

Proactive community case-finding to facilitate treatment seeking for mental disorders in Nepal

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INTRODUCTION

Globally, underutilization of mental health services is a major barrier to reducing the burden of disease attributable to mental, neurological and substance-use disorders.

Service underutilization has been attributable to lack of awareness of service availability; lack of recognition of mental, neurological and substance-use disorders in oneself or one's family; stigma against seeking mental health care; and perceived ineffectiveness of treatments.

Routine or indicated primary health-care screening has been proposed to tackle this challenge, but this

approach misses people who rarely use primary health-care services.

Moreover, many low- and middle-income countries lack resources for widespread screening, especially in populations with high illiteracy that require health staff to administer screening tools.

An alternative approach to increase utilization is community case detection, which employs a gate-keeper model where health workers have been trained in mental health care and encourage people to seek help for assessment and treatment in primary health care.

However, community case detection has received limited attention for mental health.

METHOD

To address this challenge, we developed a Community Informant Detection tool (CIDT).

The tool facilitates detection of people with depression, alcohol-use disorder, epilepsy and psychosis and helps identified people to seek care.

In two districts in Nepal, we trained lay community informants to use a tool to detect people with mental, neurological and substance-use disorders during routine community service.

The CIDT consists of vignettes, which are sensitive to the context, and pictures that are easy to understand for low literacy populations. Trained informants encouraged people they identified using the tool to seek help at health-care facilities.

A previous PRIME study, focused on evaluating the accuracy of case detection by community informants using the CIDT, found that 64% of cases were accurately

detected.¹

Three weeks after detection, people were interviewed by trained research assistants to assess their help-seeking behaviour and whether they received any treatment.

The study took place in two Nepalese districts. Chitwan district in southern Nepal has been the implementing site for the Programme for Improving Mental Healthcare (PRIME) since 2011.

The district is densely populated, is relatively well resourced and at the time of the study had 12 health-care facilities with mental health services.

Pyuthan is a more remote and poorer hill district, and was the site for the Mental Health Beyond Facilities (mhBeF) initiative from 2013 to 2015.

Both mental health programmes were implemented by the nongovernmental Transcultural Psychosocial Organization (TPO) Nepal.

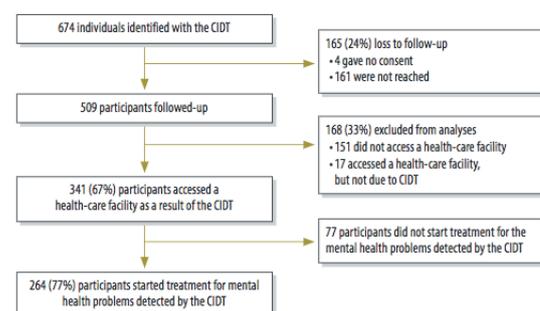
RESULTS

Out of the 509 people identified through the CIDT, two-thirds (67%; 341) accessed health services and 77% (264) of those individuals

initiated mental health treatment.

People in the rural Pyuthan district (208 out of 268) were more likely to access health care than those living in Chitwan district (133 out of 241).

Fig. 1. Flowchart for the proactive community case-finding of individuals with suspected mental disorders, Nepal, 2014



RECOMMENDATIONS FOR POLICY MAKERS

The introduction of the CIDT increased the utilization of mental health services in a low-income country with few health resources.

The tool seems beneficial in rural settings, where communities are close-knit and community informants are familiar with those in need of mental health services.

The Nepalese government has included the tool in national health care packages and the approach has been scaled up to other districts during the emergency response following the 2015 earthquakes.

To increase coverage of mental health care in low- and

middle-income countries, efforts to overcome supply-side and demand-side barriers should occur simultaneously.

Whereas the supply-side requires increased service delivery models, the demand-side requires stimulating demand, for example through proactive community case-finding.

Inclusion of the CIDT or similar case detection interventions in service delivery models, could address the treatment and access gaps for mental healthcare in low- and middle-income countries.

REFERENCES

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About PRIME

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 (UKAID). The programme aims 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.

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