and use of traditional healers to treat mental disorders is common, yet little collaboration is evident between western-based and traditional healing systems.

What did we do?

A multi-sectoral community collaborative implementation framework was adopted to improve mental health service delivery at the district level in Ghana, South Africa and Uganda. The emphasis was on increasing both access to mental health services as well as empowering community members to have control over their mental health. The following implementation framework was utilized in each of the districts:

- **Establish a multi-sectoral community collaborative forum.** These forums were established across all three countries and comprised of a number of different stake-holders representing different sectors. Regular meetings were held within country district sites with the intent of improving the public health priority of mental health, multi-sectoral collaboration and mental health literacy, as well as mobilizing resources for mental health at a district level and ensuring that services are culturally competent and meet beneficiary needs.
- **Provide training to PHC personnel in the identification and management of mental disorders appropriate for their level.** This training was provided across all three country sites.
- **Improve the capacity of community members to identify and manage mental disorders appropriate for their level.** Community Health Workers (CHWs) were trained to identify and refer persons with mental disorders across the three country sites. South Africa also provided training for CHWs in basic counseling skills and the use of an adapted version of Interpersonal Therapy (IPT) for the treatment of depression. In Ghana, CHWs were additionally

trained to monitor medication usage, refer acute cases and provide family support visits as well as record socio-demographic information. CHWs were also trained in Uganda and Ghana to deliver and support community based rehabilitation programmes.

- **Promote community user groups.** In Uganda, user groups were formed to provide psycho-education on the management of mental illness as well as generate mutual support and engage in income generating activities. In addition, they facilitated advocating access to psychotropic medicines. In South Africa, community members were trained to facilitate groups for people screened for moderate to severe depression using an adapted manualized IPT approach. Ghana, having had little or no mental health services in the district, created ten self-help groups in conjunction with district and national level user and carer associations.
- **Ensure supervision and support for non-specialists.** Roles of specialist staff were diversified to ensure the provision of technical and emotional support to non-specialist PHC nurses and community-based workers. In South Africa, in addition to an expansion of the roles of mental health specialists to include training, support and supervision to PHC nurses, a mental health counselor at a PHC level was introduced to provide specific support to CHWs in the provision of non-pharmacological treatments.

The need for increased access to mental health services in district LMICs:

The relief expressed by some in response to increased access to mental health services, provided a very clear indication of the need for increased access to mental health services at a district level in LMICs, as some health personnel explain:

Before these people of the mental and poverty project came, we could only see one or two cases of mental illness a month. As I speak now, we have over 190 patients attending the mental health clinic; and the number is still increasing (MENTAL HEALTH PRACTITIONER, UGANDA)

We are very happy to be part of this initiative because very little was happening in the district in terms of mental health care. Now we have so many people coming to the hospital and I believe there are even more at the community level. (HOSPITAL ADMINISTRATOR, GHANA)

Recommendations for improving mental health information

A community collaborative participatory approach which embraces task shifting – which refers to capacitating non-specialists to provide mental health care – is recommended for improving access to mental health services at a district level. It can assist in addressing many of the identified service gaps in a culturally competent way at reduced cost. In addition, it can assist in, improving mental health literacy and health seeking behavior; mobilizing resources; reducing stigma; and, improving community control over mental health. In the context of over-stretched primary health care systems, in addition to training of PHC personnel in the identification and management of mental disorders, the following four key strategies for scaling up mental health services at a district level are recommended:

1 **Establish a multisectoral community collaborative management forum.** Establishing such forums has been shown to be important for improving collaboration across sectors and mental health literacy, reducing stigma and mobilizing resources for mental health across sectors. It also has the potential to enhance collective efforts to address the social determinants of mental health, thereby empowering community members to have greater control over their mental health.

