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Integrating mental health into primary care re-engineering in South Africa: A no-brainer

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Outline

- Why include mental health?
  - Burden
  - Economic costs
  - Evidence for interventions
- How can we include mental health?
  - Framework
  - Roles for staff
- Some things are already happening…
  - PRIME
  - AFFIRM

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Some definitions

- A no-brainer:
  - Dictionary definition: “An easy or obvious conclusion, decision, solution or task; something requiring little or no thought.”
  - Someone who is treated in primary care as though they don’t have a brain

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Why include mental health in primary care re-engineering?

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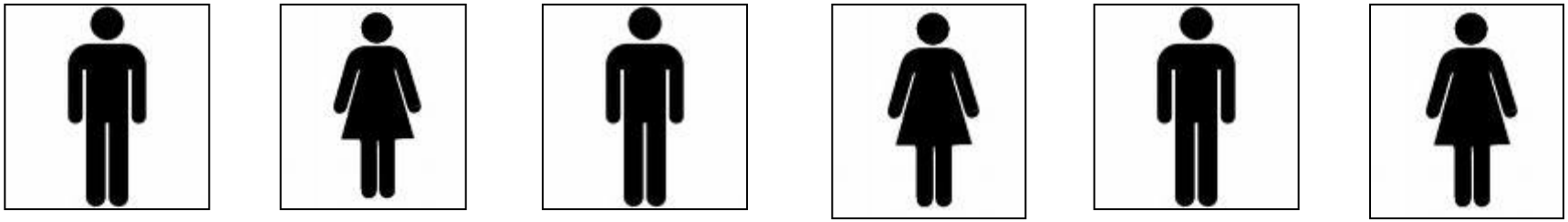
Prevalence of common mental disorders in SA



1 in 6 South Africans report depression, anxiety or substance use disorders during the past year (12-month prevalence: 16.5%; lifetime prevalence: 30.3%)

1. Williams, D. et al (2007). Twelve month mental health disorders in South Africa: prevalence, service use and demographic correlates. Psychological Medicine, 38: 211-220.
2. Stein, D. J., et al. (2008). Lifetime prevalence of psychiatric disorders in South Africa. British Journal of Psychiatry, 192, 112-117.

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Burden of Disease: South Africa

Bradshaw, D., Norman, R., & Schneider, M. (2007). A clarion call for action based on refined DALY estimates for South Africa. Editorial. *South African Medical Journal, 97,* 438-440.

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Global Burden

- Neuropsychiatric disorders account for 13% of global disease burden
- Neuropsychiatric disorders comprise 5/10 leading causes of health disability in the world
- By 2030 depression will be 2nd leading cause of health disability in the world (after ischaemic heart disease)
- Approximately 877,000 people commit suicide every year

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Comorbidity

- HIV/AIDS:
  - People with mental disorder at increased risk of contracting HIV/AIDS
  - Among HIV positive individuals prevalence of mental disorder is higher than general population eg depression (OR 2.0, 95% CI 1.3-3.0)[1]
  - Adherence to ART is adversely affected by depression, cognitive impairment and substance abuse
  - Treating depression improves ARV adherence and CD4 count[2]
  - HIV-Associated Neuro-cognitive disorder among patients commencing ART in Cape Town:[3]
    - Mild neuro-cognitive disorder: 42.4%
    - HIV-Dementia: 25.4%

1. Prince, M. et al (2007). No health without mental health. *Lancet, 370*, 859-877.
2. Horberg, M.A. et al. (2008). Effects of depression and selective serotonin reuptake inhibitor use on adherence to highly active antiretroviral therapy and on clinical outcomes in HIV- infected patients. *Journal of Acquired Immune Deficiency Syndromes*, 47(3): 384-390.
3. Joska et al (2010). Characterization of HIV-Associated Neurocognitive Disorders Among Individuals Starting Antiretroviral Therapy in South Africa. *AIDS Behav* (2011) 15:1197–1203

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Non-Communicable Diseases: Eden trial (preliminary data)

DEPRESSION COHORT		
	INTERVENTION	**CONTROL**
Number of patients recruited (% of target)	1289 (113)	1164 (102)
CO-MORBIDITY		
Depression with Hypertension	815 (63.2) n=1289	784 (67.35) n=1164
Depression with Diabetes Mellitus	413 (32.04) n=1289	422 (36.25 n=1164
Depression with Chronic Respiratory Disease	380 (29.48) n=1289	367 (31.53) n=1164
DRUGS		
on antidepressant	183 (14.20) n=1289	245 (21.05) n=1164

Source: Fairall et al Preliminary baseline findings: Eden PHC101 cluster randomised controlled trial.

