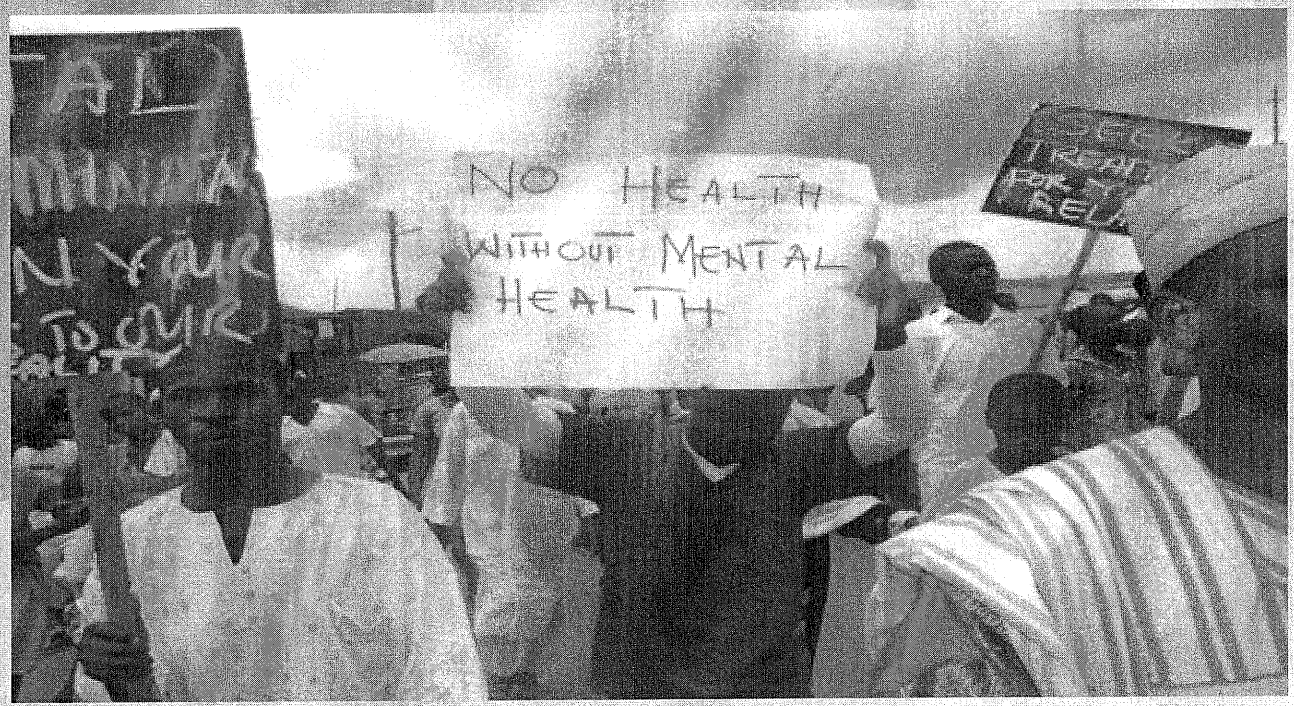
Presented at the World Mental Health Symposium, Pietermaritzburg, 7 Oct 2010.

Community-Based Approaches to Treating Depression

HSRC Human Sciences Research Council

UNIVERSITY OF KWAZULU-NATAL

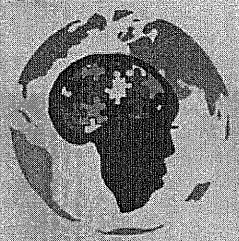


Arvin Bhana & Inge Petersen

Key Messages of Lancet Global Mental Health Series 2007[1,2]

- No health without mental health
- Mental disorders disproportionately affect poor and socially marginalized
- Scarce and inequitably distributed resources for mental health in LMICs
- Growing evidence of cost-effectiveness of psychosocial treatments - delivered by community or general health workers in LMICs
- Barriers to scaling up: stigma, poor human resource capacity, weak general health care systems, weak public health perspective, lack of political will

1.Patel et al. 2009. Scaling up services for MNDs in low resource settings. 2009. *International Health.*
2. www.globalmental health. org



Key strategies for scaling up mental health services[1]

- Advocacy efforts to increase public-health priority given to mental health
- Shift from institutional to community-based care
- Integrate mental health into general health care through task shifting
- Diversify roles of the specialist workforce - include supervisory and supportive roles to non-specialists
- Expand non-specialist community-based workforce

