Effectiveness of mental health services in primary care in Nepal: Results from PRIME studies

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Treatment Gap

- Up to 4 out of every 5 people with mental illness in low and middle income countries (LMIC) go without mental health care[1]
- 90% people with mental health problems in Nepal are not engaged in treatment [2]
- Mental health services are not accessible to all (highly centralized) [3, 4]

Source: [1] WHO, 2008; [2] Luitel et al, 2017 ; [3] Luitel et al., 2013; [4] Kohrt et al., 2012, [5] Tol 2007

TPO Nepal
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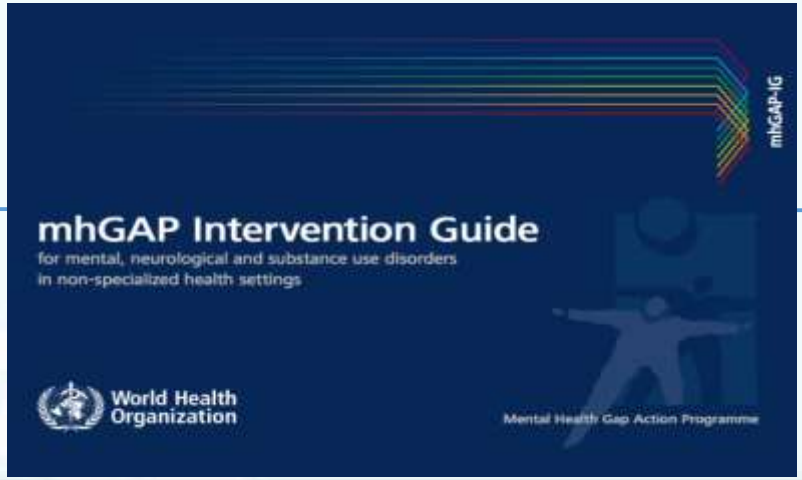

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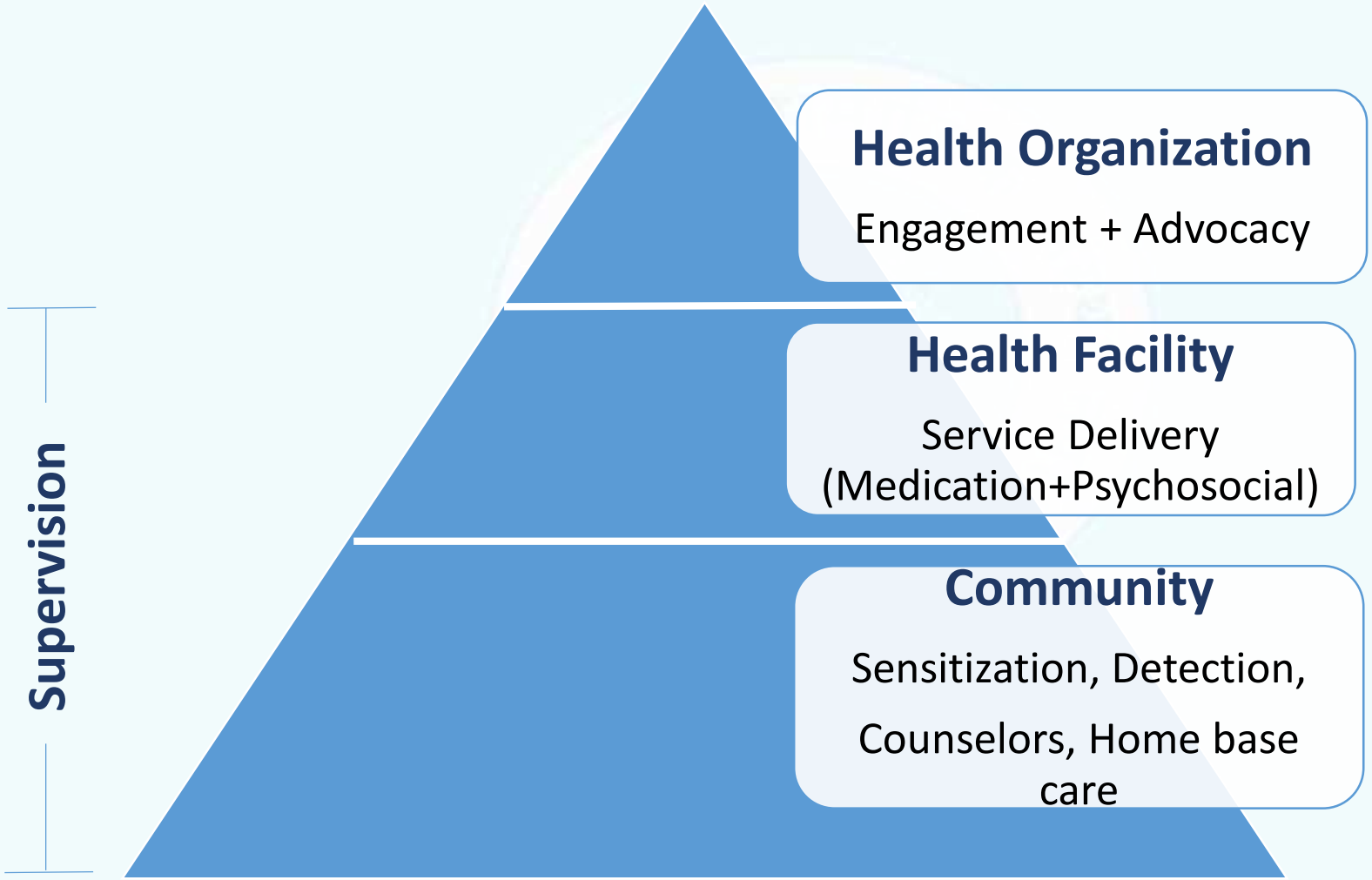
Phase 1: Inception Phase