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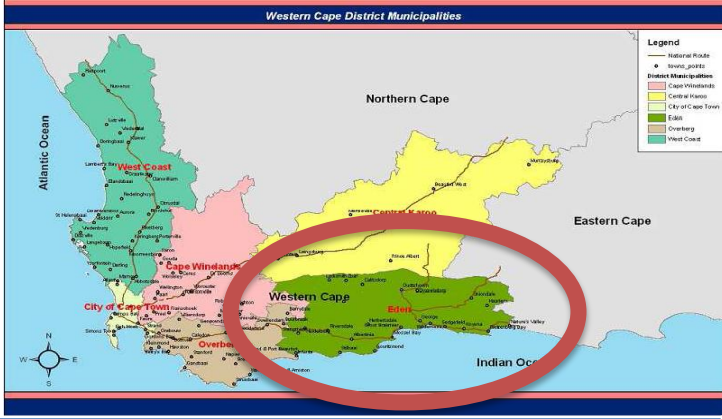
NCDs: Eden trial (preliminary data)



HYPERTENSION COHORT		
	INTERVENTION	**CONTROL**
Number of patients recruited (% of target)	1578 (138)	1660 (146)
HPT with Depression	815 (51.6) n=1578	784 (47.2) n=1660
DIABETES COHORT		
	INTERVENTION	**CONTROL**
Number of patients recruited (% of target)	865 (76)	974 (85)
DM with Depression	413 (47.75) n=865	422 (43.33) n=974
CHRONIC RESPIRATORY DISEASE COHORT		
	INTERVENTION	**CONTROL**
Number of patients recruited (% of target)	592 (111)	567 (107)
CRD with Depression	380 (64.2) n=592	367 (64.7) n=567

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The treatment gap

Williams, D. et al (2007). Twelve month mental health disorders in South Africa: prevalence, service use and demographic correlates. *Psychological Medicine*, 38: 211-220.

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Economic costs

South African Stress and Health Survey:

- Mean estimated lost earnings of $4,798 per adult per annum with severe mental illness (major depression and anxiety disorders), after adjustment for age, gender, substance abuse, education, marital status and household size
- Projections of total annual cost to South Africa in lost earnings: $3,6 billion in 2003 (2.2% of GDP)
- Cf Direct spending on mental health by DoH in 2005:
  $59 million

Lund et al (In press). Mental illness and lost income among adult South Africans. *Social Psychiatry and Psychiatric Epidemiology*

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Treatment and prevention in low and middle-income countries

- Depression:
  - Generic antidepressants and psychosocial interventions (stepped care)
  - Cost-effectiveness comparable to ART for HIV/AIDS
- Schizophrenia:
  - 1st generation antipsychotics and community-based care
- Hazardous alcohol use:
  - Brief interventions at PHC

Patel et al 2007. Treatment and prevention of mental disorders in LMICs. Lancet

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How can we include mental health in primary care re-engineering?