1. Lancet Global Mental Health Group, 2007. Scaling up services for mental disorders – a call for action. Lancet

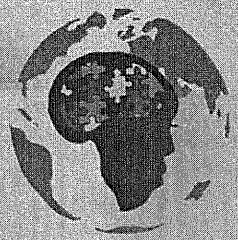
Initiatives in response to Lancet Series (2007)

- WHO Mental Health Gap Action Programme (mhGAP) – 9 packages of care for mental, neurological and substance-abuse disorders[1]
- PLoS Medicine has published a series of articles on packages of care for 6 MNDs
- Establishment of Movement for Global Mental Health:www.globalmentalhealth.org

1.WHO . 2008 . *Mental Health Gap Action Programme (mhGAP)*. Geneva: WHO

Gap

- Re-conceptualize problem of poor mental health in LMICs from purely increasing access to mental health services – to one of increasing access to mental health
  - Empowering community members to have control over their mental health
    - Engage in public mental health efforts to address social determinants of mental ill-health



Key challenges

- Integrate packages of care with existing service delivery systems[1]
- Integrate a community participatory framework into service delivery systems
  - Intervention studies using community participatory approach for isolated programmes/packages[2,3,4,5]
- Need for studies – benefits and challenges of integrating community participatory framework within primary care delivery systems

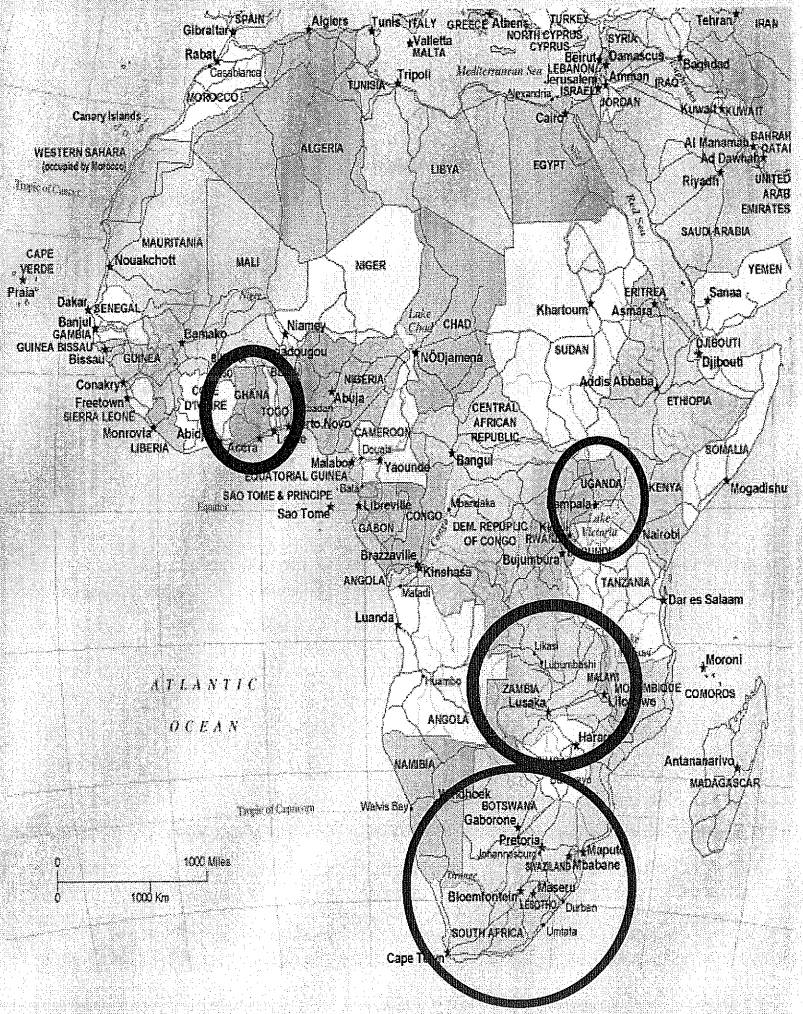
1.Patel et al. 2009. Scaling up services for MNDs in low resource settings. 2009. *International Health.*
2.Chatterjee et al. 2009. Outcomes of people with psychotic disorders in a community-based rehabilitation programme in rural India. *British Journal of Psychiatry*
3.Bell et al. 2008. Building protective factors to offset risky sexual behaviours amongst black youth. *JNMA*
4.Bolton et al. 2003. Group interpersonal psychotherapy for depression in rural Uganda: a randomized control trial. *JAMA.*
5.Cooper et al. 2009. Improving the quality of the mother-infant relationship and infant attachment in a socio-economically deprived community in a South African context: a randomised controlled trial. *BMJ*

