Integrating mental health care in priority health care platforms: addressing the Grand Challenge in Global Mental Health

Vikram Patel

London School of Hygiene & Tropical Medicine, UK

Sangath, Goa, India

Public Health Foundation of India

Priority health care platforms

Settings which are the most frequently accessed gateway for health care

In most countries, equivalent to primary health care, but also include other health care platforms for specific groups, for e.g. maternal and child health and HIV/AIDS

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The case for integration

Access

Equity

HOW?

Holistic

Patient-centred

Reducing stigma

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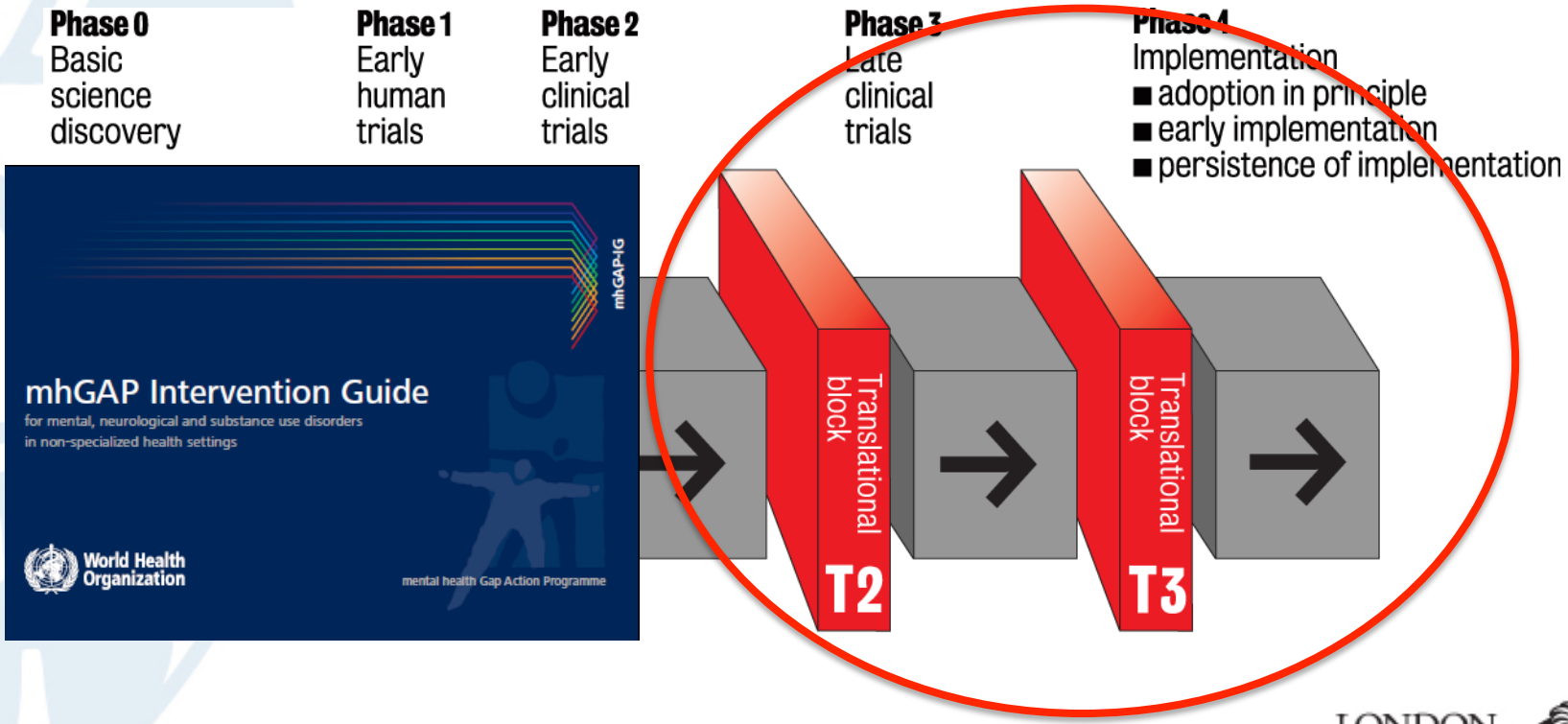
The translational continuum

Thornicroft et al, 2011



PLoS Medicine 2013
Integrating mental health: a global Perspective

- **Grand Challenges in Global Mental Health:**

OPEN ACCESS Freely available online

PLOS | MEDICINE

Policy Forum

Grand Challenges: Integrating Mental Health Services into Priority Health Care Platforms

Vikram Patel[1,2,3]*, Gary S. Belkin[4,5], Arun Chockalingam[6], Janice Cooper[7,8], Shekhar Saxena[9], Jürgen Unützer[10]

1 Centre for Global Mental Health, London School of Hygiene & Tropical Medicine, United Kingdom, **2** Sangath, Goa, India, **3** Centre for Mental Health, Public Health Foundation of India, India, **4** Program in Global Mental Health, New York University School of Medicine, New York, United States of America, **5** New York City Health and Hospitals Corporation, New York, United States of America, **6** Simon Fraser University, Burnaby, Canada, **7** The Carter Center Mental Health Liberia Program, Rollins School of Public Health, Emory University, United States of America, **8** College of Science & Technology, University of Liberia, Monrovia, Liberia, **9** Department of Mental Health and Substance Abuse, World Health Organization, Switzerland, **10** Division of Integrated Care and Public Health, Psychiatry and Behavioral Sciences, University of Washington, Seattle, United States of America

Image Credit: Flickr Ms. Phoenix

Morbid Mental Illness
http://www.plosmedicine.org/article/info%3Adoi%2F10.1371%2Fjournal.pmed.1001447

- **Grand Challenges: Integrating Mental Health Services into Priority Health Care Platforms**
http://www.plosmedicine.org/article/info%3Adoi%2F10.1371%2Fjournal.pmed.1001448

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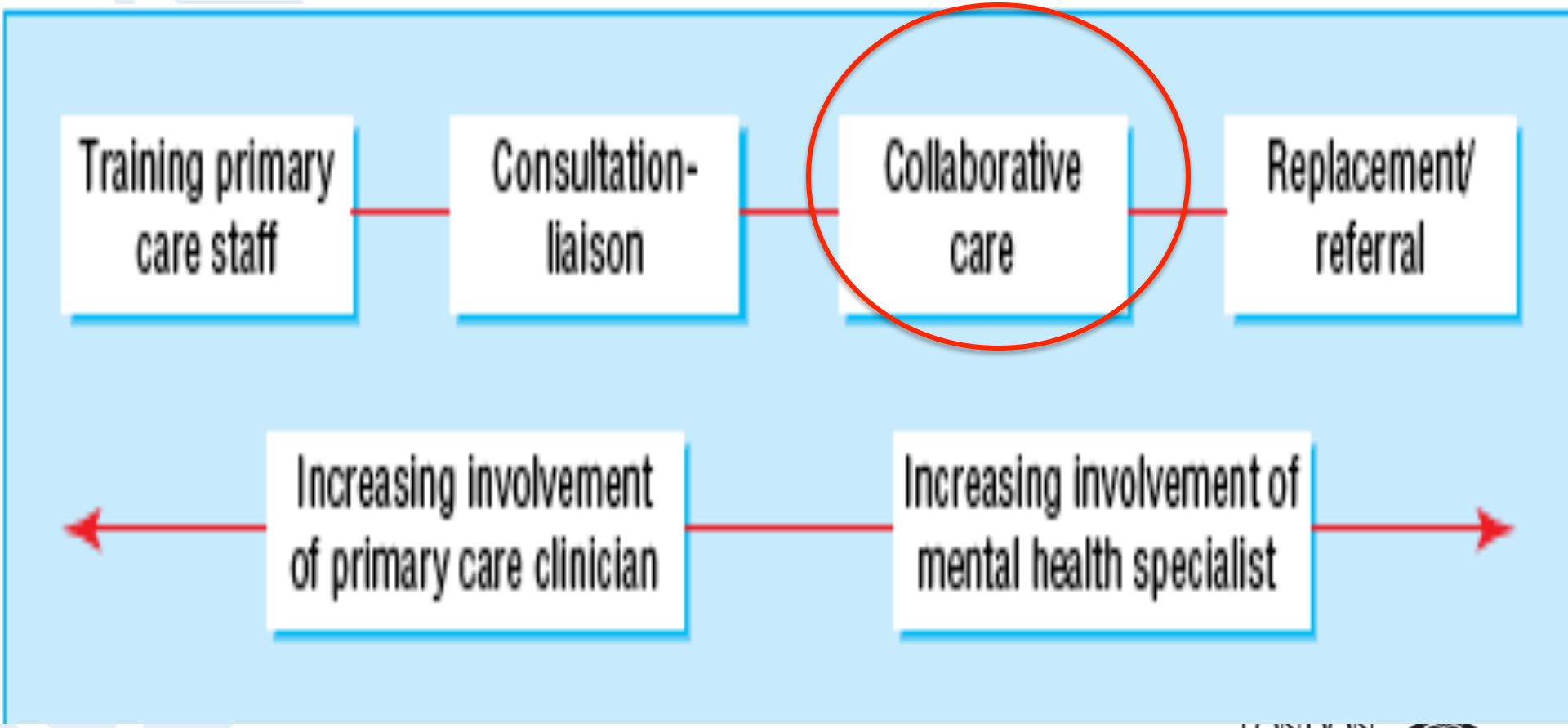
Addressing barriers to integration



