Mental health care in rural Liberia

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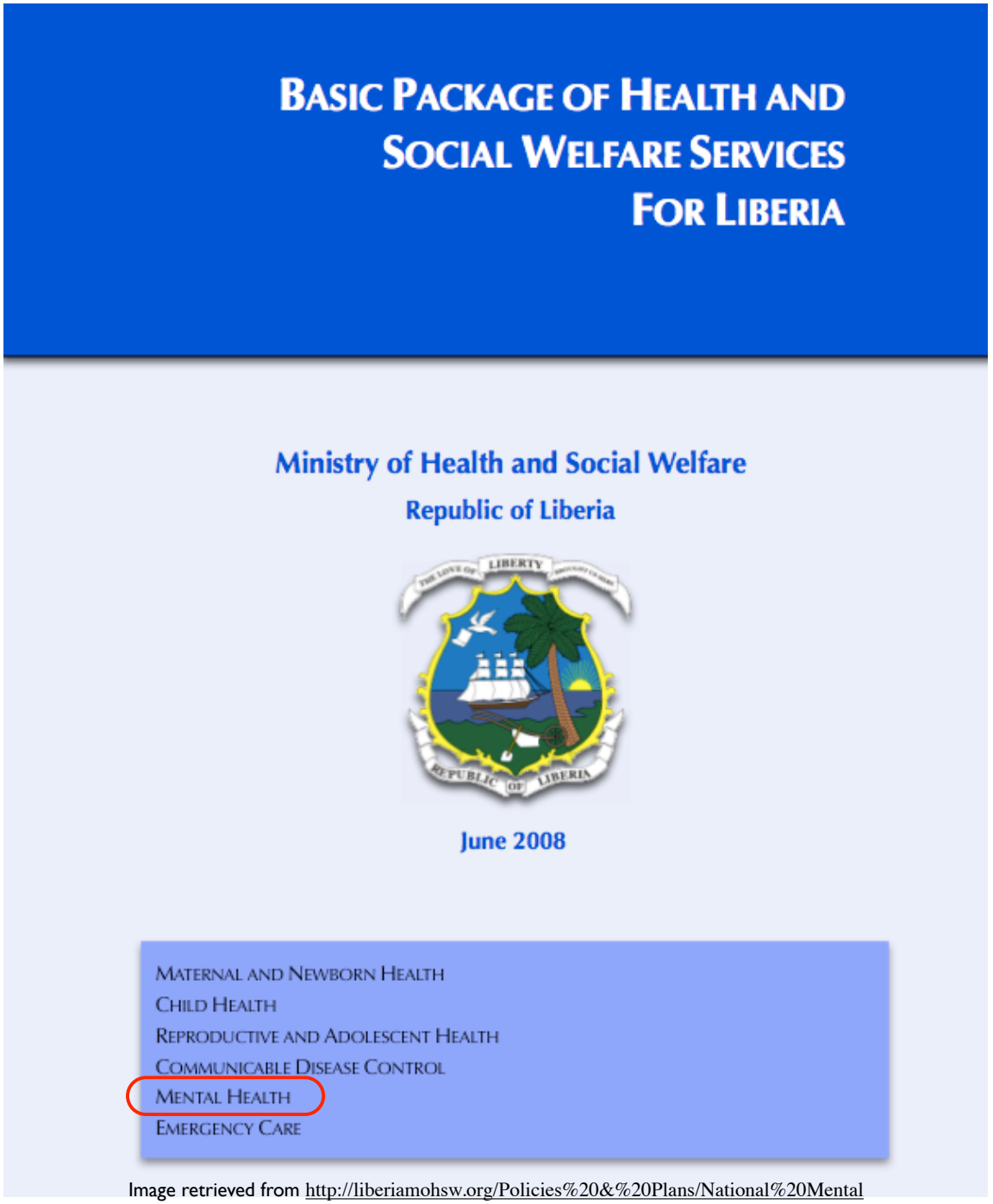
Clinical Topics in Global Health | Feb 9, 2012

Overview

- Why focus on mental health in rural Liberia?
- Designing the intervention
- Tiyatien model of depression care

Mental health burden in Liberia

- JAMA 2008, Johnston et al. – nationwide cluster survey of 1666 Liberian adults (Harvard / Tiyatien Health)
  - Depression = 40%; PTSD = 44%
  - Compare to HIV 1.5-2% nationwide