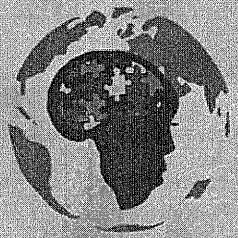
Focus of this presentation

- Report on a case study - integrating a community participatory framework in service delivery systems as part of a district demonstration site in rural SA
  - Describe implementation of framework
  - Report on benefits and challenges

Mental Health and Poverty Project (MHaPP)

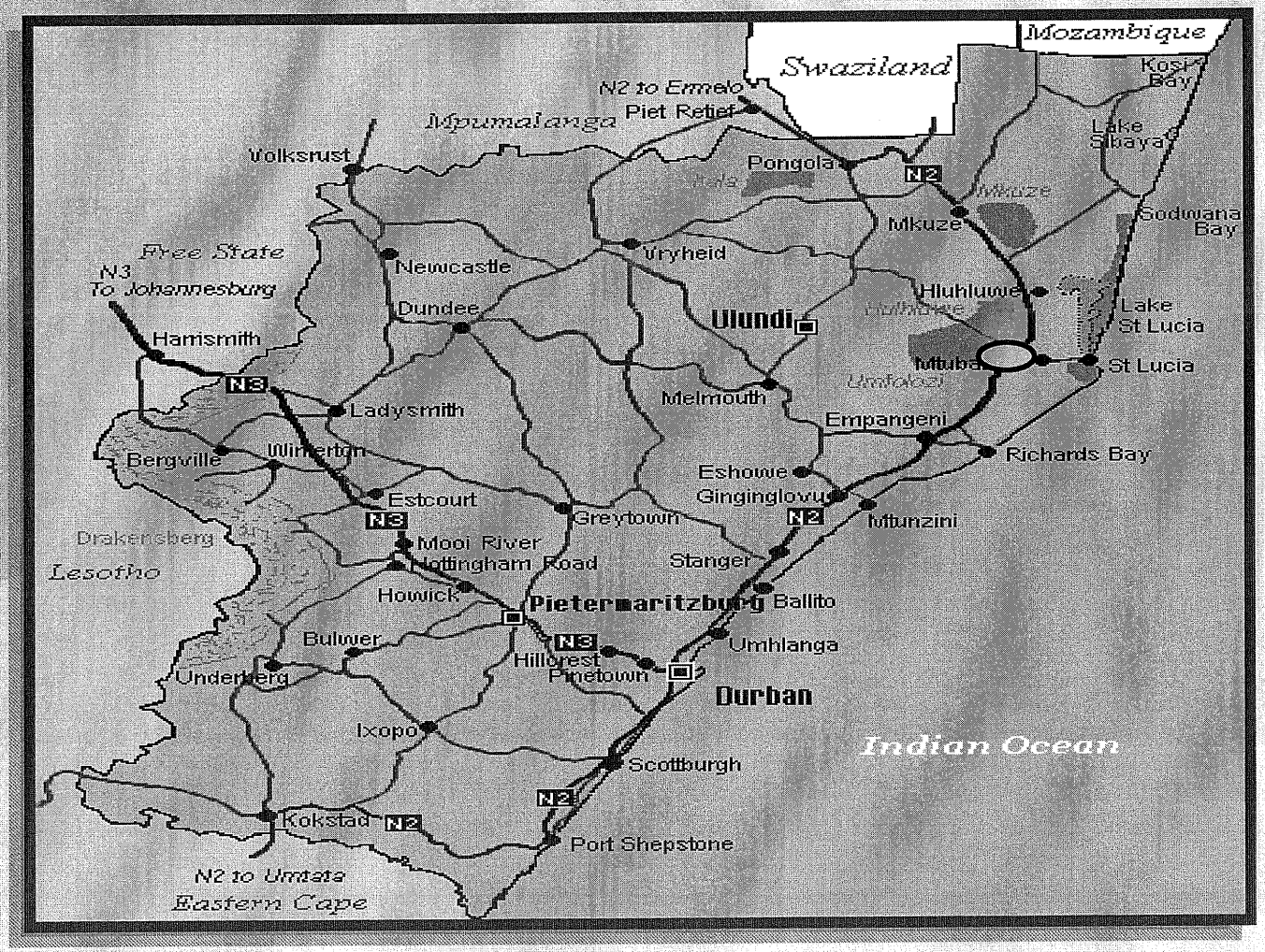
- Ghana, South Africa, Uganda, Zambia





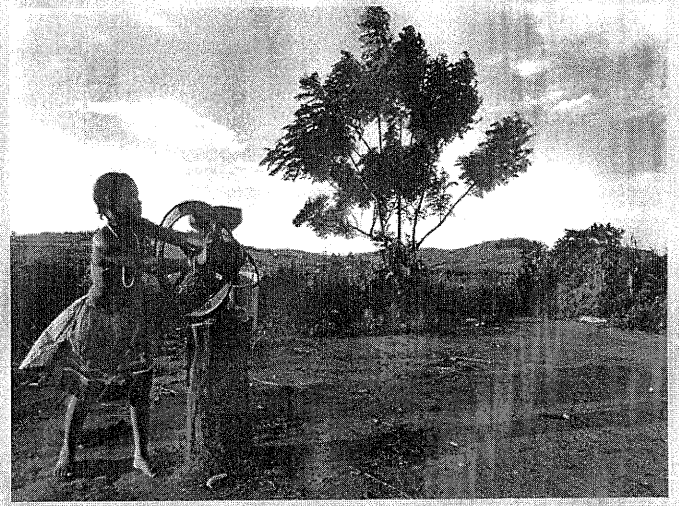
District demonstration site in South Africa

Hlabisa sub-district



Description of site

- Hlabisa sub-district - typical of most rural areas in South Africa
- Demonstration site was within a DSA area - population of 85 000 people
- Serviced by 6 primary health care clinics linked to a sub-district hospital.

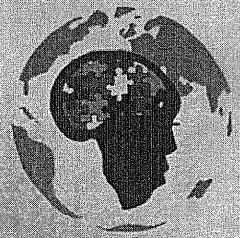


Source: www.africacentre.ac.za

Why focus on depression?

- Most prevalent 12 month individual disorder in South African adults (4.9%)[1]