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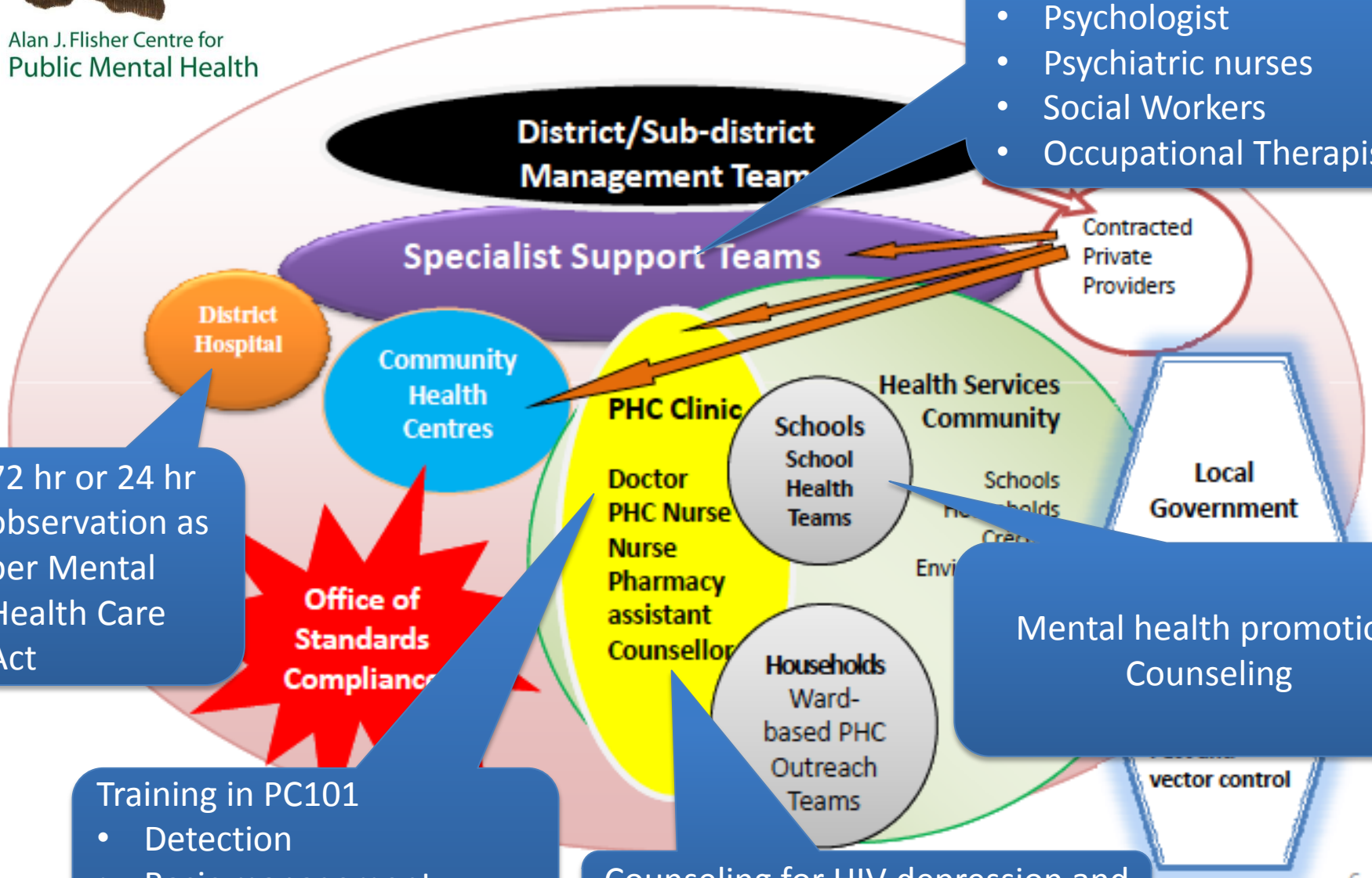
DHS MODEL



District Mental Health team
- Community Psychiatrist
- Psychologist
- Psychiatric nurses
- Social Workers
- Occupational Therapists