Bower 2005

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Collaborative Care

- >20 randomized controlled trials from high-income countries showing improved health outcomes for people with depression
- TEAM-care trial showing effective integration of depression care with other chronic diseases

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Five key ingredients

Pro-active case finding strategies, for e.g. screening

Engagement and empowerment of patients and families

Targeted, evidence based psychological, pharmacological and social interventions

Pro-active outcomes tracking and quality improvement

Specialist supervision and consultation

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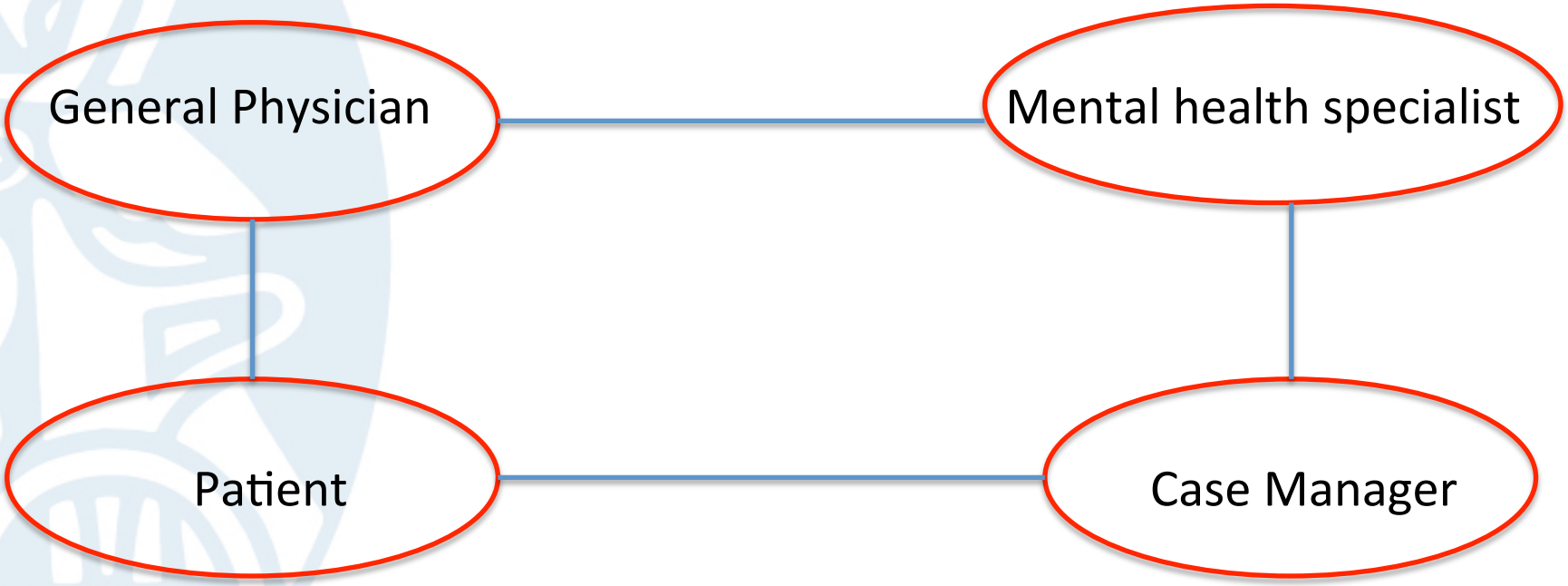
The collaborative team



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Case management

Case finding

Engagement and 'psychoeducation'

WHO?

Supporting treatment adherence

Follow-up tracking

Provision of structured psychological treatments

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The MANAS program

To evaluate the effectiveness of a **lay health counsellor** led Collaborative Stepped Care intervention for the treatment of Common Mental Disorders in Primary Care in Goa, India

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Study design

- Effectiveness trial in real world setting comparing two models of services in primary care
  - Enhanced Usual Care (EC)
  - Collaborative Stepped Care (CSC)

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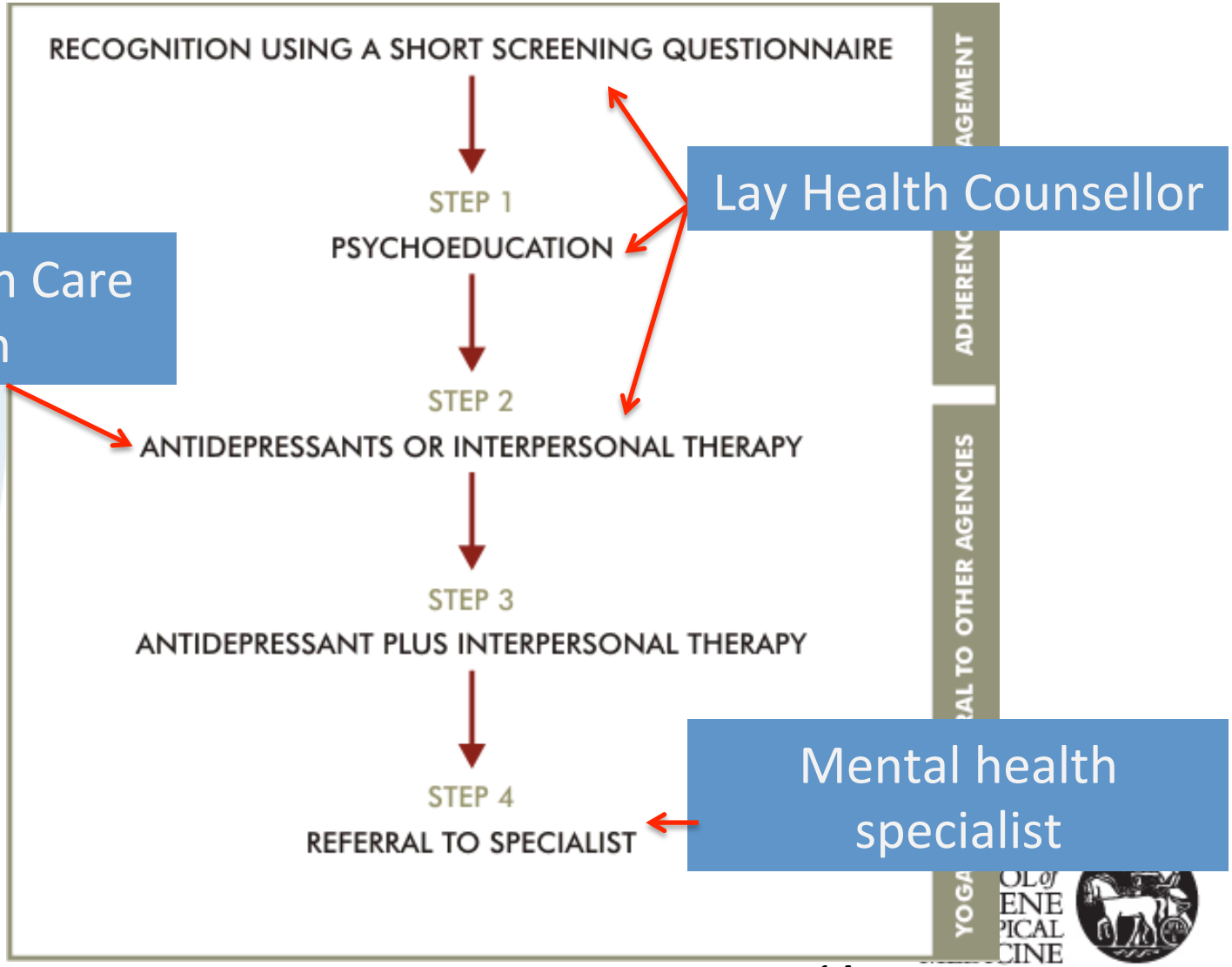
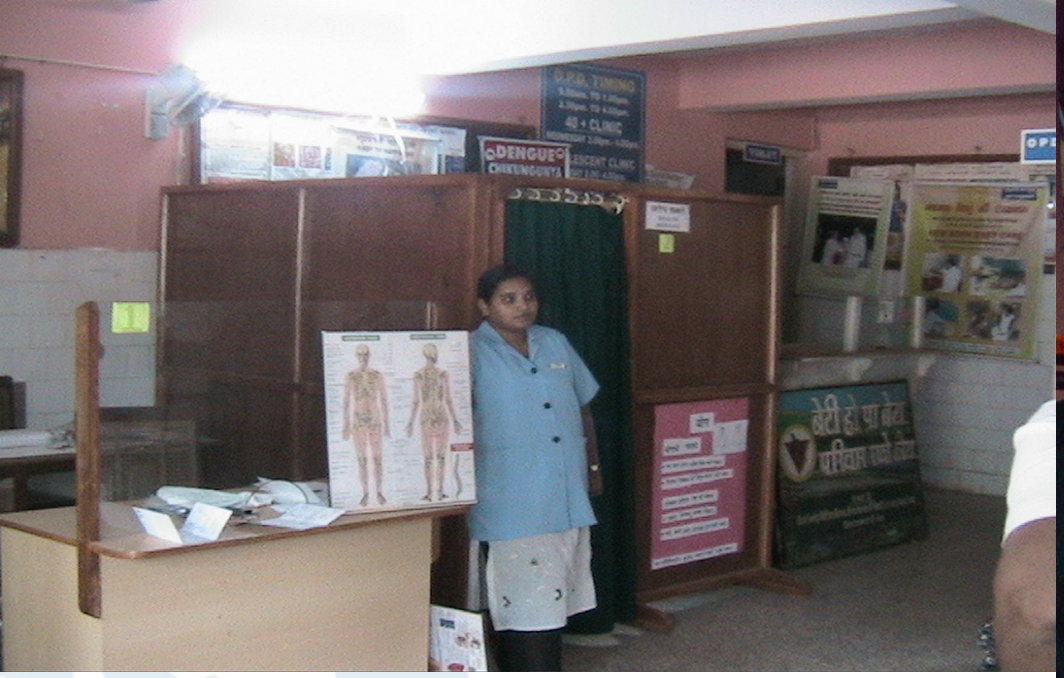
The 'enhanced' model of care