- Pre/postnatal depression high 34% (Khayelitsha)[2] , 41% at attending ante-natal clinics (rural KZN)[3]
- Depression linked to physical ill-health[4]
  - Cardiovascular disease
  - Diabetes
  - Poor maternal and child health
  - HIV

1. Williams et al. 2008.12-month mental disorders in South Africa: prevalence, *Psychological Medicine*
2. Cooper et al 1999 Post-partum depression and the mother-infant relationship. *Brit J Psych*
3. Rochat et al 2006 Depression among pregnant rural women in SA. *JAMA*.
4. Prince et al. 2007. No health without mental health . *Lance*



PARTICIPATORY IMPLEMENTATION FRAMEWORK

1. Evidence-based community partnership research approach[1]

- Elements of health services research
  - improve access & quality of mental health care & enhance sustainability
- Community intervention research
  - promotes cultural congruence and community competency and control over mental health

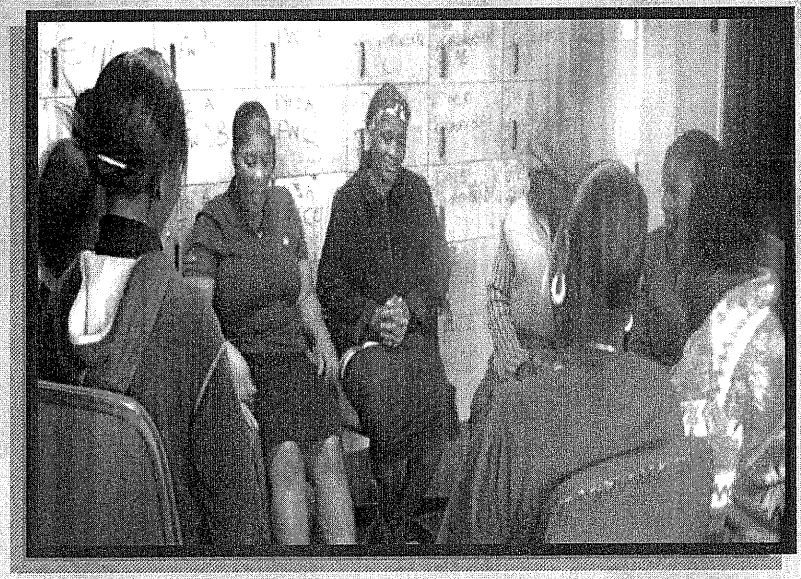
Wells et al. 2004. Bridging community and health services research. *American Jnl of Psychiatry*