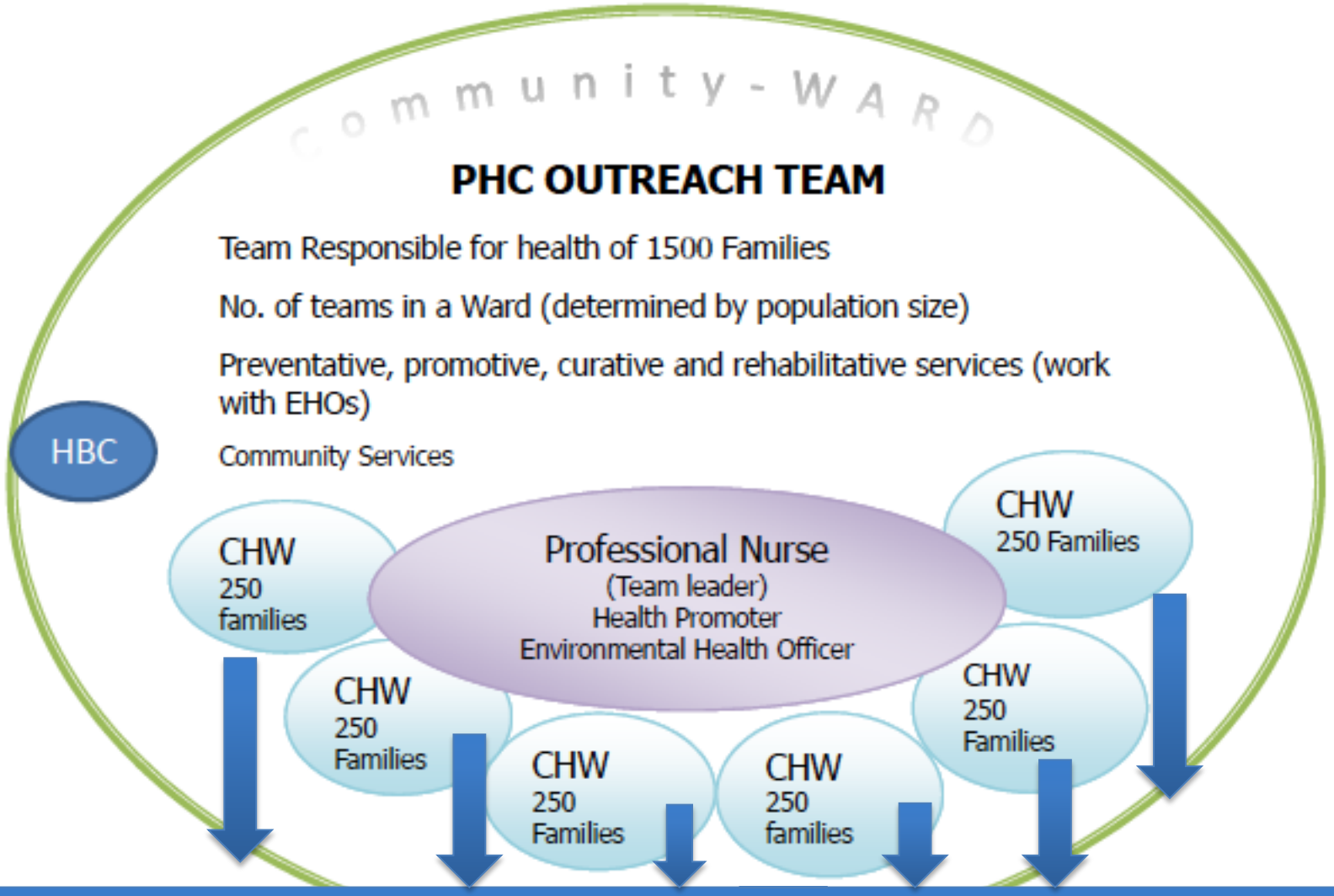
72 hr or 24 hr observation as per Mental Health Care Act

Mental health promotion
Counseling

Training in PC101
- Detection
- Basic management
- Referral

Counseling for HIV depression and maternal depression

WARD BASED PHC OUTREACH TEAMS



Psychotropic adherence, Checking for domestic violence
Referral for counseling, User self-help support groups

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District Mental Health team

- Provide specialist training, supervision and support for the district

Specialist	Generalist
Psychiatrist	Family physician, Medical Officers
Psychologist	Counselors
Psychiatric Nurses	General PHC Nurses

- Assist in planning mental health service needs of the district (public health approach)
- Treat complex cases

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District hospital: Psychiatric Emergencies and Outpatients

Target conditions	Service	Staff
• Suicide attempts • Acute psychotic episodes • Severe mental disorders	• 24 hr and 72 hr observation, as per the Mental Health Care Act and PC101 • Upward referral to specialist facilities • Outpatients	Medical Officers Nurses Consultation by psychiatrist and psychologist

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PHC Clinics and Community Health Centres

Target conditions	Service	Staff
Severe mental illness: • Schizophrenia • Bipolar disorder Common mental disorders: • Depression • Anxiety Childhood disorders: • Behavioural • Developmental Substance abuse	• Identification, management and referral as per PC101 • Review of chronic medication management for severe mental illness • Counseling (brief manualised group/individual psycho-social interventions) • Counselor to train and supervise CHWs • Mental health education material in waiting rooms	Medical Officers Nurses Counselors

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School health teams

Target conditions	Service	Staff
Child/adolescent disorders: • Behavioural • Developmental Substance abuse	• Identification, management and referral • Counseling • Mental health component of health promotion programmes	Nurses Counselor