Community Collaboration: The multi-sectoral forum as an example

Groups such as the mental health multi-sectoral forum provide a concrete example of how mental health literacy at the individual level cascades to community awareness and decreases stigma. A forum member from South Africa illustrates this point:

> *The awareness was created at an individual level… (before) when you look at people who have got mental ill health, you wouldn't bother much… But now, this has actually conscientized us that we really have to find means and ways of helping people who have got mental health disorders... It can have far reaching effects in terms of even changing the attitude and the mentality of the community towards mental health patients.*

The group also assisted at a grass roots level in mobilizing resources needed for community mental health empowerment programmes as is explained in Uganda:

> *You know we had the department for agriculture stepping in and assisting the local community rehabilitation project with seeds they could plant in their gardens. It was a real example of how a person outside mental health, stepped in to assist our area.*

2 **Train local community members to supplement formal mental health services.** Increasing mental health personnel to aid service delivery does not need to be a costly task. Use of trained community members to provide manualized treatments and psychosocial rehabilitation within a task shifting supervisory structure has been shown to be effective both in terms of capacity to aid mental health service delivery and in terms of cost to the system (Petersen, Lund, Bhana & Flisher, submitted). This approach also promotes culturally competent services given that community members are best placed to understand their own cultural and social realities.

3 **Promote community user groups** This appears to be an effective means of treatment, rehabilitation and mental health promotion at a community level as well as increasing community control of mental health. In South Africa, groups were formed with a view to treating depression using community facilitators trained in an adapted IPT approach with the support and supervision of a mental health counselor. The effects suggest this package of care has the potential to close the treatment gap for depression at minimal cost. Participants in the groups not only demonstrated significantly reduced depression scores compared to controls but they also appeared to have developed strengthened social connections – leading to better social support, increased coping skills, increased knowledge and greater agency over their own lives through pro-active behaviours (Petersen, Bhana & Baillie, submitted). In Uganda, the groups have helped the mental health service users and carers receive information on mental illness, cope with their illnesses as well as find avenues to help them lead a productive life.

4 **Establish a supervisory support structure.** For task shifting to be effective it is essential that non-specialists are provided with supervision and support from mental health specialists.. supervisory support structure is put in place. In South Africa, the introduction of mental health counselors with a lower level training than psychologists at PHC level was found to be a cost effective means of providing technical and emotional support in non-pharmacological care and treatment to community-based workers (Petersen, Lund, Bhana & Flisher, submitted).

Addressing Common Mental Disorders (CMDs): The case in South Africa

There is a large treatment gap for CMDs in South Africa; as indicated by one user; many people just tolerate depression in the community:

> *I think a lot of people have this depression that I had. In most cases a lot of people do not like to talk about their problems to other people. They like to bottle things up inside and maybe end up thinking about committing suicide. They just keep them bottled up inside, like me - I spent most of my time alone and thinking. One day I even thought what's the reason for me to live?*

A pilot programme using trained community members to treat moderate to severe depression in women using an adapted Interpersonal group therapeutic approach under the supervision of a mental health counselor revealed positive results. There was a significant reduction in depressive symptoms as measured by the Beck Depression Inventory in the intervention participants compared to the controls over a 12 and 24 week period, $F(2,1.739) = 46.645$, $p < 0.0001$. Similarly, with the overall Hopkins Symptom Checklist -25 scale, a significant reduction in symptoms of overall psychological dysfunction was found in the intervention group compared to the controls at 12 and 24 week intervals $F(2, 1.651) = 34.55$, $p < 0.0001$. The results suggest that it is a feasible and potentially effective package of care for depression in rural areas. A facilitator from one of the groups describes some of the effects on participants:

> *When the group was almost finished, they would come with good news. They would say that I have done this and this. Even when a person was no longer studying she would think of going back to school. You find that she has found a job. She is thinking of selling things for herself… They grew. Their minds are thinking differently. Like a person would come and say I am thinking of killing myself. You can see that that person's mind is disturbed. But as time goes on, you ask her if she still has thoughts of killing herself and she doesn't. She would explain that it's because she can see that if she does this - things will be ok.*
> (GROUP FACILITATOR)

Where can I find out more about this issue?

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MHaPP website: www.psychiatry.uct.ac.za/mhapp

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