2.Capacitating community members to provide MHC

- Existing CHWs (30) were trained to:
  - Identify mental disorders
  - Refer
  - Provide basic counselling
  - Provide a manualised adapted version of Interpersonal Therapy (IPT) for depression

3.Peer facilitated user groups

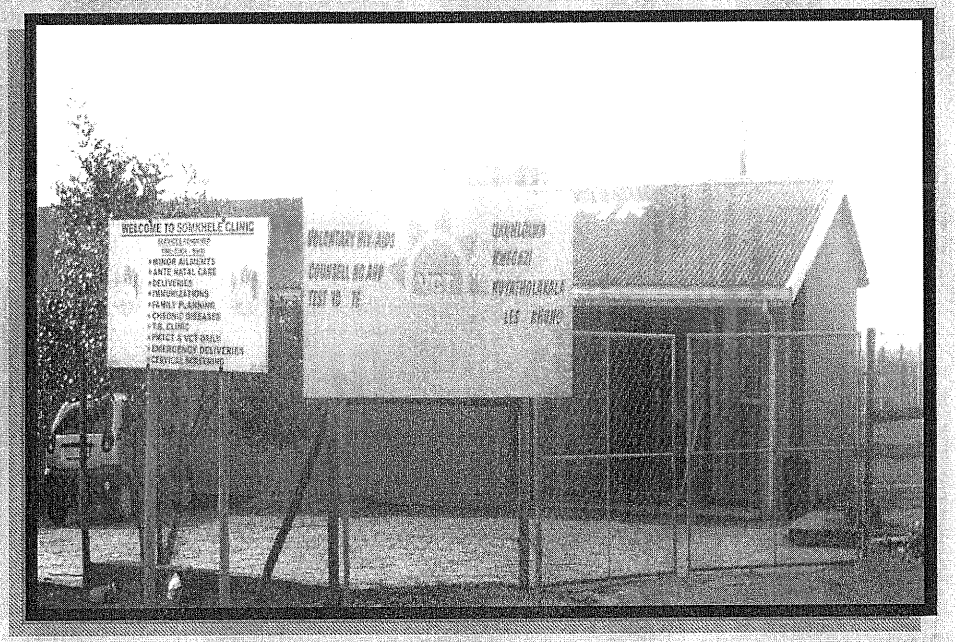
- Two community members trained to facilitate groups for people screened for moderate to severe depression using an adapted manualized IPT approach.
- Issues included:
  - Grief/bereavement
  - Interpersonal disputes
  - Finding out your HIV+ status
  - Financial stress
  - Becoming a mother



[1]Petersen , Bhana , Baillie . under submission. Adapting Interpersonal Therapy (IPT) for the treatment of depression by community health workers within the context of task shifting in South Africa. A feasibility study

4.Support for community care-givers

- Technical and emotional support
- Expansion of roles of mental health specialists to include training, support & supervision
- Introduction of a mental health counsellor (B.Psych qualification) at PHC clinic level



EVALUATION

Methodology

- Qualitative interviews
  - 4 focus groups with CHWs (15)
  - 2 peer group facilitators
  - 9 group participants
  - Mental health counsellor
  - 4 PHC nurses
  - 2 psychiatric nurses
  - 2 health managers
  - 2 community leaders

26 community members

11 healthcare providers

Methodology (cont)

- Users screened by MHC for depression
  - SRQ (1st stage screening)
  - Beck Depression Inventory (BDI), Hopkins Symptom Checklist (HSCL -25) (2nd stage screening)
- Participants with moderate to severe depressive symptoms placed in 4 intervention groups (30) or control group (30) over 12 weeks
- BDI and HSCL-25 administered at baseline, 12 weeks and 24 weeks

FINDINGS

Mobilization of resources for mental health

- Increased priority afforded to mental health in public health sector reflected in increased dedicated resources

