



IMPLEMENTATION OF PRIME MENTAL HEALTH CARE PLAN IN SEHORE DISTRICT, MADHYA PRADESH, INDIA: OUTCOMES & LEARNINGS

BACKGROUND

In India, the weighted prevalence of any mental disorder is 10.6% (point prevalence) and 13.7% (lifetime prevalence) as per the findings of the National Mental Health Survey (NMHS). There is also a huge treatment gap for mental disorders.

To address this huge burden of mental health conditions, the District Mental Health Program (DMHP) was launched in 1996. However, the National Mental Health Policy Group reviewed this in 2012 and 2013 and found that it requires a complete restructuring of DMHP.

There are very few evidence-based implementation models in India which provide a plan to integrate mental healthcare delivery in existing primary healthcare system which can ultimately improve access to care.

The Programme for Improving Mental Healthcare (PRIME) launched in 2011 with a goal to generate world-class research evidence on the implementation and scaling-up of treatment programs for priority mental disorders in primary and maternal health care contexts in low-resource settings.

PRIME is a consortium of research institutions and ministries of health in five countries in Asia and Africa (Ethiopia, India, Nepal, South Africa & Uganda), with partners in the UK and the World Health Organization (WHO).

In India, PRIME is implemented in three Community Health Centres (CHC) of the Sehore district in Madhya Pradesh in a close collaboration with Department of Health Services.

DEVELOPMENT OF MENTAL HEALTH CARE PLAN

The core emphasis for PRIME was on the design, implementation and evaluation of a district mental health care plan (MHCP).

WHO mhGAP treatment guidelines and the PLoS Medicine series on global mental health served as the foundation and a starting point for creation of draft packages of care for priority mental disorders constituting the MHCP. Depression, psychosis and alcohol use disorders were selected as the three priority mental disorders as these are the three leading mental health causes of the burden of disease.

Formative research was then carried out to model the mental health packages that could be delivered in the context of the Sehore district. This was followed by pilot testing specific packages of the MHCP in a single facility to evaluate their acceptability and impact, and making adaptations to the plan based on learning

from the pilot.

MHCPs can be broadly divided into enabling and service delivery packages. The enabling packages essentially focus on establishing the foundation for facilitating the service delivery packages.

The key lessons from the piloting of selected packages were that:

- (a) mental health service delivery can be strengthened only with strong facilitation by an external resource team such as the PRIME team;
- (b) an additional human resource in the form of a case manager is essential to establish true collaborative models of care;
- (c) enabling packages need to be installed as a foundation prior to the implementation of service delivery packages.

DEVELOPMENT OF MENTAL HEALTH CARE PLAN

The implementation of the MHCP started with the training of service providers to implement and deliver evidence-based treatments at health facilities.

Mann-Kaksha, a unique innovation to integrate mental health care into primary health care was set up in three implementation health facilities.

Along with service delivery and enabling activities at facilities, the Case Managers visited communities for community processes such as community mobilisation, identification and referral to

the health facility for further mental health services as well as improving adherence among in-treatment patients.

Support processes were established using the process map approach to enable the support team to facilitate service delivery such as training, supervision and enabling packages such as drug supply and the health monitoring information system (HMIS).

A rigorous evaluation of feasibility, acceptability and impact of the MHCP was completed. This was based on following research designs:

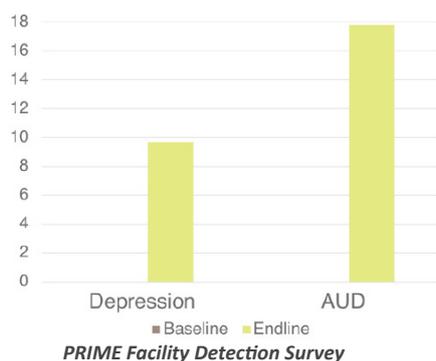


Figure: Overview of Programme for Improving Mental Health Care (PRIME) study designs*