- Screening for CMD: using a brief tool, the GHQ -12
- Reporting of results to doctor: Results presented as absent/mild/moderate-severe depression
- Provision of guidelines on how to use cost-effective antidepressants

Collaborative Stepped Care Intervention




O.P.D. TIMING
40 + CLINIC
DENGUE
CHIKUNGUNYA


वेळार उपाय केलो जाल्यार मनावयलो ताण कमी जावक शकता
तुमका आरोग्याच्यो ह्यो तक्रारी आसात ?
• न्हीद पडना
• काळजान धडधडता
• रोकडेच पुरो जाता
• तकली उसळता
• कसलेय काम करपाक बेजार येता
शांत मनान चिंतन करप, हे सगळ्या प्रश्नांचेर खरे वखद
आरोग्याकडेन दुर्लक्ष करनाकात आरोग्यकेंद्रान वचून स्वत:ची तपासणी करून घेयात
काळजावयलो ताण कमी करप, म्हळयारच भांगराची जीण जगप
घर माहितीखातीर प्राथमिक आरोग्य केंद्रान आरोग्य सल्लागाराक मेळात !


Malaria Control
आरोग्य सल्लागार
HEALTH COUNSELLOR
वेळार उपाय केलो जाल्यार मनावयलो ताण कमी जावक शकता
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RESEARCH REPORT

Integrating evidence-based treatments for common mental disorders in routine primary care: feas inte

Articles

SUDIPT
RICARD
KATHLE

Effectiveness of a for depressive an India (MANAS): a

Vikram Patel, Helen A Weiss, Neerja Cho
Ricardo Araya, Michael King, Gregory Sir

Summary

Lay health worker led intervention for depressive and anxiety disorders in India: impact on clinical and disability outcomes over 12 months

Vikram Patel, Helen A. Weiss, Neerja Chowdhary, Smita Naik, Sulochana Pednekar, Sudipto Chatterjee, Bhargav Bhat, Ricardo Araya, Michael King, Gregory Simon, Helena Verdeli, Betty R. Kirkwood

Background
Depressive and anxiety
are the most common
primary healthcare.

RESEARCH Open Access

The integration of the treatment for common mental d health ca India

Bernadette Pereira[1],

Contents lists available at SciVerse ScienceDirect

Social Science & Medicine

journal homepage: www.elsevier.com/locate/socscimed

ELSEVIER

Research

Economic evaluation of a task-shifting intervention for common mental disorders in India

Christine Buttorff,[a] Rebecca S Hock,[b] Helen A Weiss,[c] Smita Naik,[d] Ricardo Araya,[e] Betty R Kirkwood,[f] Daniel Chisholm[g] & Vikram Patel[f]

Objective To carry out an economic evaluation of a task-shifting intervention for the treatment of depressive and anxiety disorders in primary-care settings in Goa, India.
Methods Cost–utility and cost–effectiveness analyses based on generalized linear models were performed within a trial set in 24 public and private primary-care facilities. Subjects were randomly assigned to an intervention or a control arm. Eligible subjects in the intervention arm were given psycho-education, case management, interpersonal psychotherapy and/or antidepressants by lay health workers. Subjects in the control arm were treated by physicians. The use of health-care resources, the disability of each subject and degree of psychiatric

Outcomes over 12 months in PHC attenders

(Patel et al, Br J Psychiatry, 2011)

- 30% decrease in the prevalence of common mental disorders among baseline ICD-10 cases (RR=0.70, 95%CI 0.53, 0.92)
- 36% reduction in suicide attempts/plans months among baseline ICD-10 cases (RR=0.64, 95%CI 0.42, 0.98)
- 5-6 fewer days of disability in the past month than those in the control arm

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The economics

(Buttroff et al, Bull WHO 2012)

- Economic analyses show that the intervention is associated with reduced health care costs in both settings

- Thus, in PHCs, the intervention is DOMINANT in economic terms (more effective and cost-saving)

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wellcome trust

The effectiveness of non-specialist health workers in delivering mental health care in LMIC

The evidence base

- Randomised controlled trials
  - 17 RCTs
- 2 Non randomised controlled trials
- 9 Controlled before and after studies

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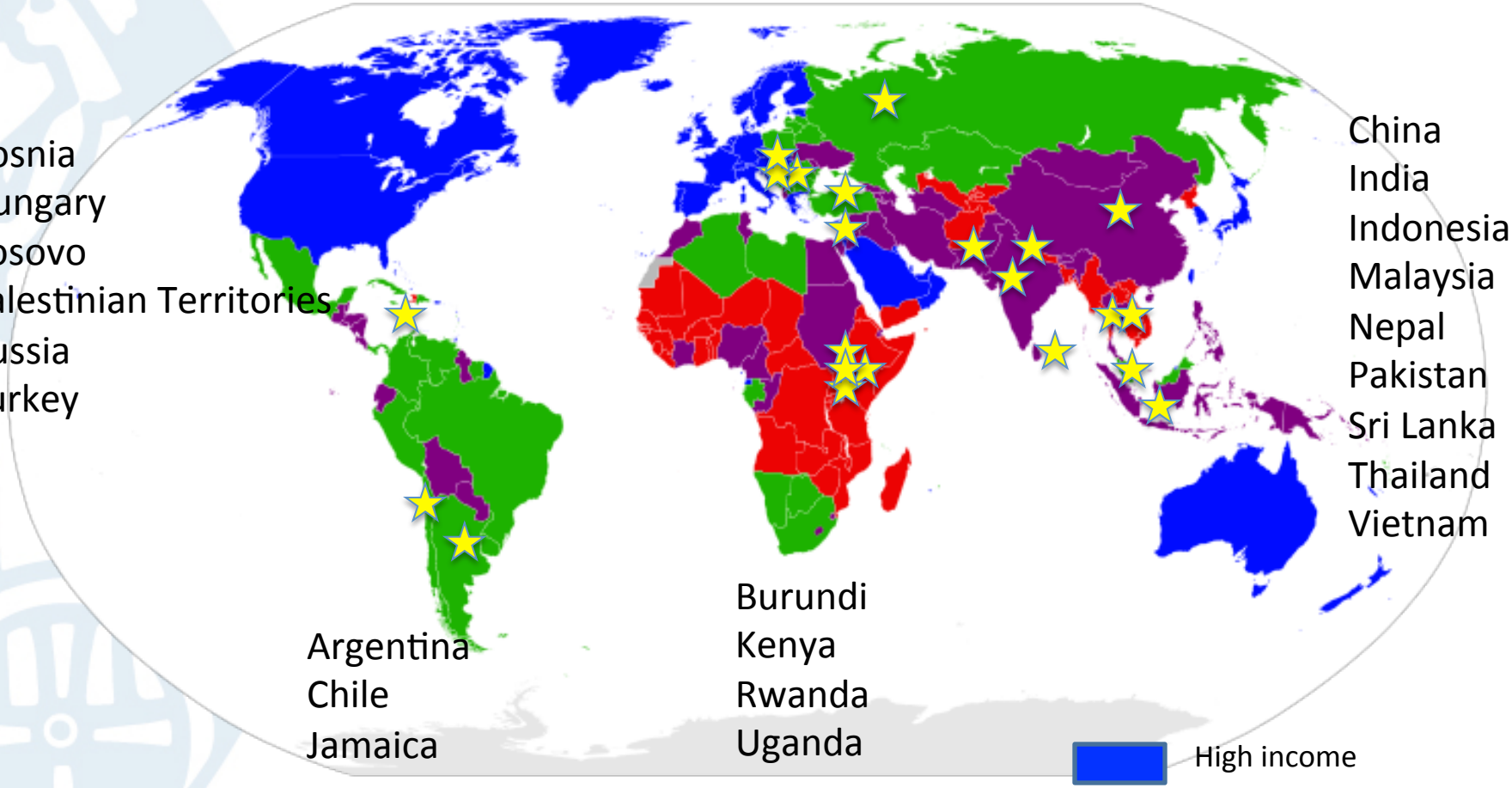
LMICs covered by the review



Countries based on World Bank income groupings (2006)