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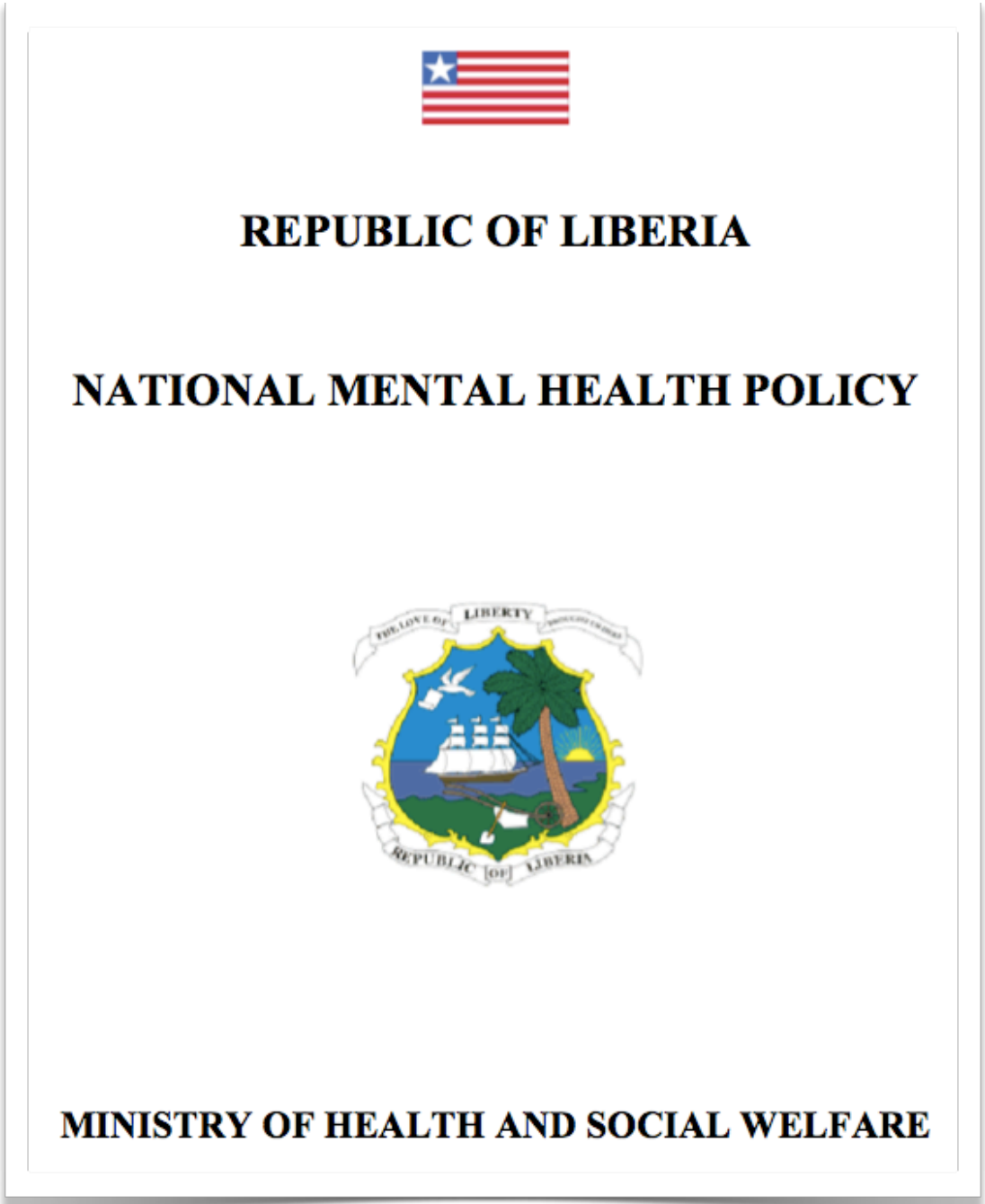

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Key findings and recommendations

- War destroyed previous centralized services
- Currently, <1% public health spending for MH; absence of trained workers; unreliable drug supply
- Addresses range of MH disorders, including alcoholism, epilepy, gender-based violence, as well as vulnerable populations (women and children)
- Advocates for integrating MH into primary care

Why treat people…

then send them back to the conditions that made them sick?

Returning to 2008 JAMA mental health study

- #1 barrier to accessing care = inability to pay; #2 = distance
- Strongest correlate with risk for depression in multivariate analysis – inadequate cooking fuel
- Informally – #1 answer in our clinic to "why are you feeling down-hearted?" = poverty; #2 = gender-based violence / inequity

You cannot treat poverty
with antidepressants

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Integrated approach to poverty and health

Permission received from Partners In Health

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Our HIV "Friends"

Integrated approach to poverty and health

Why focus on mental health in rural Liberia?

Why focus on mental health in rural Liberia?