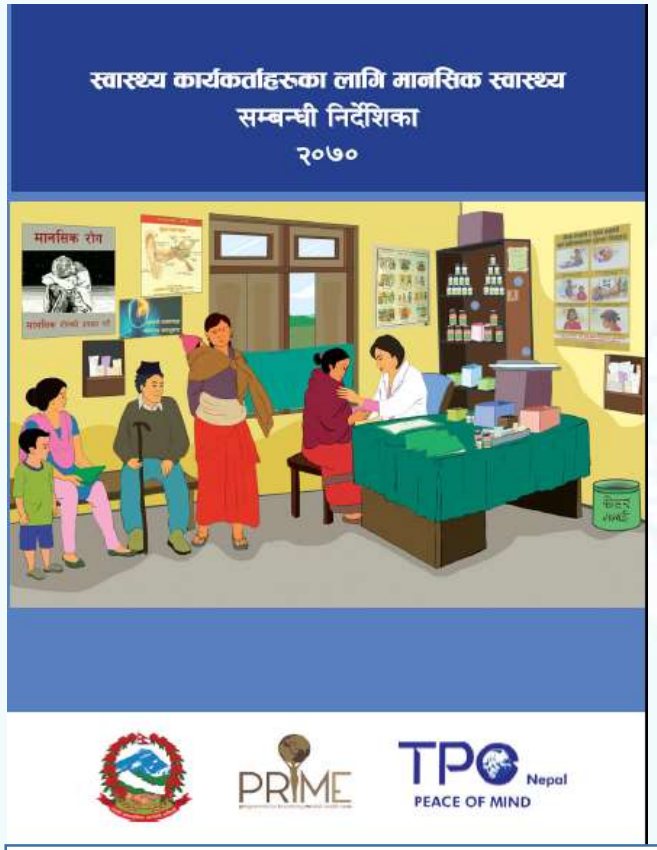
Mental Health Care Plan (MHCP)

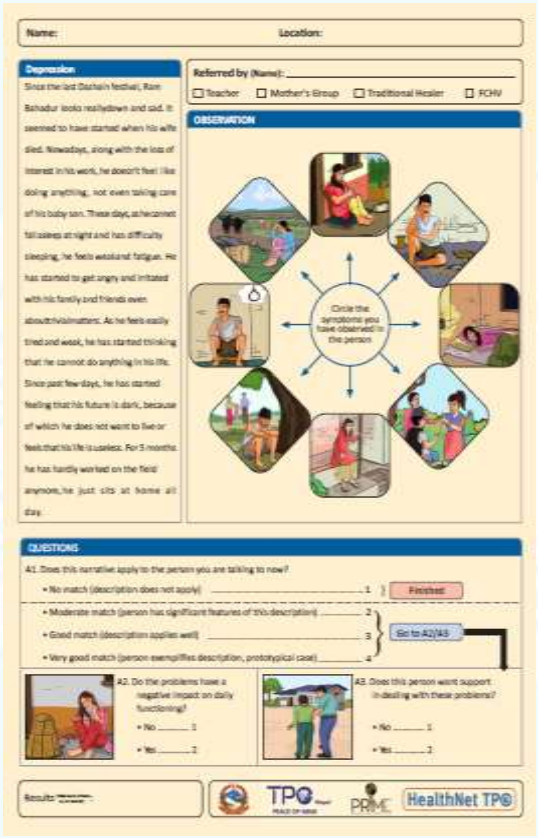
	Awareness	Detection	Treatment	Continue care
1. Health Organization	1.1 Engagement and advocacy	1.2 Referral for specialists consultation/ inpatient care		
2. Health Facility	2.1 Service Providers awareness raising/anti-stigma	2.1 Screening and assessment (mhGAP)	2.3 Basic Psychosocial support 2.4 Focus psychosocial support (HAP/CAP) 2.5 Psycho-tropic treatment (mhGAP)	2.6 Supervision
3. Community	3.1 Mass sensitization	3.2 Community informant case detection (CIDT)	3.4 Focus psychosocial support (HAP/CAP)	3.5 Home base care (HBC)

Mental Health Care Plan (MHCP)



Pilot test- Feasibility and acceptability assessment in two health facilities





Major Lessons from pilot test:

1. Overburdened health workers; pharmacological management to prescribers (AHW, doctors); psychosocial training component to non-prescribers (ANM)
2. Home based care to ensure treatment adherence