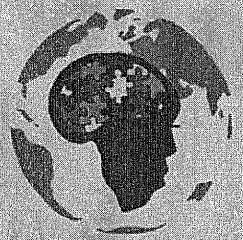
> *You know we have allocated Sister S (an additional psychiatric nurse) to run with mental health… Sister K is also assisting and then of course the psychologist (newly appointed) is helping so there is more representation in general for mental health. Then of course we've also got Sister N who is helping out in the clinics with the mental health side of things (sub-district health manager).*

- Mobilization of some resources from community e.g., community hall

Improved mental health literacy

- Community participation improved mental health literacy & help seeking

I found that it was very helpful to get together with the group; it really helped me because most times we black people don't have the knowledge that mental and emotional problems can be treated. We just know them as things you just live with until it kills you…
Most of them are hearing now how successful it was and are now asking 'you really went there? What did you do there? How do you become part of it?', and I tell them what we do and how it happens (group participants)



Decreased stigma

- Participation – potential to reduce stigma

So 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 (community leader).

Feasibility of peer facilitated IPT groups[1]

- Retention
  - 23 (77%) completed the programme over the 12 week period
- Dosage
  - 23 participants attended 8-12 sessions
  - Over 50% attending all 11-12 sessions.

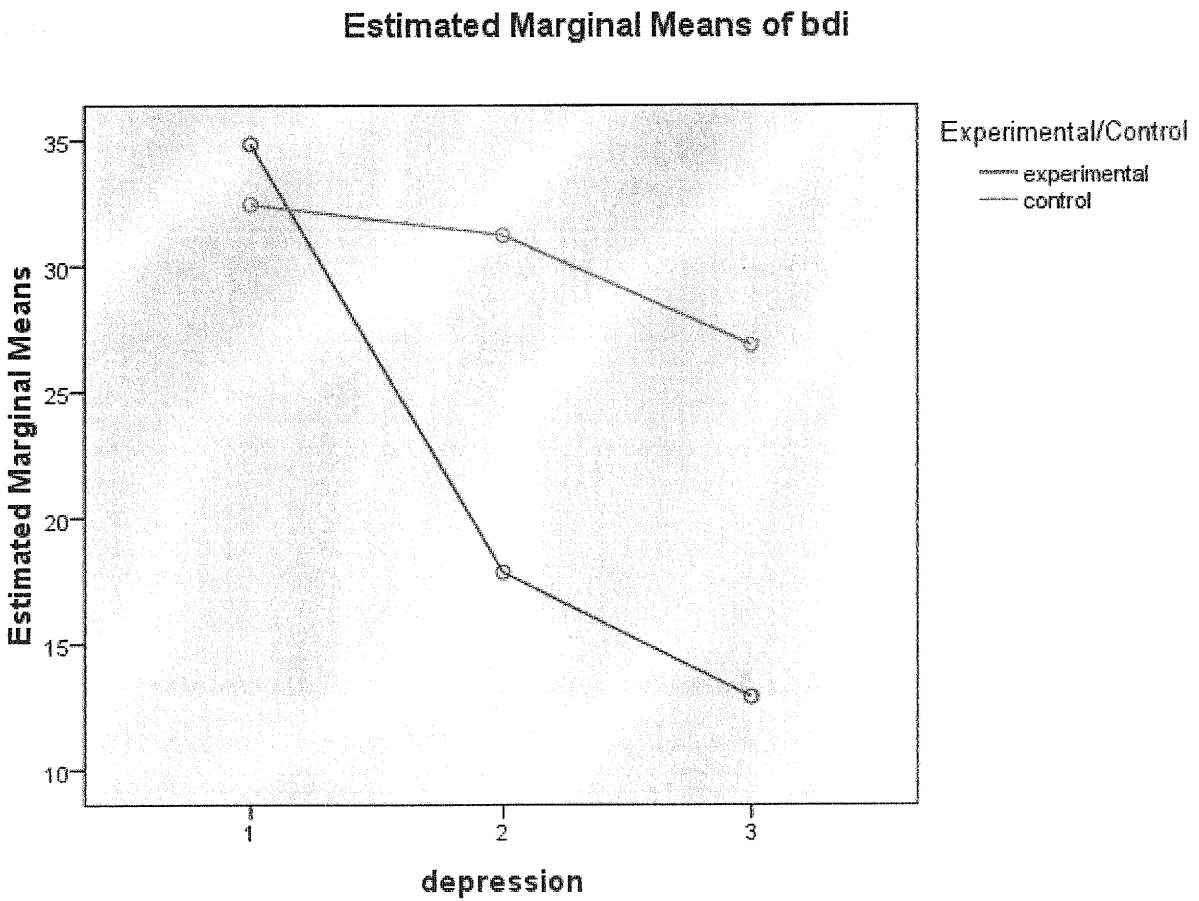
[1]Petersen , Bhana , Baillie . under submission. Adapting Interpersonal Therapy (IPT) for the treatment of depression by community health workers within the context of task shifting in South Africa. A feasibility study