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Community outreach teams

Target conditions	Service	Staff
Severe mental illness: • Schizophrenia • Bipolar disorder Common mental disorders: • Depression • Anxiety	• Case identification • Psychotropic adherence • Psychosocial rehabilitation eg user self-help support groups • Counseling groups • Checking for domestic violence • Public education and stigma reduction	Nurse (team leader) Community Health Workers

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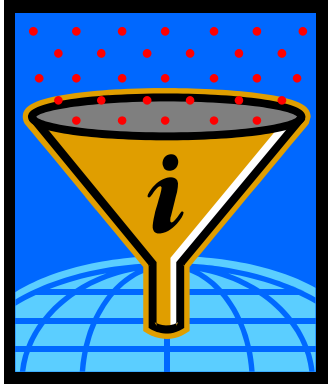
Mental health Indicators in District Health Information System



Level	Input	Process	Outputs	Outcomes
PHC	Staff Budgets Psychotropic meds IEC materials	Mental health visits total New mental health visits No. of mental health visits by 5 diagnostic categories	Scripts Counseling sessions Referrals to hospital	Global Assessment of Functioning
District hospital	Staff Beds Budgets Psychotropic meds IEC materials	Admissions Discharges Average length of stay Admissions by 5 diagnostic categories Adverse events. Readmissions within 3 months.	Referrals to tertiary facility Referrals back to clinic services Scripts by drug class Counselling sessions Deaths Unnatural deaths	Global Assessment of Functioning

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Some things are already happening…

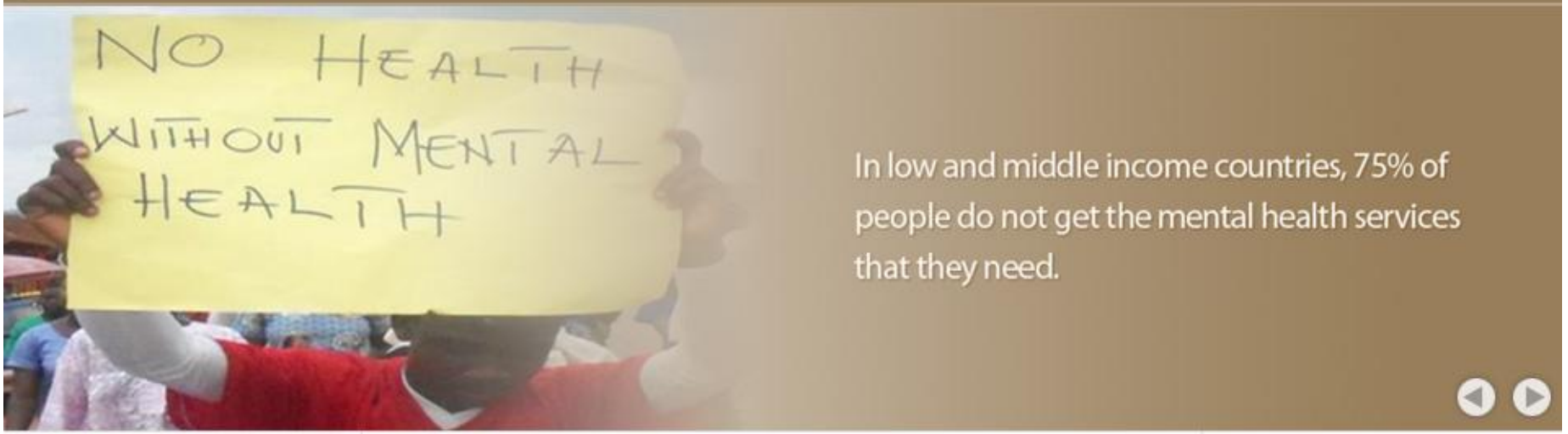
PRIME

programme for improving mental health care

Evidence on scaling-up mental health services for development

search... GO

Home | Background | Research | Partners | People | Mental Health and Development | Research Uptake | Capacity Building | Contact



Download Brochure

Download PRIME brochure

Latest Publications

2nd Lancet Series on Global Mental Health (launches 17 Oct 2011 at 2nd Summit of Movement

PRIME Research District Information

ETHIOPIA

PRIME in the media

12 Jul 2011: PRIME time for new project

11 Feb 2011: New project to PRIME mental health services

Latest Video

- WHO mhGAP video

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PRIME District site: Kenneth Kaunda, North West Province








primary care 101

Integrated guideline | On-site training

Symptom-based approach to the adult in primary care

HIV/AIDS
TB
Asthma/COPD
Diabetes
Cardiovascular disease
Mental health conditions
Women's health
Epilepsy
Musculoskeletal disorders