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Types of non-specialists

- Non-specialist health workers (NSHW):
  - **Doctors (9)**
  - **Nurses (6)**
  - **Social workers (3)**
  - Other paraprofessionals
  - **Lay health workers (LHWs) (22)**
- Other professionals with health roles (OPHR):
  - **Teachers (6)**
  - School support workers
  - Community based workers etc

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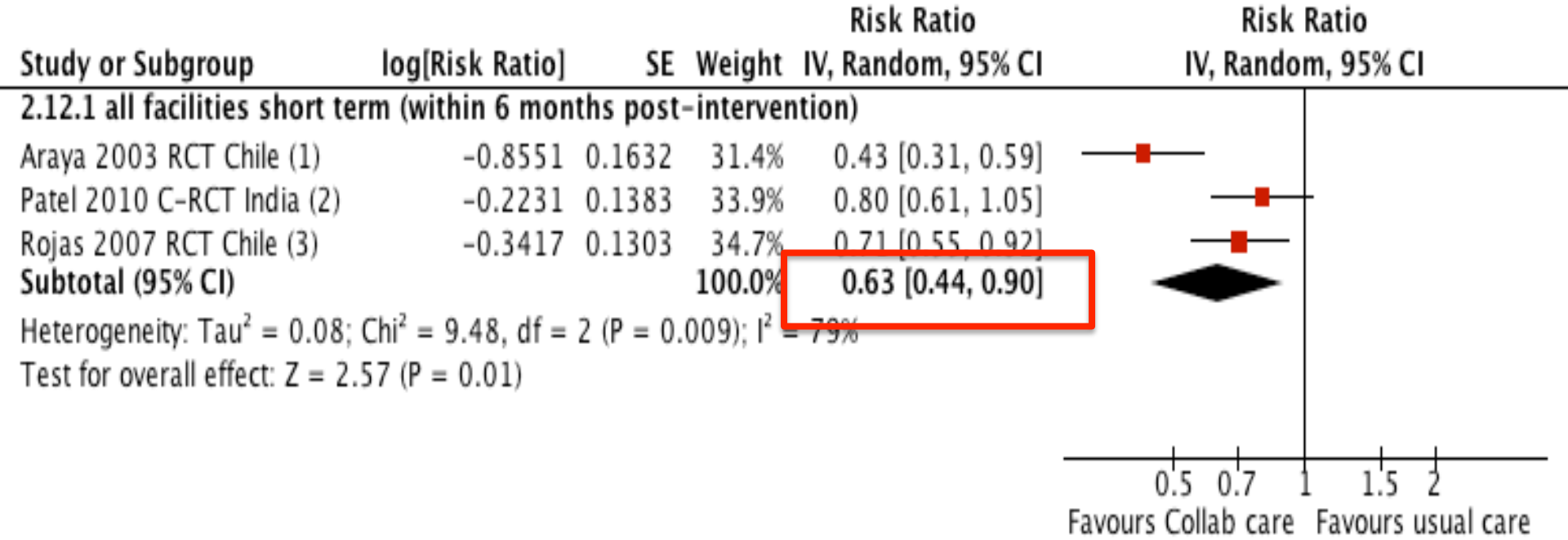
NSHW led Collaborative care Prevalence of CMDs



(1) Collab model for persistent recurrent depression;HRDS scores<8 (ie recovered) at 6 months; transformed to fit with Patel preva

(2) stepped care for CMDs; CIS-R; 6 month prevalence of CMDs adjusted RRs

(3) collab care for post natal depression; nb of patients with EPDS 6 point reduction 3 mths post-int (=6 mths post baseline).prev c

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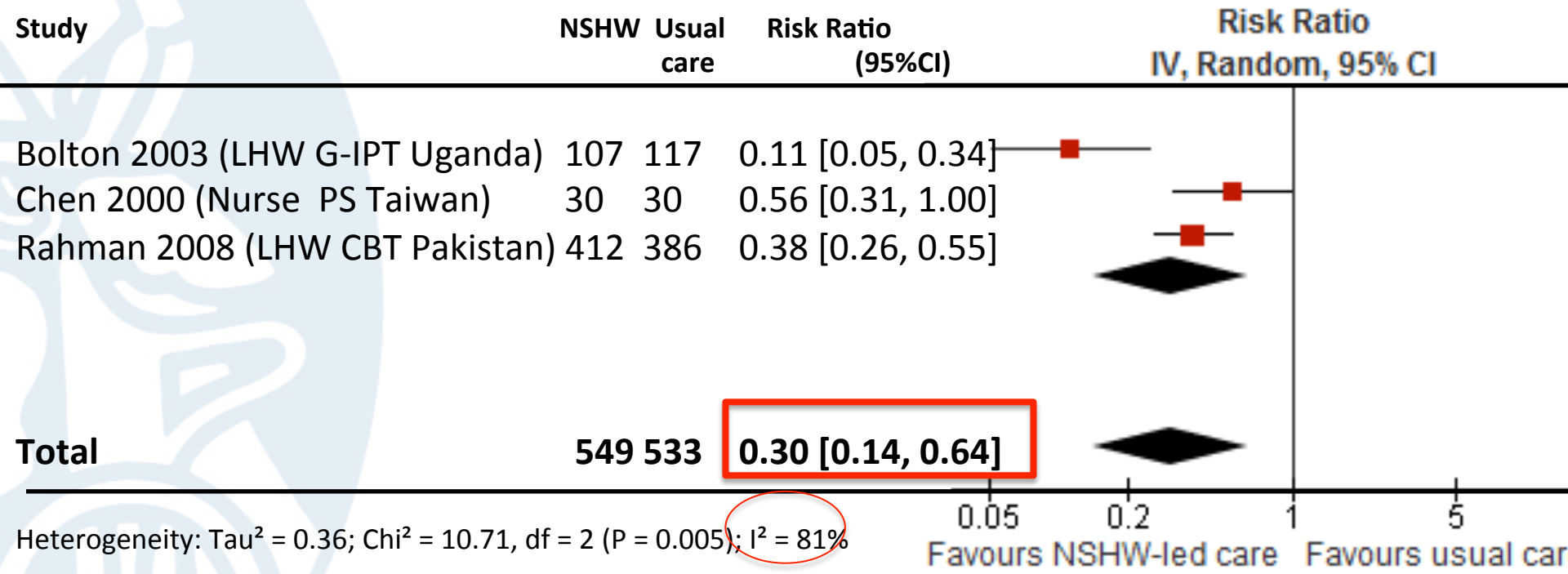
NSHW psychological interventions prevalence of depression



GRADE overall quality: low

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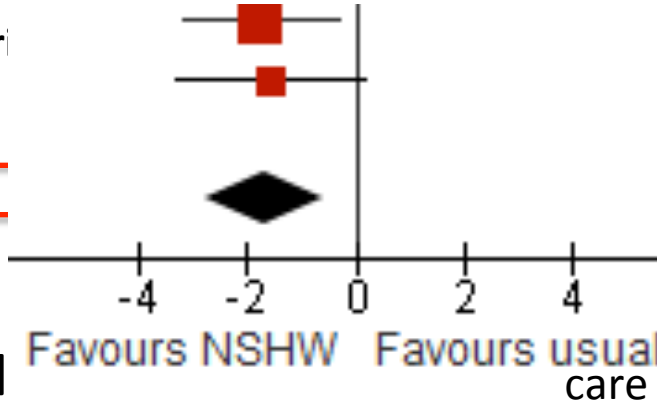
NSHW psychological interventions
Amount of alcohol consumed

Study	NSHW	Usual care	Mean difference (dr (95%CI)
Noknoy 2010 Nurse MET Thailand	51	41	-1.76 [-3.19, -0.33]
Papas 2011 LHW CBT Kenya	42	33	-1.56 [-3.30, 0.18]
Subtotal (95% CI)	**93**	**74**	**-1.68 [-2.79, -0.57]**

Heterogeneity: $Tau^2 = 0.00$; $Chi^2 = 0.03$, df = 1 (P = 0.86); $I^2 = 0\%$



GRADE overall quality:
Low quality evidence

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The human experience

Experiences of people with schizophrenia, their family members and the collaborative team in a trial of community based care in India

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SUNDAR

Simplify the message

UNpack the treatment

Deliver it where people are

Affordable and available human resources

Reallocation of specialists to train and supervise

A paradigm shift

From whining about what we do not have, to celebrating what we do, we move from being ‘under-resourced’ to being ‘richly resourced”

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Implementation

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PRIME

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.