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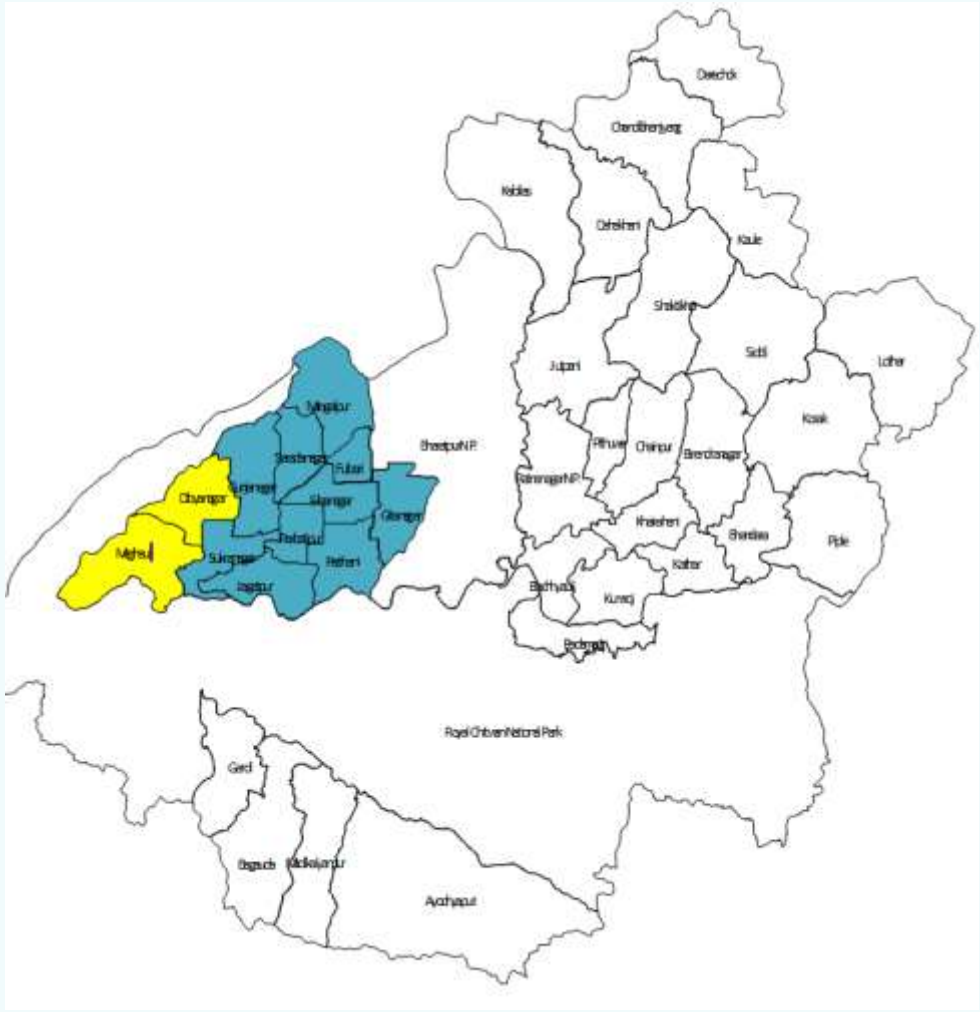
Phase 2: Implementation Phase

