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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Overview of presentation

- Background to PRIME
- Why integrate mental health in PHC in SA?
- Where & how? Formative Phase of PRIME

programme for improving mental health care
Evidence on scaling-up mental health services for development
Background
Partners

- Centre for Public Mental Health
- WHO
- Centre for Global Mental Health
- Basic Needs
- Perinatal Mental Health Project

- Ethiopia
  - Addis Ababa University, MoH
- India
  - Sangath, PHFI, MP State MoH
- Nepal
  - Healthnet TPO, MoH
- South Africa
  - UKZN, HSRC, UCT, DoH
- Uganda
  - Makerere University, MoH

“The most exciting thing about PRIME is the fact that Ministries of Health in 5 countries, and the WHO, have joined mental health research leaders as equal partners.”

Prof. Vikram Patel, PRIME Research Director
An overview

The purpose of PRIME is to generate world class research on the implementation and scaling up of treatment programmes for priority mental disorders in primary and maternal health care contexts in low resource settings.
The motivation: the treatment gap

- 13% of the global burden of disease is due to mental illness
- The majority live in low or middle income countries
- 1 out of 5 people living with mental illness in low and middle income countries receive treatment

Photo: Mental Health & Poverty Project (MHaPP)
mhGAP

• Adapt & test interventions based on WHO mhGAP IG
• Identify additional resources needed

• Priority disorders
  • Alcohol abuse
  • Depression
  • Psychosis
  • Epilepsy (Ethiopia & Uganda only)
Research phases

- Inception phase
- Implementation phase
- Scaling-up phase

Mental health coverage

Year 0 - Year 6

Time
PRIME-SA - Why
Motivation: South Africa

- Mental disorders rank third in their contribution to the burden of disease in this country\(^1\)
- 1 in 6 South Africans are likely to experience a common mental disorder (CMD) during a 12 month period\(^2\)
  - Only 1 out of 4 people with a CMD receive treatment
- High co-morbidity with HIV/AIDS, cardiovascular disease and diabetes\(^3\)
  - Burden likely to increase with the epidemiological transition to chronic and non-communicable diseases
- CMDs in PLWHAs - compromise adherence to ART & virological suppression\(^4\)

PRIME-SA - Where
Evidence on scaling-up mental health services for development
Kenneth Kaunda District
How?
FORMATIVE PHASE

- Develop a district mental health plan
  - Facilitate the integration of mental health into the re-engineered PHC service delivery platform
- South African focus:
  - Depression and alcohol misuse co-morbid with HIV
  - Maternal depression
  - Psychosocial rehabilitation for chronic psychotic disorders
Methods

1. Situational Analysis
2. Participatory Theory of Change Workshops (ToCs)
3. Formative qualitative interviews with service users & providers
4. One final workshop on the integrated plan
# 1. Situational Analysis

| Population | 632790  
Four sub-districts (2 urban, 2 rural) |
|---|---|
| **Socio-economic characteristics** | **Literacy rate:** 45% in rural areas and 75% in Urban areas  
**Mainly urban (15%)**  
**Life expectancy - 51 years**  
76% flush toilets, 97% clean water, 82% electricity  
**Economic activity:** mining & agriculture |
| **Health priorities** | **Top 3 health conditions – HIV/AIDS, hypertension, TB**  
**HIV prevalence – 30%**  
**82% coverage of ART for eligible population (35 000 per annum)** |
| **Number of PHCs** | 58 PHC facilities  
8 full-time PHC doctors  
Over 100 PHC nurses  
1 CHW per 250 households (new plan)  
Lay counsellors (HIV counsellors)  
Information officers  
Training officers |
| **Number of MH specialists servicing PHC** | 2 Psychiatrists (P/T)  
1 Psychologist  
2 MH Co-ordinators  
(psychotropic medication available at PHCs) |
programme for improving mental health care
2. Participatory Theory of Change Workshops (ToCs)

- Workshops to develop plans for specific disorders
  - One with policy makers, managers and service providers from national through to district PHC facility level (27 participants) (01-02 March 2012)
  - One with community level service providers (CCGs, Traditional healers, NGOs) and users (23 participants) (29 March 2012)
Theory of Change

• Participatory approach which allows participants to develop a plan for achieving the outcomes that they want from an intervention\(^5\)
  • Start with the end goal
  • Work backwards identifying preconditions that need to be achieved to reach the goal
  • Interventions and resources that are needed to achieve the pre-conditions
  • Indicators used to measure each pre-condition
• Helps build consensus among participants