Photo: Mental Health & Poverty Project (MhaPP)

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Partners

Centre for Public Mental Health, South Africa; 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, DoH, Uganda: Makerere University, MoH

Principles

1. Focus on priority conditions: depression, alcohol use disorders, schizophrenia, epilepsy (in two countries)
2. Use building blocks of a mental health plan at 3 levels:
   - Components of care for specific disorders
   - Packages for delivering components
   - Mental health care plan for the district/AHU
3. Methodological framework: MRC framework for evaluation of complex interventions
4. Focus on key disadvantaged groups: the poor, women and people living with mental illness

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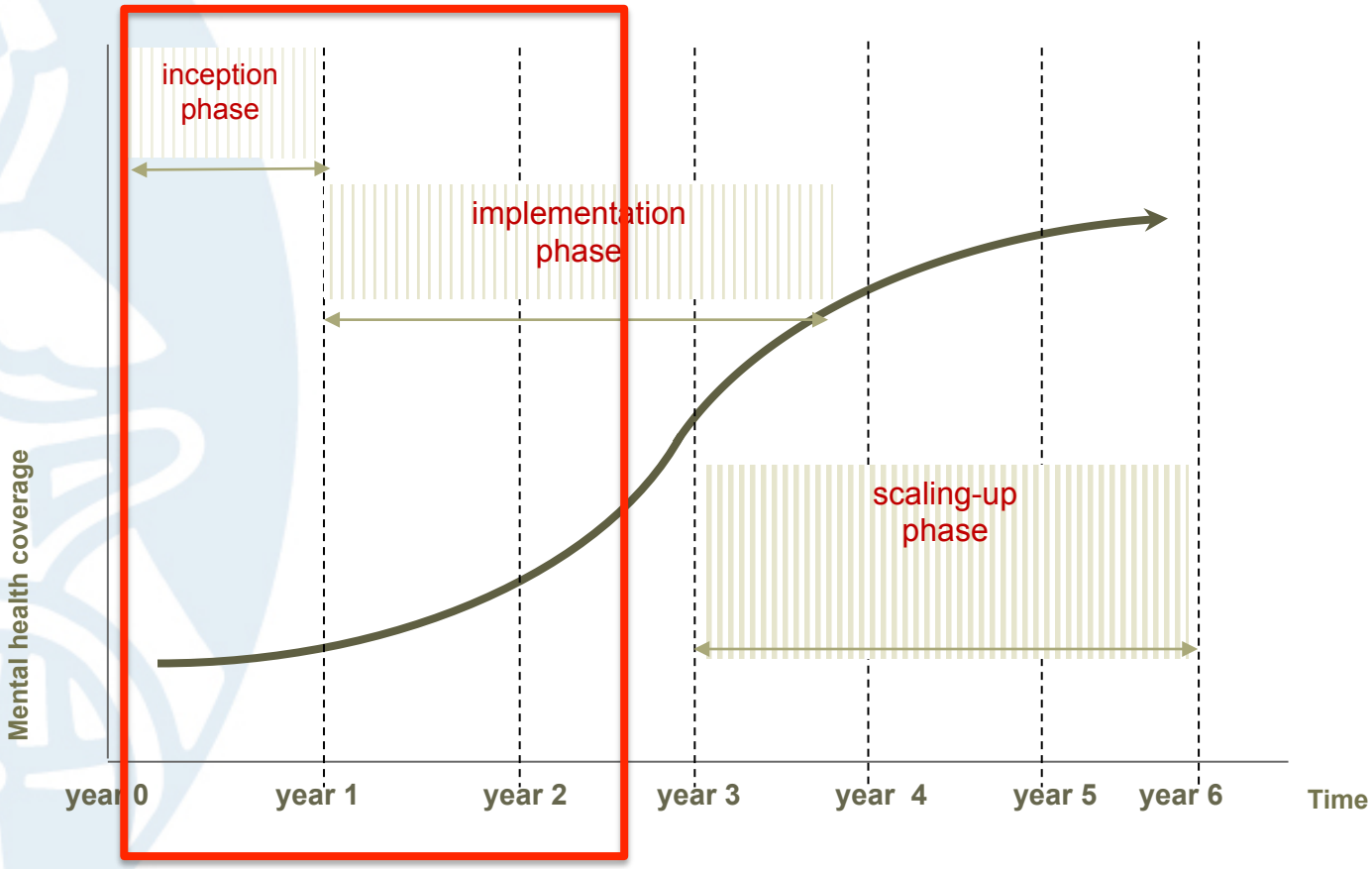
Country sites

Country	District	Population	Number of PHCs	Socio-economic characteristics	Number of MH specialists
Ethiopia	Sodo	165,000	8	Literacy rate: 22%; 90% rural	None
India	Sehore (Madhya Pradesh state)	1,311,008	15	Literacy rate: 71% 81 % rural	1 part-time psychiatrist, 1 psychologist
Nepal	Chitwan	575,058	4	Literacy rate: 70% 73% rural	2 Psychiatrists
South Africa	Kenneth Kaunda (North West Province)	632,790	28	Literacy rate: 88% 14% rural	1 Psychiatrist, 1 Psychologist
Uganda	Kamuli	740,700	41	Literacy rate: 62% 97% rural	1 Psychiatric Clinical Officer

Research phases



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Development of mental health care plans

- Literature Reviews
- Situational analysis
- Qualitative formative research
- Development of a Theory of Change
- mhGAP costing tool

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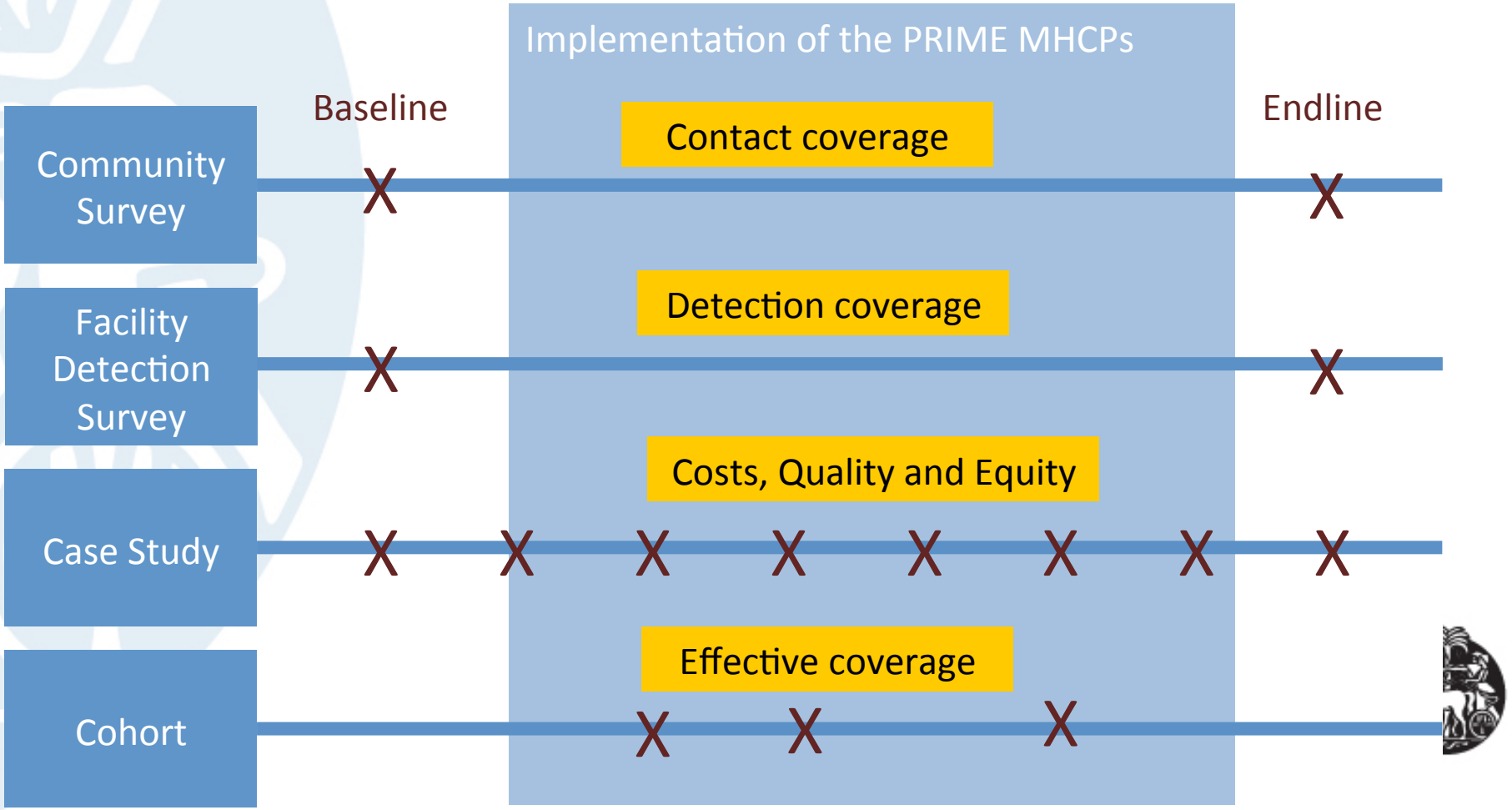
Mental Health Care Packages

	Demand	Detection	Treatment	Recovery	Enabling
Healthcare organisation	Engage and mobilise district stakeholders				Programme management, HMIS, Capacity Building
Specialist MH services			Provision of specialist care to complex cases	Provision of case reviews for complex cases	Ensure specialist MH care interfaces with PHC
Health Facility	Increase awareness of service users and providers	Detect/carry out screening and assessment for priority disorders	Provide psychotropic medication and basic psychosocial interventions	Ensure continuing care	Build capacity of facility staff to deliver facility level packages
Community	Improve awareness and decrease stigma	Improve case detection in the community	Provide basic psychosocial interventions and peer support	Promote rehabilitation & recovery	Build capacity of community to support mental health care