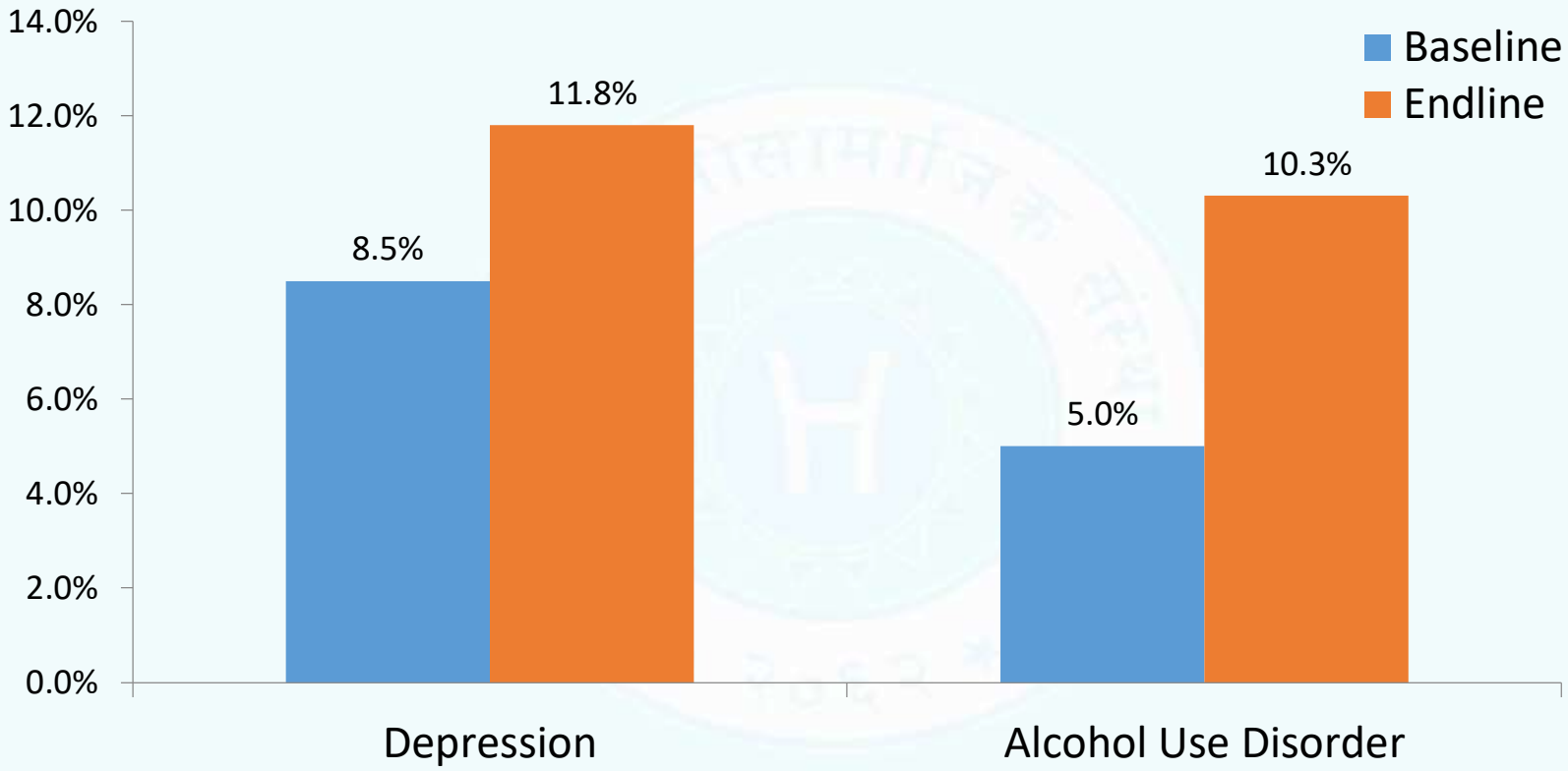
MHCP Implementation



MHCP Evaluation in ten health facilities

- **Community Survey** - To assess population level impact
- **Facility Detection Survey** - To assess health facility level impact i.e. detection and treatment
- **Cohort Studies –** To assess change in symptoms severity and functional impairment