DEPARTMENT of HEALTH
Provincial Government of the Western Cape

2011/12

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For more details…

- Prof Inge Petersen's presentation tomorrow (Friday):
- 11h15 The inception phase of PRIME-SA. Developing a district mental health plan for the integration of mental health into the re-engineered PHC service platform in the Dr Kenneth Kaunda district

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AFFIRM – SubSaharan Africa Hub

African partners:

- University of Cape Town
- Addis Ababa University
- Makerere University
- University of KwaZulu-Natal
- Stellenbosch University
- Human Sciences Research Council
- University of Ghana
- University of Zimbabwe
- University of Malawi
- BasicNeeds Ghana and Uganda
- Ministries of Health: Ghana, SA, Ethiopia

Other International partners:

- Columbia University
- Centre for Global Mental Health (IoP)
- Johns Hopkins University

Research site

Capacity development partner

Shared project site

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1st Annual NIMH Hubs Meeting, Cape Town, 8-11 Aug 2012

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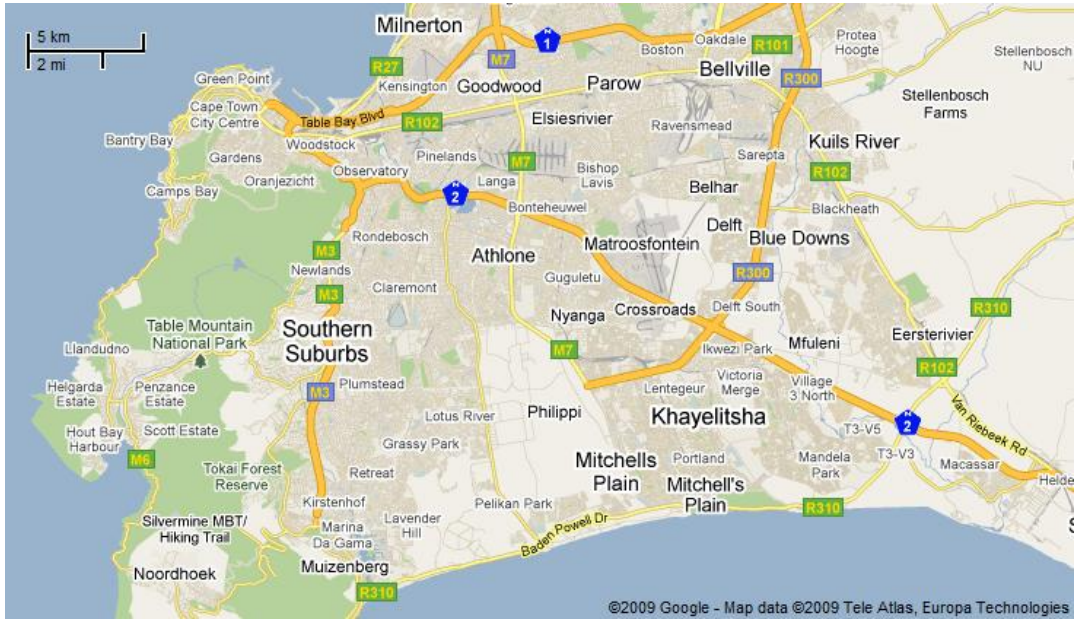
South African trial

Aim: To narrow the treatment gap for maternal depression in South Africa by providing cost-effective care using lay community health workers in Khayelitsha

Three phases:

1. Formative phase (18 months)
   - Consultation with stakeholders
   - Qualitative research
   - Piloting
2. RCT (2 years)
3. Qualitative evaluation (6 months)



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Policy recommendations

- Include mental health in primary care re-engineering and the NHI
- Improve monitoring of mental health delivery and outcomes in primary care

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Acknowledgments

- Dept of Health: Prof Melvyn Freeman, Sifiso Phakathi, Nomvula Sibanyoni, Eva Mulutsi, Dudu Shiba
- PRogramme for Improving Mental health carE (PRIME) South Africa team: Prof Inge Petersen, Prof Arvin Bhana, Dr Lara Fairall : www.prime.uct.ac.za
- Alan J Flisher Centre for Public Mental Health: www.cpmh.org.za
- Department for International Development (DFID)
- National Institute of Mental Health