Evaluation


Implementation of the PRIME MHCPs
Baseline
Endline
Community Survey
Contact coverage
Facility Detection Survey
Detection coverage
Case Study
Costs, Quality and Equity
Cohort
Effective coverage

Scaling Up

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The Chile CC trial for depression

(Araya et al, Lancet 2003)

% Recovered

	Usual Care	Collaborative Care	Difference
3-MONTH	15%	**49%**	34%
6-MONTH	**30%**	**70%**	**40%**

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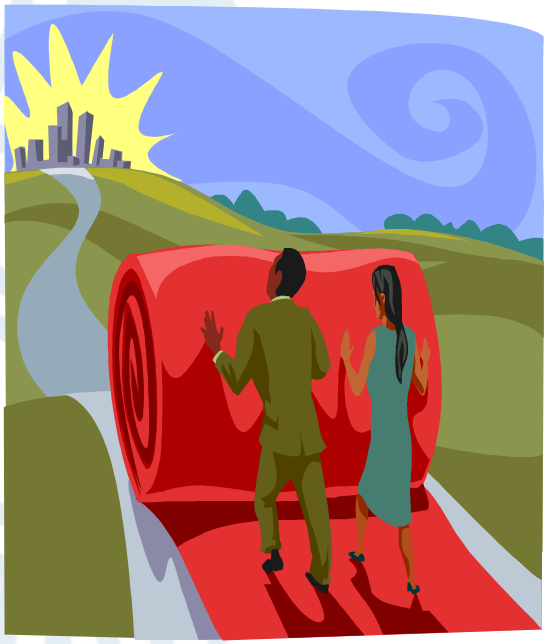
Two Major Government Initiatives



- 2003 - Depression in Primary Health Care (PHC) Programme
- 2004-5 - Regime of Explicit Health Guarantees (AUGE)

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Depression in PHC Programme

Number of people treated by year

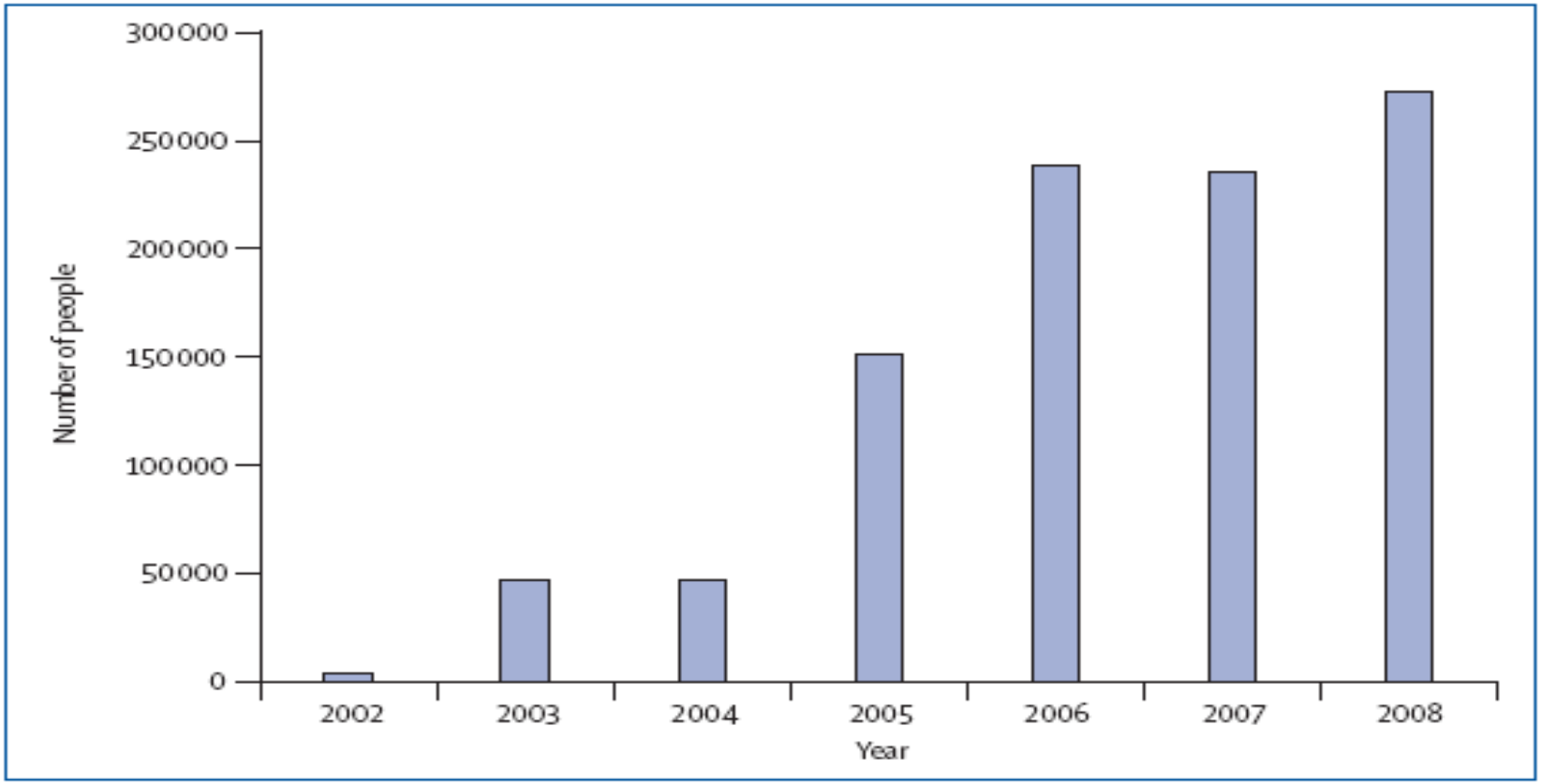

Figure: Number of people receiving treatment in the Chilean public health-care sector, 2002–08

Araya et al. *Lancet* 374: 59-8, 2009

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Reducing Inequalities: Access to treatment for depression according to education before and after reforms

		DEPRESSION			HYPERTENSION		
		2003	2010	P	2003	2010	P
		%	%		%	%	
Sex	*Women*	41.6	66.3	<0.001	76.9	77.1	0.939
	Men	42.7	33.5	0.430	47.9	56.9	0.056
Education	*> 12 yrs*	57.1	60.8	0.795	47.7	65.3	0.093
	8-12 yrs	37.4	55.3	0.012	58.3	64.5	0.178
	< 8 yrs	40.3	66.5	0.001	69.3	70.6	0.863

Araya & Zitko, manuscript in preparation

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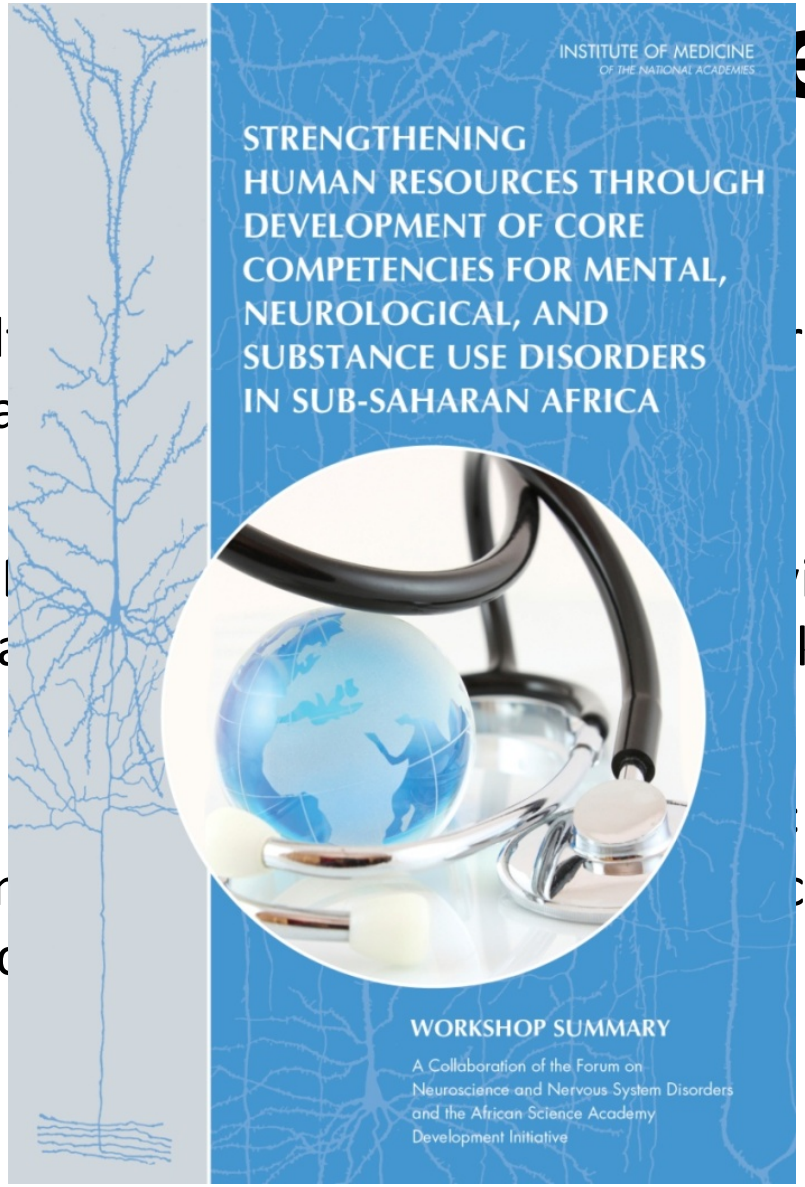
The I ence