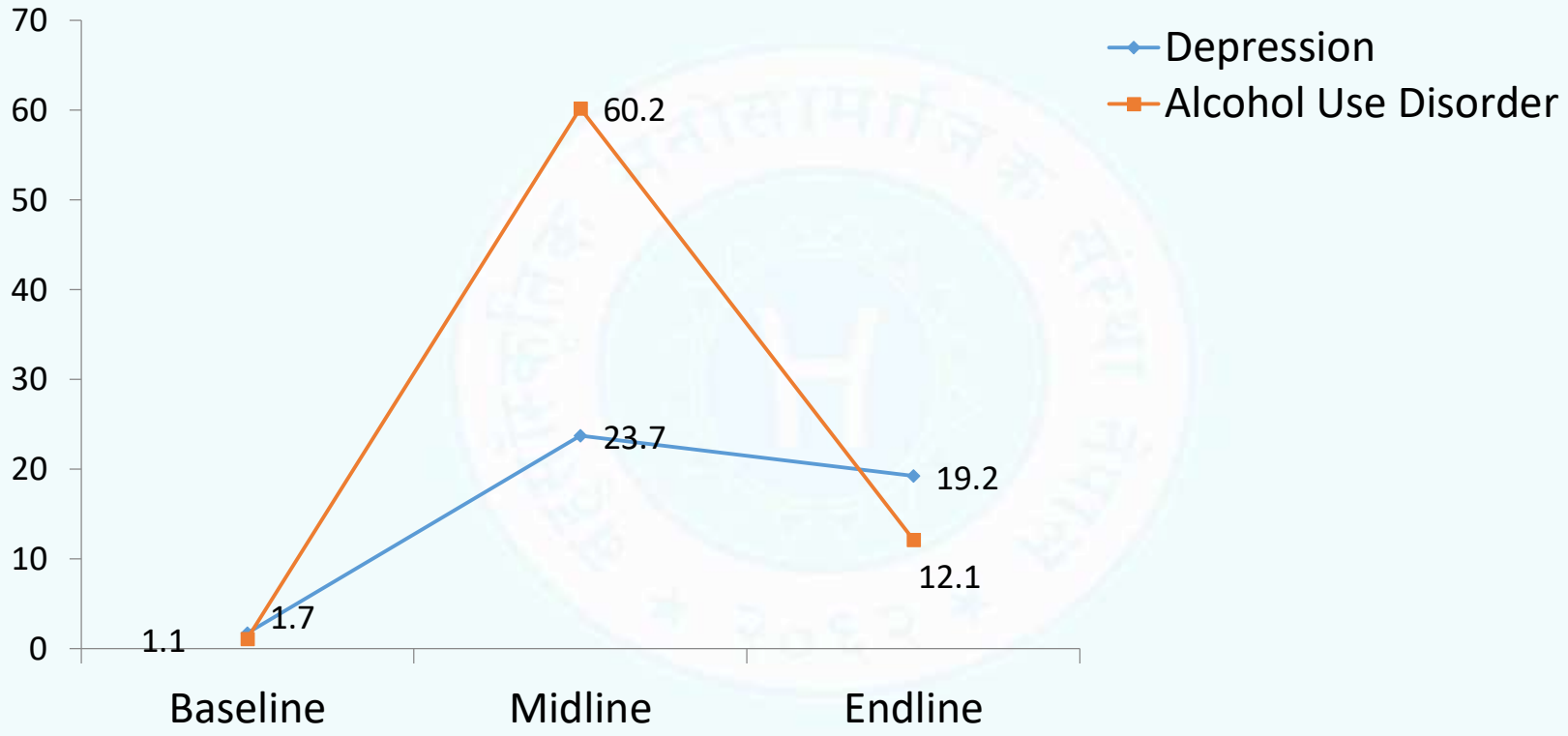
Change in contact coverage



Baseline= 1893; Endline=1499

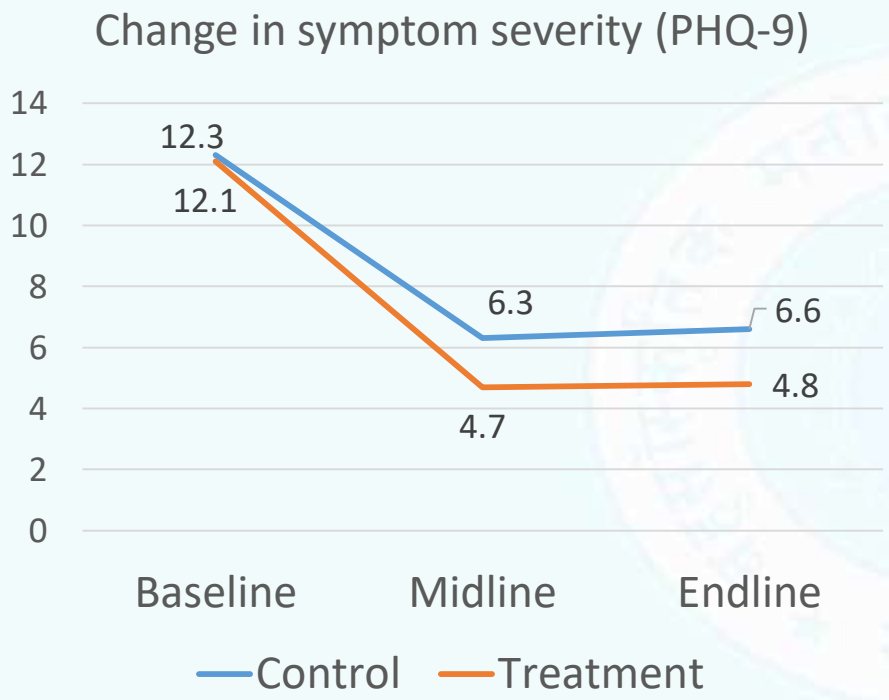
For both depression and AUD, more people in the community reported to have received services for their condition in the endline compared to the baseline. However, the changes are not statistically significant.

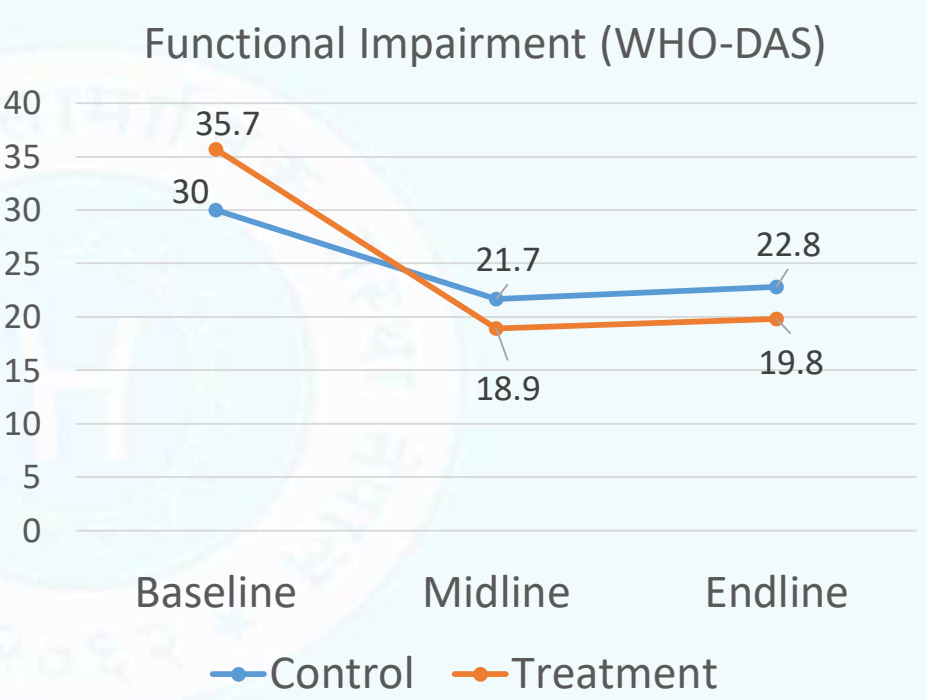
Change in detection



For both AUD and depression, diagnosis increased in midline but reduced in endline. The difference in diagnosis at midline and endline is statistically significant (*p* value= <0.005) from baseline.