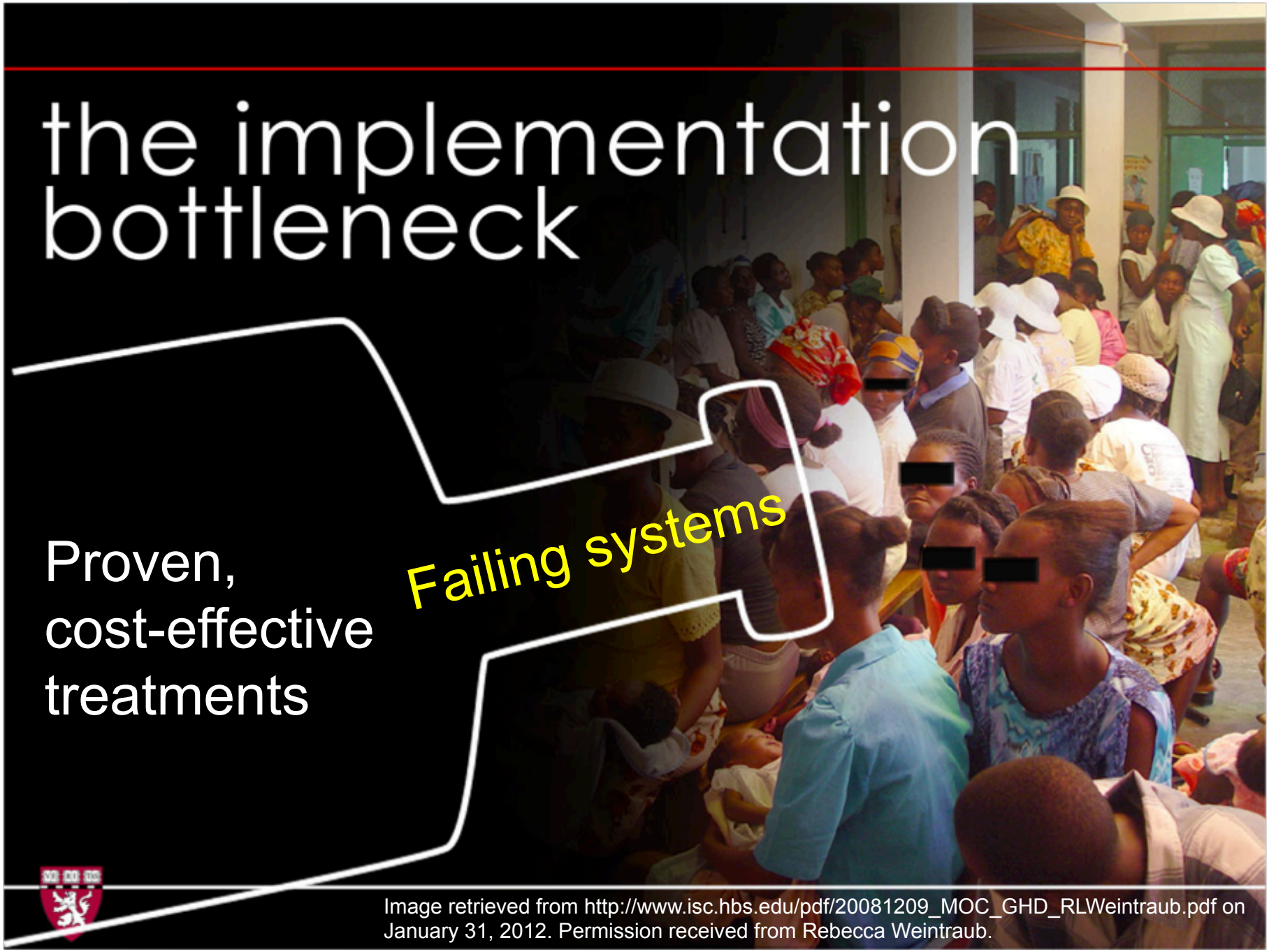
- #1 – huge burden, almost entirely untreated
- #2 – central focus of Liberia's national health policy
- #3 – opportunity to innovate (primary care systems for poor, rural, post-conflict settings – where MH >> HIV >> CVD)

Designing the intervention

the implementation bottleneck

Proven, cost-effective treatments

Failing systems



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Principles of chronic disease care in developing contexts

- Make the best use of available resources
- Human workforce strategy (training, retention, task-shifting, decentralization)
- Patient/community-centeredness
- Address social determinants (break cycle of poverty and disease)
- Data management / QI / M&E
- Supply chain / procurement

Challenges

- Shortage of workers, resources, and experience in chronic care
- Widely dispersed rural populations
- Poverty and stigma

Goal

To deliver high quality, accessible, equitable, and people-centered healthcare within a strengthened primary health care system delivered by a well trained and motivated health care team.