People with priority disorders demand services
People with priority disorders are identified
People with priority disorders are diagnosed
People with priority disorders willing to receive interventions
Interventions available (meds, psycho-social)
People with priority disorders receive quality interventions
People with priority disorders adhere to interventions for intended duration
Improved health, social and economic outcomes for people with priority disorders

Services are accessible, affordable and acceptable for people with priority disorders

Service providers at facility level adequately supervised
Results from ToC Workshops

- Disorder specific plans for different level
- Mental Health Plan South Africa- submitted_EB.docx
• Provides screening for co-morbid mental illness alongside provision of routine care for other chronic conditions (HIV, diabetes, antenatal care)

• Adaptation of WHO’s MhGAP guidelines

• PRIME-SA
  • Strengthen mental health component
    • Stepped care for depression – include counselling component
    • Brief screening & intervention for alcohol misuse
3. Formative qualitative interviews with service providers and service users

- HIV+ service users (SU) with co-morbid depression (20)
- Ante-natal and post-natal SU with maternal depression (20)
- Psychiatric SU and caregivers (20)
- Managers & service providers at national, provincial and district level (6)
Results from formative interviews

• Informed the development of a structured manualized counselling intervention for depression to be delivered by lay counsellors
  
• Section A
  • Basic counselling skills
  • Healthy thinking
  • Getting Active
  • Problem management

• Section B
  • Modules based on emergent themes on triggers/exacerbating factors e.g., internalized stigma, poverty, external stigma, withdrawal/social isolation, partner rejection.
  • Lay counsellor chooses which modules to focus on during initial group/individual session

• Will inform the adaptation of the Basic Needs/KZN manual for psychosocial rehabilitation for chronic psychotic conditions
4. Final Workshop: Integrated Plan

• Participants from both previous workshops (31 participants) (23 Aug 2012)
• Integrated plan (4.).docx
PRIME-SA MHC Plan at a glance

Organizational level
Strengthen the mental health component of the specialist support team to ensure adequate training, support and supervision to facility and community level generalists - diversification of roles. Strengthen Inter-sectoral collaboration esp. with DSD

Facility level
1. Primary Care 101 for PHC nurses and doctors to detect, manage and refer mental disorders.
2. Task sharing of brief treatment interventions for alcohol misuse (PHC nurses), depression co-morbid with HIV & other priority chronic diseases & maternal depression (Lay counsellors)

Community level
Task sharing interventions to community outreach teams:
1. Home visitation programme for maternal depression & depression co-morbid with HIV (enrolled nurse).
2. Psychosocial rehabilitation groups for chronic psychotic disorders (Aux. social workers in collaboration with NGOs and DSD).
Lessons for developing district mental health plan

• ToC process
  • Stakeholders from national to community level (Top down and bottom up)
  • Participatory process
• Increased awareness of service needs and systems requirements to meet these needs
  • District & province taking leadership to increase resources (e.g. motivation for B. Psych posts)
Next Phase (Implementation)

- Implementation site identified
  - Kanana area (65,000 people) serviced by 4 PHC facilities in Matlosana sub-district
- Costing of integrated package
- Motivation for B.Psych counsellor
- Finalization of packages
- Implementation of baseline surveys in identified area
  - Community survey
  - Facility survey
- Training of PHC staff, lay counsellors & Community outreach teams
- Orientation of specialist support personnel
- Implementation of cohort studies for identified disorders
PRIME is a Research Programme Consortium (RPC) led by the Centre for Public Mental Health at the University of Cape Town (South Africa), and funded by the UK government’s Department for International Development (DFID). The project aim is to develop world-class research evidence on the implementation, and scaling up of treatment programmes for priority mental disorders in primary and maternal health care contexts in low resource settings. Partners and collaborators in the consortium include Addis Ababa University and Ministry of Health (Ethiopia), Sangath, Public Health Foundation of India and Madhya Pradesh State Ministry of Health (India), Health Net TPO and Ministry of Health (Nepal), University of KwaZulu-Natal, Human Sciences Research Council, Perinatal Mental Health Project and Department of Health (South Africa), Makerere University and Ministry of Health (Uganda), BasicNeeds, Centre for Global Mental Health (London School of Hygiene & Tropical Medicine and Kings Health Partners, UK) and the World Health Organisation (WHO).