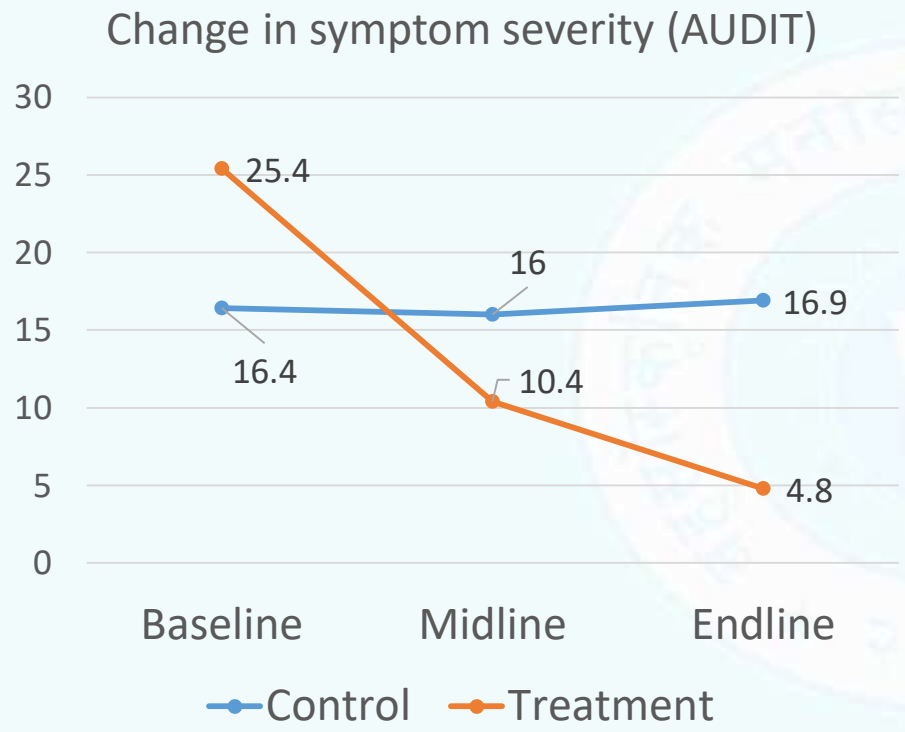
Changes in Depression cohort

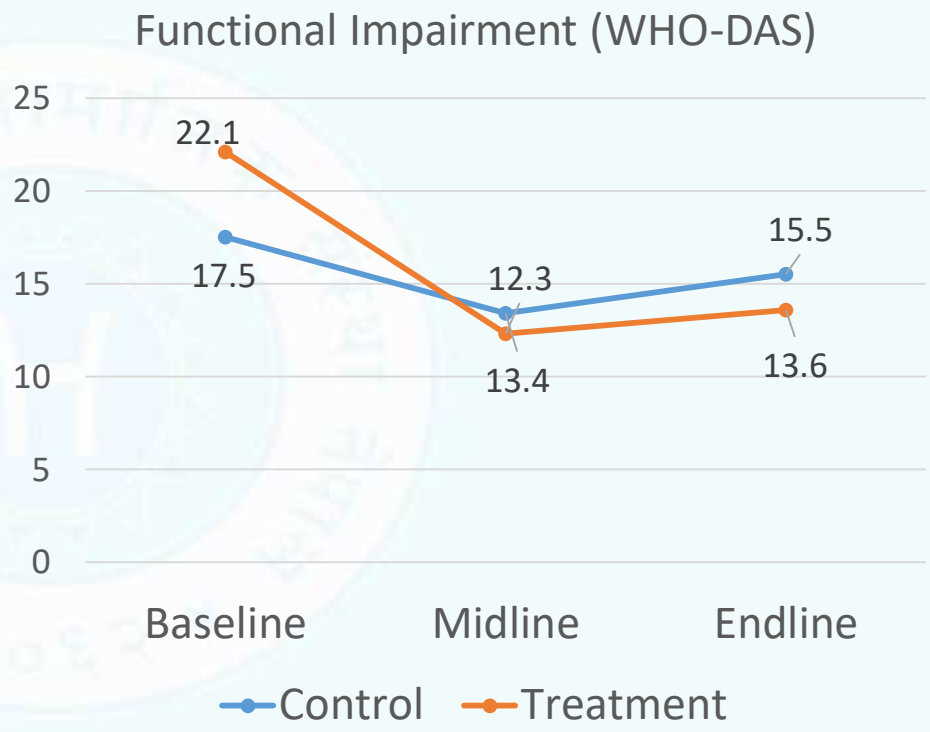




Changes in both symptom severity and functioning are not statistically significant in the intervention group (*p* value=0.620 and *p* value=0.872)