- New Mental Heal re in the most accessible and lea
- Radically revised ith new cadre of community/prima ker
- New partnership Society and PHFI to launch a natior core competencies in mental health c



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Building the evidence base

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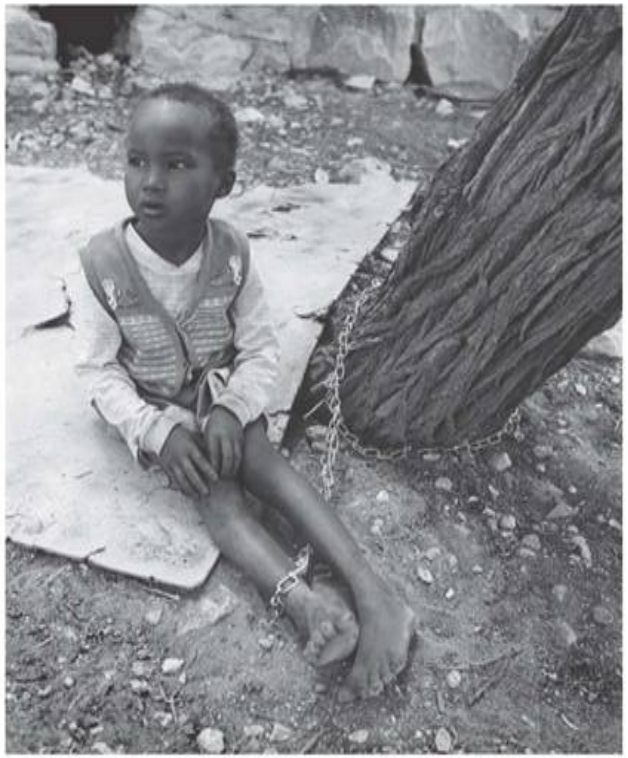
COMMENT



H. TIMMERMANS/GLOBAL INITIATIVE ON PSYCHIATRY

Improving treatment for children with mental illness, like this girl in Somalia, is an urgent priority.

Grand challenges in global mental health

A consortium of researchers, advocates and clinicians announces here research priorities for improving the lives of people with mental illness around the world, and calls for urgent action and investment.

Schizophrenia, depression, epilepsy, dementia, alcohol dependence and other mental, neurological and substance-use (MNS) disorders constitute 13% of the global burden of disease (Table 1), surpassing both cardiovascular disease and cancer[1]. Depression is the third leading contributor to the global disease burden, and alcohol and illicit drug use account for more than 5% (ref. 2). Every seven seconds, someone develops dementia[3], costing the world up to US$609 billion in 2009 (ref. 4). By 2020, an estimated 1.5 million people will die each year by suicide, and between 15 and 30 million will make the attempt[5].

The absence of cures, and the dearth of preventive interventions for MNS disorders, in part reflects a limited understanding of the brain and its molecular and cellular mechanisms. Where there are effective treatments, they are frequently not available to those in greatest need. In 83% of low-income countries, there are no anti-Parkinsonian treatments in primary care; in 25% there are no anti-epileptic drugs[6]. Unequal distribution of human resources — between and within countries — further weakens access: the World Health Organization's European region has 200 times as many psychiatrists as in Africa[7]. Across all countries, investment in fundamental research into preventing and treating MNS disorders is disproportionately low relative to the disease burden[8].

To address this state of affairs, the Grand Challenges in Global Mental Health initiative has identified priorities for research in the next 10 years that will make an impact on the lives of people living with MNS disorders. The study was funded by the US National Institute of Mental Health (NIMH) in Bethesda, Maryland, supported by the Global Alliance for Chronic Diseases (GACD), headquartered in London. Answers to the questions posed will require a surge in discovery and delivery science. We use the term 'mental health' as a convenient label for MNS disorders. We exclude conditions with a vascular or infectious aetiology (such as stroke or cerebral malaria), because these fell within the scope of the two previous grand challenges initiatives — in global health and in chronic non-communicable diseases[9].

This initiative differs from previous priority-setting exercises for mental ▶

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Priority actions

Collins et al, 2011

Top 5 challenges ranked by disease-burden reduction, impact on equity, immediacy of impact and feasibility.

	Challenge
1	**Integrate screening and core packages of services into routine primary health care**
2	**Reduce the cost and improve the supply of effective medications**
3	**Improve children's access to evidence-based care by trained health providers in low- and middle-income countries**
4	**Provide effective and affordable community-based care and rehabilitation**
5	**Strengthen the mental-health component in the training of all health-care personnel**

Opportunities

- New resources: >70m US$ in past two years from a range of donors such as NIMH, DFID, the EU and Grand Challenges Canada

- New global networks, with strong South-South collaborations, involving over 50 institutions globally

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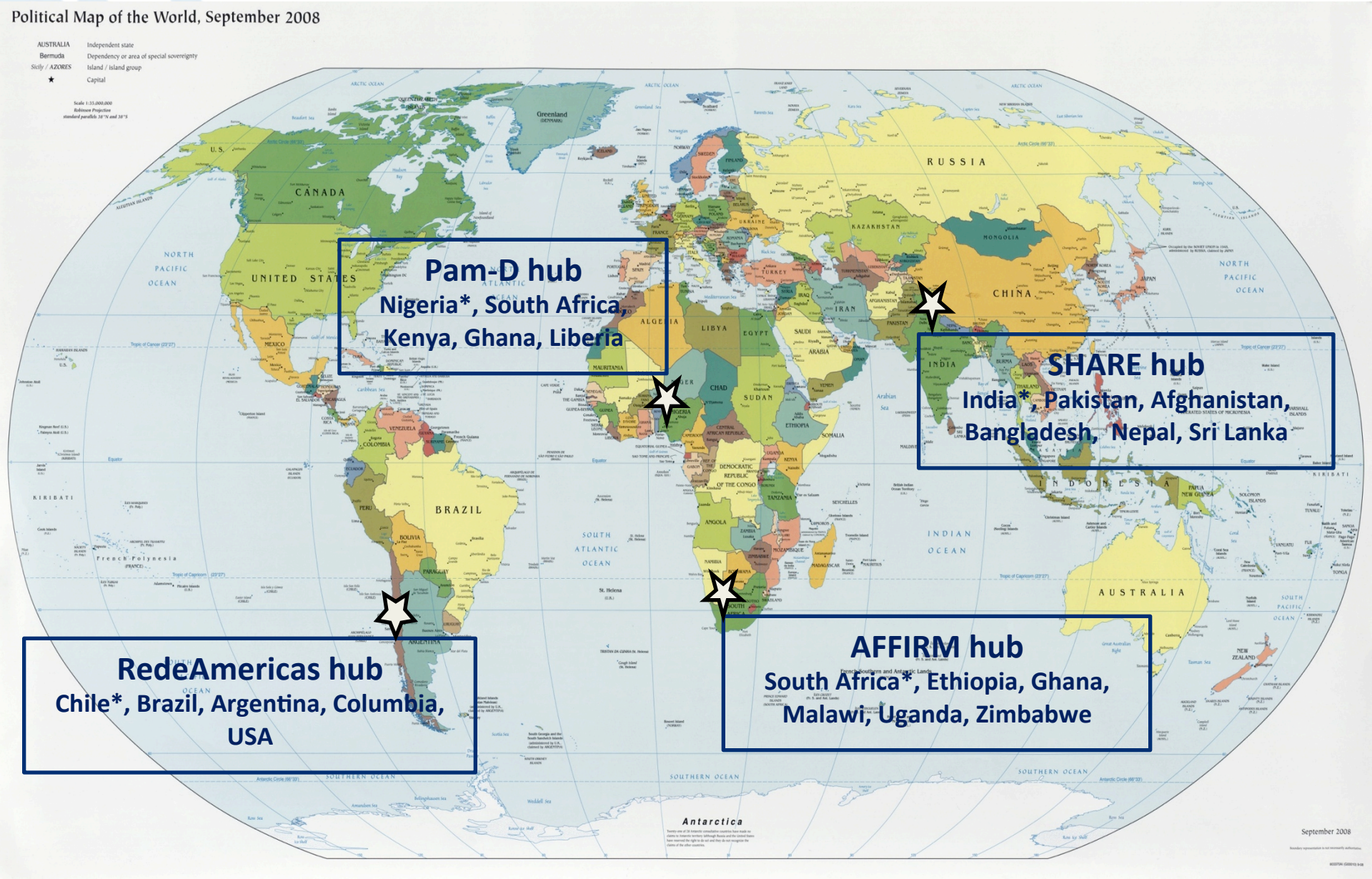
NIMH Collaborative Hubs for International Research in Mental Health in low- and middle-income countries



2013 Grand Challenge

Integrating Mental Health into Chronic Disease Care Provision in Low- and Middle-Income Countries