Results of outcome measures[1]

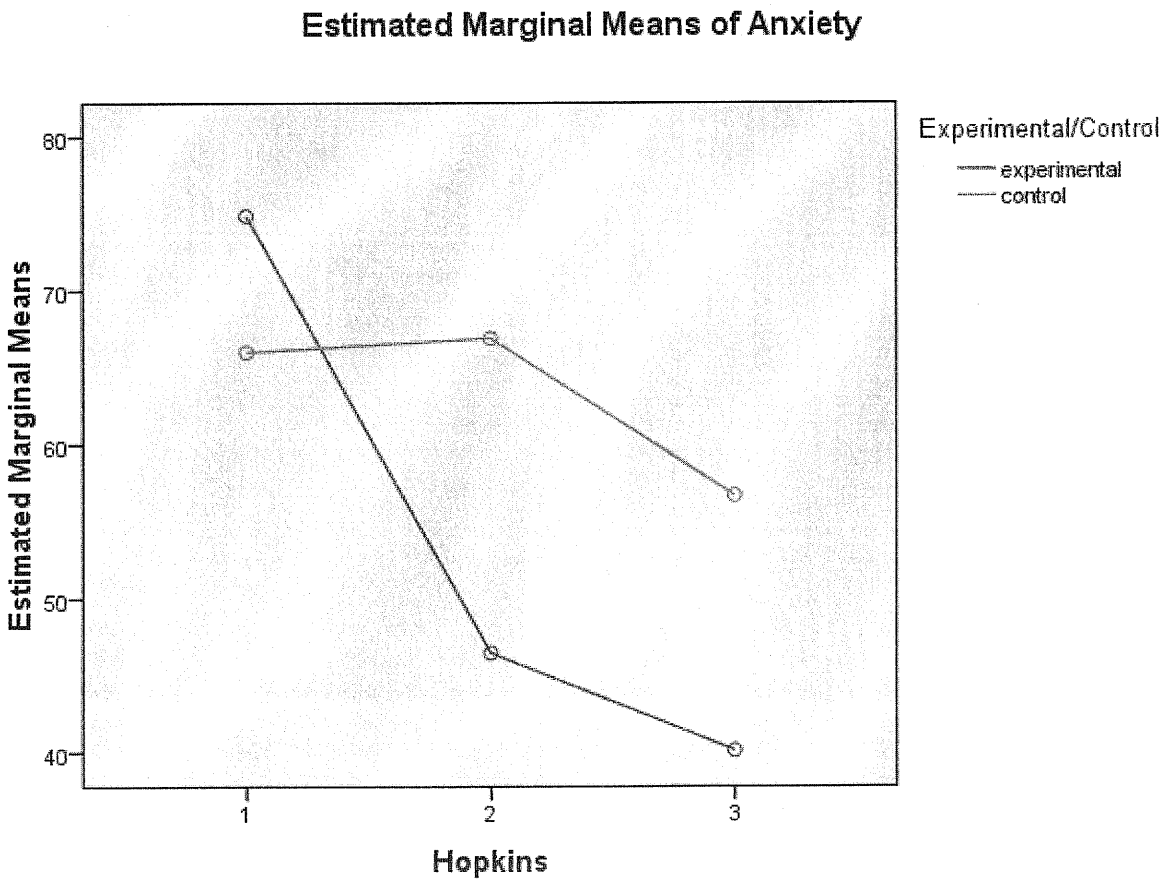
Group	Time	N	Mean	Std Dev	F	Significance
BDI						
Experimental		20	34.85	7.058		
Control	Pretest	22	32.45	7.539		
Experimental		20	17.85	8.833		
Control	12 weeks	22	31.23	7.880		
Experimental		20	12.90	10.015		
Control	24 weeks	22	26.86	7.760	46.65*	*p = .0001*
HSCL – 25						
Experimental		17	74.88	13.346		
Control	Pretest	22	66.00	15.657		
Experimental		17	46.47	13.776		
Control	12 weeks	22	66.91	13.995		
Experimental		17	40.12	6.763		
Control	24 weeks	22	56.68	8.828	34.55*	*p = .0001*
HSCL (Anxiety sub-scale)						
Experimental		18	28.72	8.864		
Control	Pretest	22	25.45	6.773		
Experimental		18	17.94	5.567		
Control	12 weeks	22	24.68	6.342		
Experimental		18	16.72	4.574		
Control	24 weeks	22	20.50	3.569	22.51*	*p = .0001*
HSCL (Depression sub-scale)						
Experimental		18	43.94	5.886		
Control	Pretest	22	38.05	8.899		
Experimental		18	27.56	9.544		
Control	12 weeks	22	38.95	8.477		
Experimental		18	24.61	4.394		
Control	24 weeks	22	36.18	6.638	24.09*	*p = .0001*