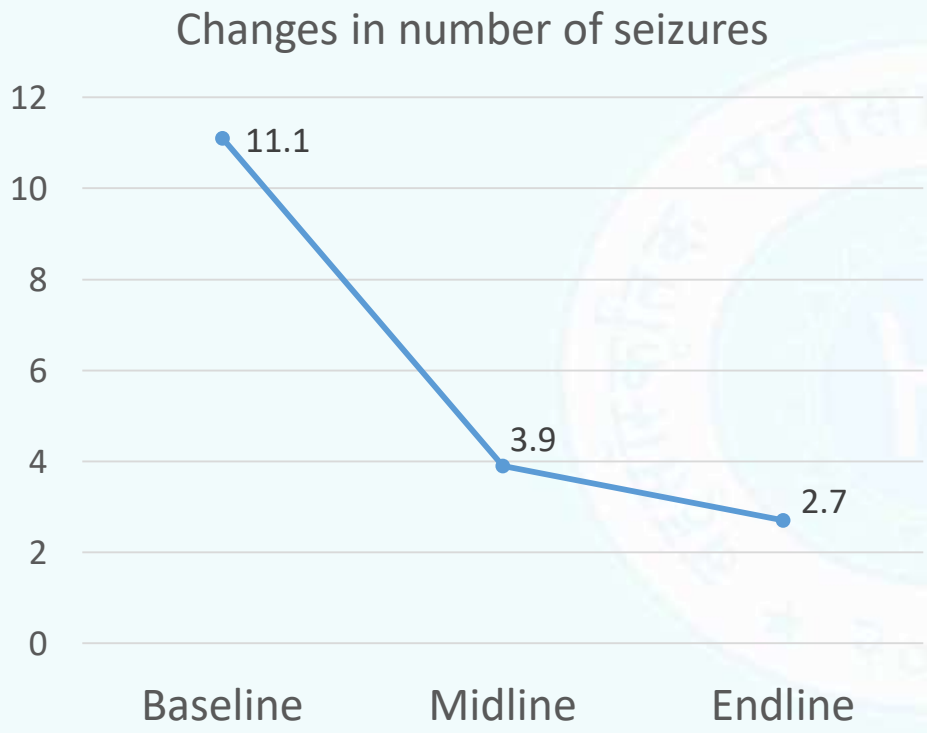
Changes in AUD cohort

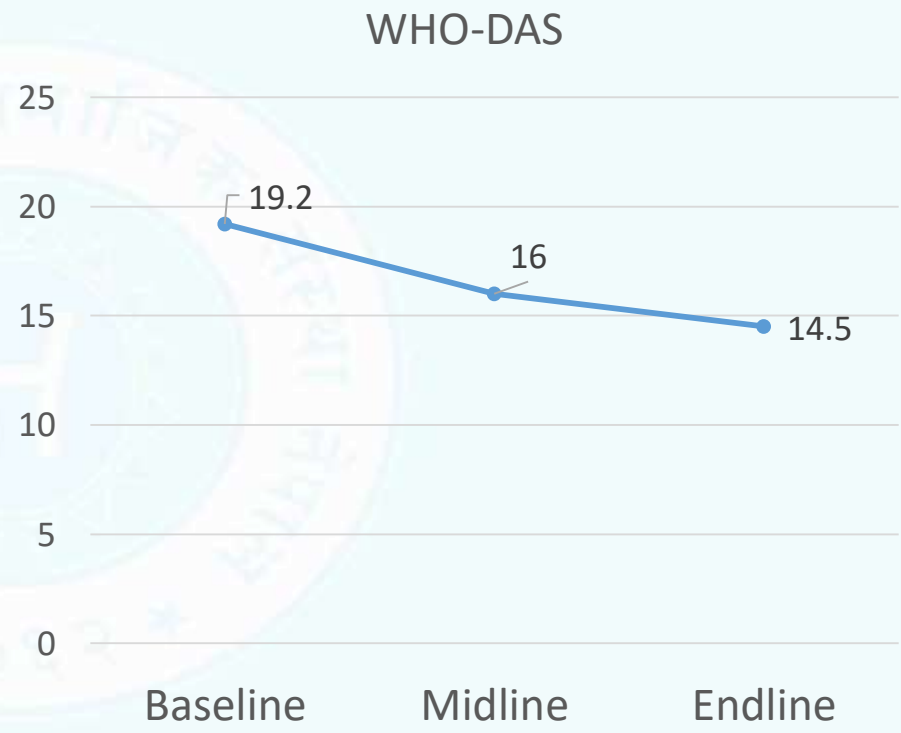




Changes in both symptom severity and functioning are significantly different in the intervention group (*p* values are <0.001 and 0.032 respectively)