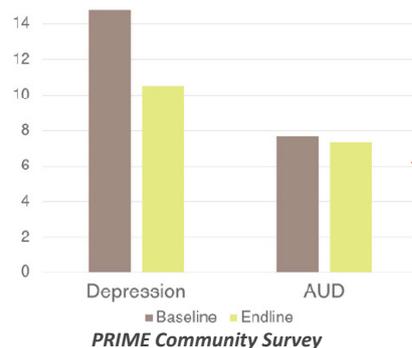
* De Silva MJ, Rathod SD, Hanlon C, Breuer E, Chisholm D, Fekadu A, Jordans M, Kigozi F, Petersen I, Shidhaye R, Medhin G, Ssebunnya J, Prince M, Thornicroft G, Tomlinson M, Lund C, Patel V. Evaluation of district mental healthcare plans: The PRIME consortium methodology. *British Journal of Psychiatry*. Cambridge University Press; 2016;208(s56):s63-s70.

- During the implementation period (Aug 2014 - Aug 2016), 14 110 patients were screened for mental disorders. Out of those screened, 1 033 (7.3%) patients with depression, 575 (4.1%) patients with AUD and 143 (1%) patients with psychosis were enrolled to receive PRIME interventions.
- At the individual patient level, there was moderate impact of PRIME MHCP interventions. Patients with depression who received care as part of the MHCP had higher rates of response, early remission and recovery compared to those who did not receive care, but there was no impact of treatment on their functioning.
- PRIME implementation at CHC level helped in reducing the missed opportunity to identify and treat patients attending out-patient clinics and provided a clear idea of how to install and operationalise key service delivery processes on healthcare and community platform.
- There was no impact of PRIME implementation on contact coverage for depression and AUD at the community level.
- Establishing a collaborative model of care remains a very challenging task, especially in resource-poor settings.
- Facilitation/role of implementation support teams is of paramount importance to operationalise and improve mental health services. This can serve as a basis for establishing 'technical support units' for scaling up mental health services.
- Dedicated human resources (e.g. Case Managers) and dedicated spaces for mental health clinics (e.g. Mann-Kaksha) strengthen 'formal' healthcare platform. However, substantial additional investments in staff, such as Community Health Workers/Accredited Social Health Activists to improve community level processes and provision of community-based continuing care to patients is essential to ensure improvement in access to care as well as better clinical outcomes.

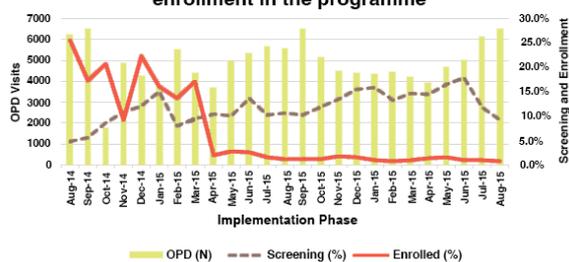
DETECTION



COVERAGE

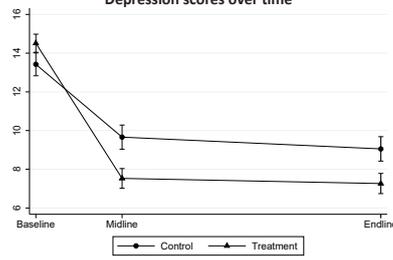


Facility OPD, Screening with Master Chart and enrollment in the programme



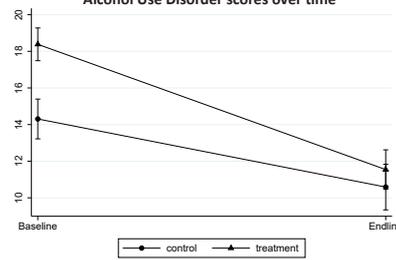
PRIME Implementation Phase: Key Service Delivery Indicators

Depression scores over time



Depression Cohort

Alcohol Use Disorder scores over time



Alcohol Use Disorder Cohort

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