

PRIME: Improving access to mental health care in five countries

Executive statement

Through our work in the Programme for Improving Mental health care (PRIME), we have developed processes and tools that are a resource for Ministries of Health, NGOs and researchers wishing to implement and scale up mental health services in low- and middle-income countries (LMICs). Our hope is to draw attention to the urgent global need to address mental health as a public health and development issue.

Key messages and recommendations

There is an urgent need to narrow treatment gap for mental health in low- and middle-income countries.

- **Recommendation 1:** Develop evidence-based district-level mental health care plans
- **Recommendation 2:** Make budgetary allowance for mental health care plans
- **Recommendation 3:** Implement comprehensive monitoring and evaluation of the mental healthcare plan and scale-up

Context

The cost of mental health conditions is high and soaring around the world. In 2010 this cost was estimated at US\$ 2.5 trillion and is projected to surge to US\$ 6.0 trillion by 2030. In LMICs, that cost was US\$ 870 billion in 2010 with an estimated increase to US\$ 2.1 trillion in 2030.

Urgent action is needed to provide adequate care for mental health conditions, to address not only the rising costs but also the devastating consequences of untreated mental disorders. These include suffering, diminished quality of life and disability, human rights abuses, discrimination, poor physical health and premature mortality.

In response to this gross neglect of people with mental health disorders, the World Health Organization (WHO) launched the Mental Health Gap Action Programme (mhGAP) which advocates scaling up of mental health care through integration into primary health care (PHC) and general medical services. To maximise the beneficial impact of mhGAP, the process of how to successfully implement and scale up mental health care in PHC needs to be investigated. Evidence and experience indicate that stand-alone training of PHC workers in mental health care is necessary but by no means sufficient to guarantee delivery.

About the innovation

PRIME is uniquely innovative in its setup. It is a consortium of research institutions working collaboratively with Ministries of Health in five countries simultaneously (Ethiopia, India, Nepal, South Africa and Uganda), with partners in the UK and the WHO.¹ We are supported by the UK government's Department for International Development (DfID) in this six-year programme which was launched in May 2011. The consortium is coordinated and led from the University of Cape Town, South Africa. PRIME's goal is to generate research evidence on the implementation and scaling up of treatment programmes for priority mental conditions in primary and maternal health care contexts in low-resource settings.

Through PRIME, a variety of LMICs have for the first time devised detailed district mental health care plans (MHCPs) for the integration of mental health into routine primary care systems, using a common implementation and design framework. The PRIME MHCPs are multi-faceted and targeted at the health service organisation, the health facility and its existing staff, and the community. The health facility level intervention is based on the mhGAP-Intervention Guide packages, adapted for the country and restricted to priority mental health conditions: depression (including maternal depression), alcohol use disorder and psychosis, with epilepsy included additionally in Ethiopia, Nepal and Uganda.

There are a number of common elements which mark the PRIME implementation across the five countries: a common overall planning framework; high level of participation and engagement with local stakeholders; focus on community, health facility and health organisation levels; challenges of overburdened primary healthcare systems; and limited impact of training without systemic changes in the form of new mental health resources, sustained supervision, referral pathways, improved medication supply and reorientation of health facility managers.



*PRIME site visit to
Uganda
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“The PRIME idea of trying to focus on one district, looking at what lessons have been learnt, and then scaling-up services is a good one.”

– Prof Melvyn Freeman, Chief Director: Non-Communicable Diseases, Department of Health, South Africa

In the CEO's words...



*Professor
Crick Lund*

“So what makes PRIME unique? Firstly, PRIME partners have shown a high level of commitment, in five very different countries, towards a single goal: to implement, evaluate and scale up district mental health care plans, and thereby to improve the lives of people living with mental illness, particularly vulnerable groups such as women and people living in poverty. The energy and the drive towards reaching this common goal over the six-year period is remarkable. Secondly, PRIME has used rigorous scientific methods to develop and evaluate mental healthcare plans. While improving mental health services, PRIME has therefore also taken the field of Implementation Science forward in low- and middle-income countries. And thirdly, PRIME has forged remarkable friendships and collaborative relationships between policy makers, researchers and practitioners through the process. This is truly a unique group.”

Recommendations

Recommendation 1: Develop evidence-based district level mental health care plans

- Use the Theory of Change (ToC) process to develop MHCPs. ToC is a powerful planning and evaluation tool. The causal pathway set out in the ToC map enables the identification of key indicators for the successful implementation of a MHCP and can be adapted to different settings.ⁱⁱ
- PRIME's planning templates can be used by other countries or districts.ⁱⁱⁱ

Recommendation 2: Make budgetary allowance for mental health care plan implementation

- To make the necessary financial and human resource provisions to implement the MHCPs, estimate the cost of implementing MHCPs by utilising the cost-calculation methodology developed by PRIME.^{iv}
- Key parameters for calculating the costs of implementing the MHCP per country, over a 5- to 15-year scale-up period, include: target population, prevalence of the priority disorders, resource quantities (including human resource needs and essential psychotropic medications), prices or unit costs and coverage.

- As an indication, the estimated cost of scaled up provision in non-specialist healthcare settings of an evidence-based package of care, over a 5- to 15-year scale-up period, ranges from US\$ 0.20-0.60 per capita in India, Nepal, Uganda and Ethiopia. In South Africa, an upper-middle income country, the cost nears US\$ 2 per capita.