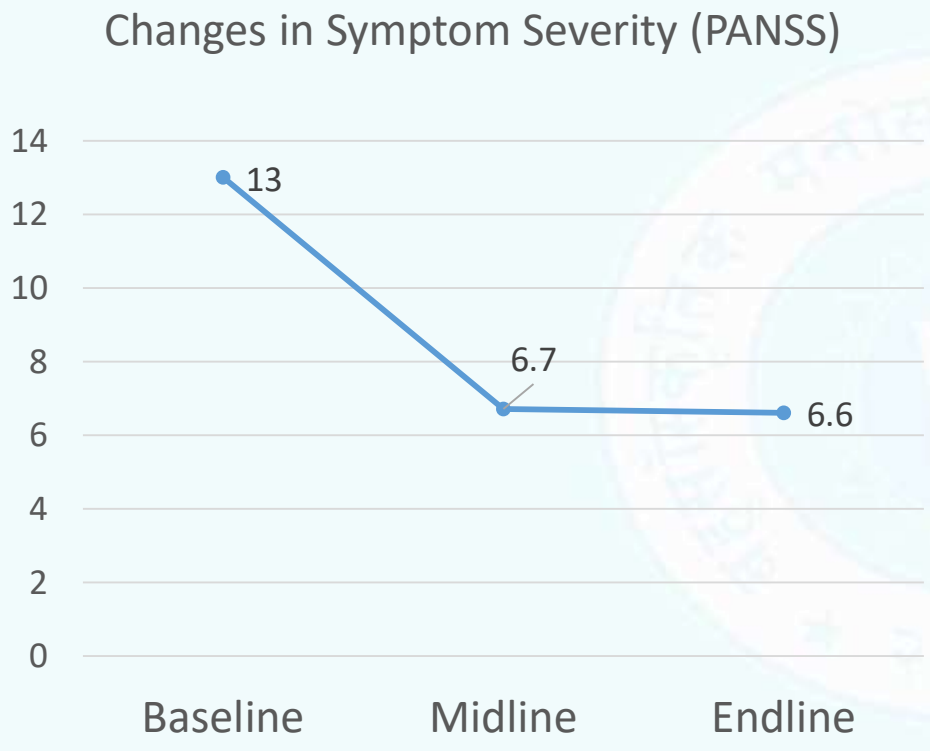
Changes in Epilepsy cohort

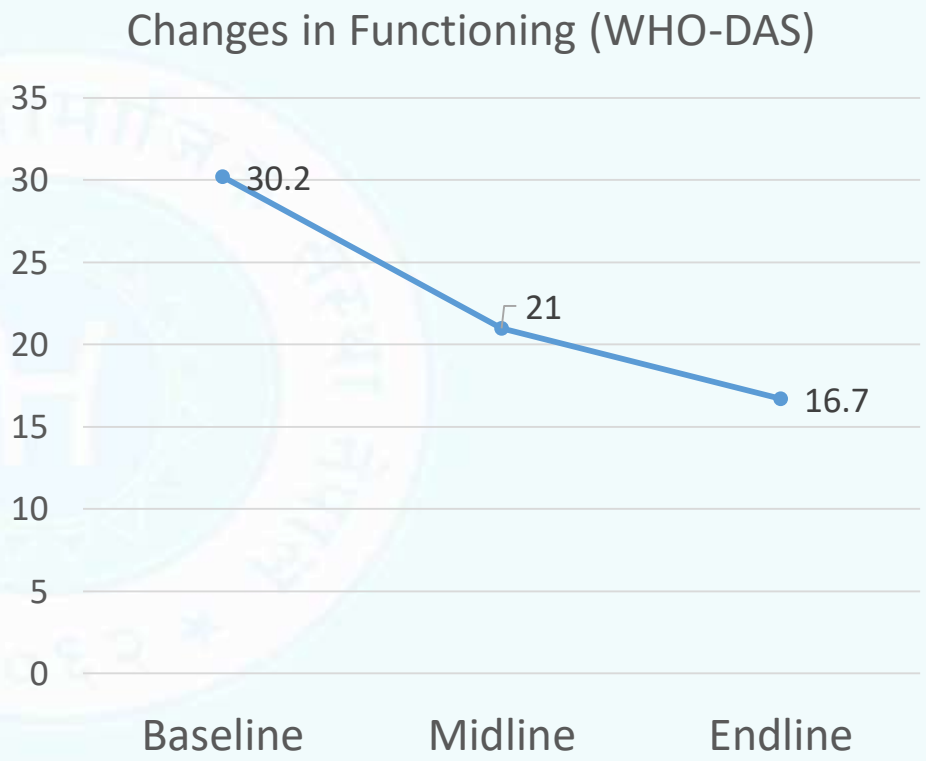




Changes in seizure occurrence decreased significantly (P value <0.001) in the endline while no significant change was seen in functioning .

Changes in Psychosis cohort





Changes in both symptom severity and functioning but not statistically significant

Conclusion

- Summary of findings
  - Not much change in treatment coverage
  - Detection of priority disorders increased significantly
  - MHCP is effective to improve health outcomes and functioning of all 4 disorders but more significant in AUD patients
- MHCP scale up
  - Replicated in 6 districts after earthquake
  - PRIME model adopted in Standard Treatment Protocol endorsed by the government
  - Accredited by National Health Training Centre

Recommendations

- Community based activities should be encouraged to increase demand of care
  - Mobilization of FCHVs in detection and home base care
  - Community sensitization programmes
- Regular supervision of the health workers should be continued to ensure quality of care

For further information/questions:

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