- Healthy Options: Group psychotherapy for HIV-positive depressed perinatal women (Smith Fawzi)
- Integrated care for co-morbid depression and diabetes in India (Ali)
- The depression hypertension COACH study (Yeates)
- Integrating depression care for acute coronary syndrome patients in low-resource hospitals in China (Wu)
- COBALT: Comorbid Affective Disorders, AIDS/HIV, and Long Term Health (Thornicroft)

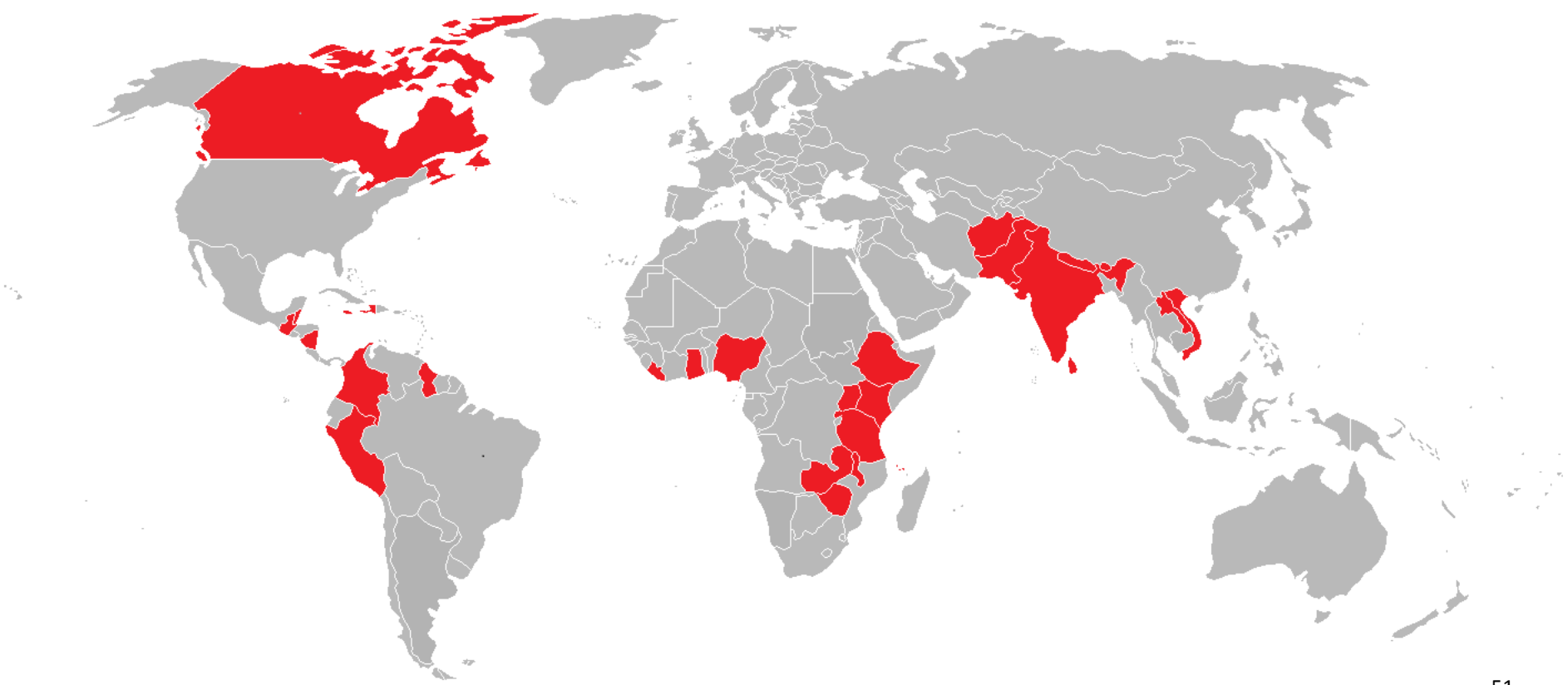
1 more to be funded !

RFA-MH-13-040, expired

NIH National Institute of Mental Health

Grand Challenges Canada Global Mental Health Program

Total of 35 grants implementing mental health innovations in 28 low- and middle-income countries (>20MCan$)



A rapidly growing knowledge base of innovations

- Rapidly growing number of innovations in diverse contexts
- Need to prospectively document, synthesize and disseminate the findings of these innovations for diverse audiences, from policy makers to practitioners to researchers
- Ultimate goal: to facilitate knowledge sharing and research uptake to maximize impact on population mental health

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Platform for Innovations in Global Mental Health

Grand Challenges Canada™
Grands Défis Canada™
BOLD IDEAS FOR HUMANITY.™

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Global Mental Health

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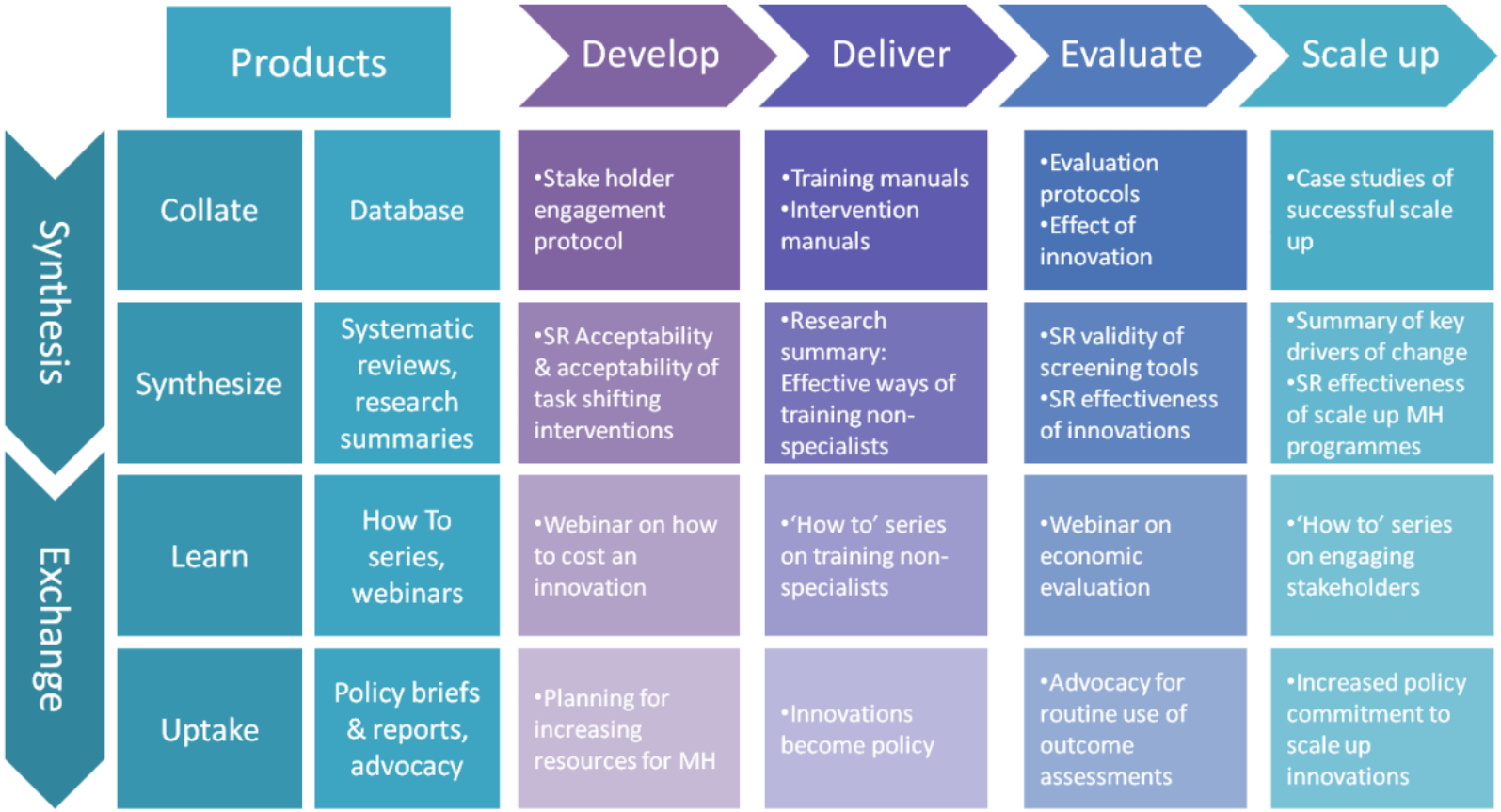
World Health Organization

Platform Framework



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Website

Accessible + Functional

Intuitive, user-driven interface

Links with other initiatives

MGMH
Movement for Global Mental Health

MENTAL HEALTH & PSYCHOSOCIAL SUPPORT NETWORK

Webinars

Online groups and forums

vimeo LinkedIn

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Conclusion

Wide and growing acknowledgment of the need to address mental health problems through routine health care in global health

Foundation of effective and cost-effective treatments for a range of MNS disorders

Growing evidence base on how these treatments can be delivered in routine health care settings, primarily based on collaborative care models led by appropriately trained and supervised non-specialist health workers

Growing commitments at international and national policy levels for investing in such integrated models of care

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