Recommendation 3: Implement comprehensive monitoring and evaluation of the scale-up

Use the following measures to evaluate scale-up:

1. Scale up implementation logs: to assess the resources needed.
2. Facility profiles: to determine the drivers and constraints and how to address these.
3. Quality of care study: to understand whether people are being given the appropriate evidence-based treatment corresponding to their diagnosis.
4. Assessment of training quality: to find out the extent and quality of training delivered.
5. Assessment of supervision quality: to understand the extent and quality of supervision delivered.
6. Routine health management information systems: to record the number of service users by diagnosis, age and gender.

Impact

Preliminary unpublished findings from the team in South Africa show very positive trends for the impact of PRIME on the service user population. They show a positive impact on detection rates for depression and alcohol use disorder (AUD) (Fig. 1) and improvements in depression scores for patients living with depression (using the PHQ-9 tool) (Fig. 2).

Figure 1: Response of patients with depression

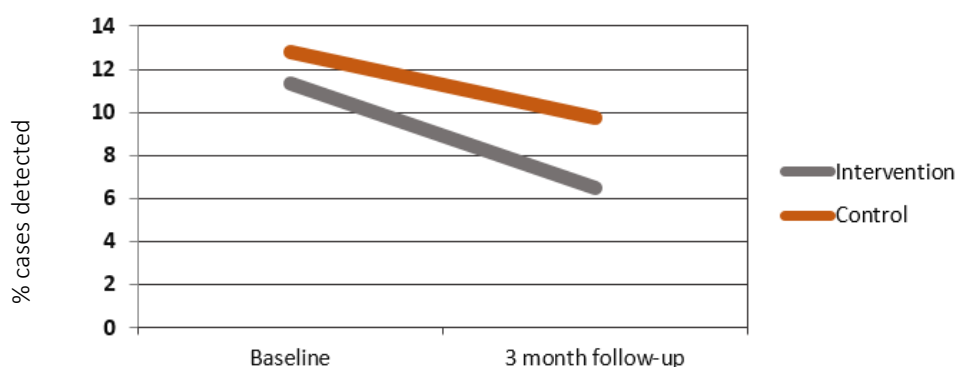
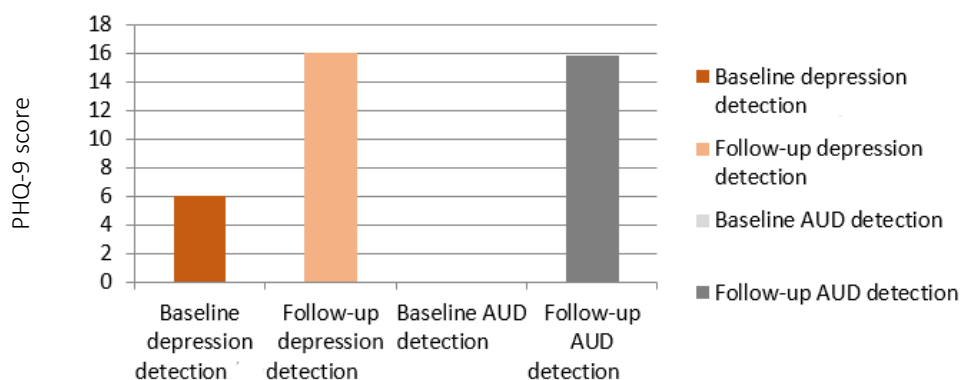


Figure 2: Improvements in detection rates in PRIME clinics 12 months after training



Limitations

This research has not yet reached the phase in which it can assess the impact of the implementation of MHCPs on treatment coverage and individual outcomes. This will form part of the next stage of research and will include assessing changes in detection rates for depression and alcohol use disorders (the results from South Africa presented above are very promising), changes in treatment coverage for these disorders, and the clinical, social and economic outcomes for individuals who receive care for depression, alcohol use disorders, psychosis and epilepsy. Further research is needed on the scaling up of such treatment packages for larger populations, and the implementation of treatment packages for other priority disorders, for example disorders of childhood and adolescence.

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References

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- ⁱ Lund C, Tomlinson M, Da Silva M, Fekadu A, Shidhaye R, Jordans M, Petersen I, Bhana A, Kigozi F, Prince M, Thornicroft G, Hanlon C, Kakuma R, McDaid D, Saxena S, Chisholm D, Honikman S, Fairall L, & Patel V (2012). PRIME: A programme to reduce the treatment gap for mental disorders in five low and middle-income countries. *PLoS Med* 9(12): e1001359. doi:10.1371/journal.pmed.1001359
- ⁱⁱ Breuer E, De Silva MJ, Shidhaye R, Petersen I, Nakku J, Jordans MJD, et al. Planning and evaluating mental health services in low- and middle-income countries using theory of change. *Br J Psychiatry* 2015, in press (doi: 10.1192/bjp.bp.114.153841).
- ⁱⁱⁱ Hanlon C, Fekadu A, Jordans M, Kigozi F, Petersen I, Shidhaye R, et al. District mental healthcare plans for five low- and middle-income countries: commonalities, variations and evidence gaps. *Br J Psychiatry* 2015, in press (doi: 10.1192/bjp.bp.114.153767)
- ^{iv} Chisholm D, Burman-Roy S, Fekadu A, Kathree T, Kizza D, Luitel NP, et al. Estimating the cost of implementing district mental healthcare plans in five low- and middle-income countries: the PRIME study. *Br J Psychiatry* 2015, in press (doi: 10.1192/bjp.bp.114.153866).