[1]Petersen , Bhana , Baillie . under submission. Adapting Interpersonal Therapy (IPT) for the treatment of depression by community health workers within the context of task shifting in South Africa. A feasibility study

BDI – comparison of scores of experimental and control groups: Baseline, 12 weeks, 6 months



HSCL-25 (anxiety) – comparison of scores of experimental and control groups: Baseline, 12 weeks, 24 weeks



Process evaluation – IPT groups

- Social support afforded by group assisted

There is this woman whose child died. The women in a group comforted her

Sometimes you find that a group member would say that I have money problems

What the group helped me with is that they were able to correct me (and tell me)

The other woman in the group lost her son... he had been gone for a very long time. We started raising suggestions as to how she could start looking for him. She would tr... w... to...

A person would come and you would see that every time when she has to talk she cries... by coming to the group you see that she is better. 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)

participants

Development of culturally competent services

The manual was very helpful because it spoke about things that we have experienced...it went hand in hand with what we were dealing with...it was as if you saw what was in us and then put it in that book. It assisted us a lot (group participant).

I think this was the most appropriate way because when you had a problem, you would ask others for help and they will give you different ideas/ suggestions and that made it easy to find a solution to the problem... we came as a group (where) people's problems are similar in life (group participant).

Improved community control - CHW actions to promote Mental Health

- Build social networks for people

> *I would say that it (the training) helped me a lot in the community. We started a group for old people there at kwa(S). I found that old people have many different problems at their homes. Others have sick children, others their children died. Others are abused by their children. Then I used the knowledge I received from the training. I talked to them. I heard all about their problems. The group is still going on. We do handwork. We pray. They open up and we talk about their problems (CHW group 3).*

- CHWs network people in crisis to gain help from other community members or government services

> *'Others they call us ambulances'*

Challenges

- CHWs capacity to engage in public mental health activities constrained by their marginalized position as poor women

It's difficult for us to enter family matters because it's not safe for us. The man (they)see us as nothing. Even in clinics when you go there to fetch medication for people. You will be in the queue and you sit like everybody else. They don't regard you as a person with a job. We feel offended… they look down on us as if we are stupid, we are something useless. But we do play an important role... (CHW group 3)

and my family might die (CHW group 1).

Needs

- Symbols of power

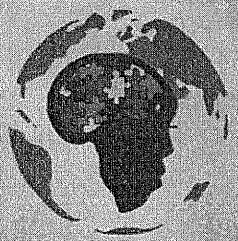
> *Even if we get a little difference like a name tag. So that we can be known that these people are doing work...You see, when someone comes wearing a uniform, it makes a difference... If we can also get that. To have something different that will highlight us in the community. That we are CHWs and we are also educated. (CHW group 1)*

- Support

> *It (support) helps because you may find a house that has got problems. You take them and make them your own. Even when you are at home, you find these problems ringing in your head. You feel like this problem is facing you directly. (CHW group 4).*

Conclusion

- Community collaborative participatory framework at district level can assist with:
  - Mobilization of resources
  - Improving mental health literacy and help seeking
  - Reducing stigma
  - Improving access to culturally competent mental health services - community capacity building
  - Improved community control over mental health - support groups and public mental health actions



Conclusion

- Community health workers well placed to address social determinants of mental ill-health
- Need symbolic and economic empowerment
- Need to make greater use of CHWs as a collective – improve collective agency
- Need to institutionalize multi-sectoral community collaborative mental health management structures across sectors

Acknowledgements

- Kim Baillie (Research Officer)
- MHaPP consortium www.psychiatry.uct.ac.za/mhapp
- Department of International Development (DFiD)