Design parameters

- Address key challenges
- Apply available evidence
- Be rigorous (e.g., design with M&E in mind)
- Leverage existing strengths

Depression

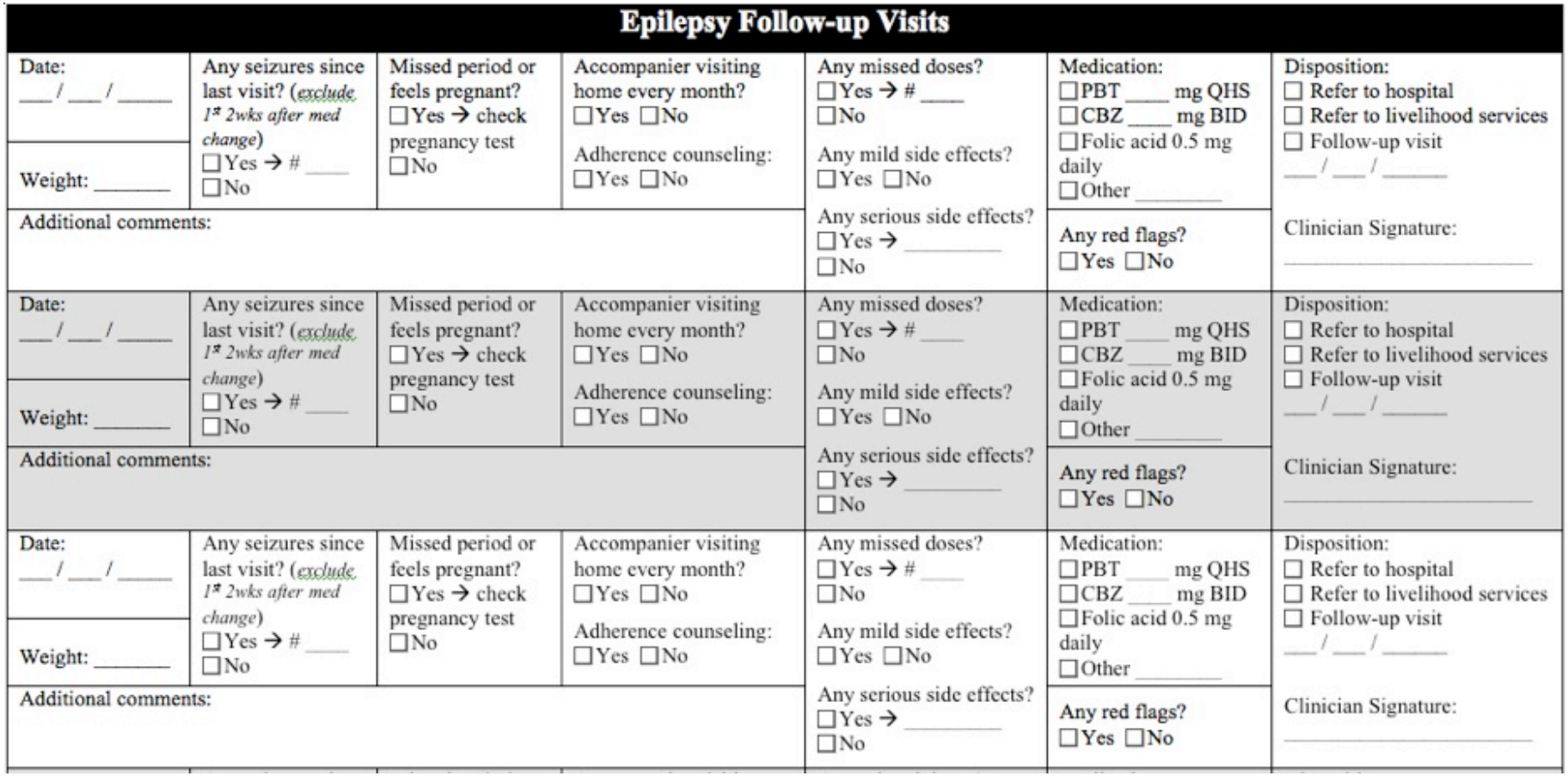
Task-shift + decentralize

- Apply Manas strategy[1] to Liberian context (tiered, task-shifted care; operationalized by Patel et al. in Goa, India)
- Task-shift further downstream:
  - Head of program – psychiatrist => general physician
  - Clinicians – family doctors => PA / RNs
  - Counselors – social workers => CHWs
- CHWs extend care to community level (case finding, support groups, adherence support, stigma reduction)

[1] *Available at:* www.globalmentalhealth.org

Simplify, strengthen, motivate

- Simplified, evidence-based protocols
- Training seminars + clinical mentoring
- Rigorous M&E* – identify gaps, improve services, advocacy, research, fundraising
- Strengthen supply chain
- Ongoing quality improvement



Epilepsy Follow-up Visits

Date: ___/___/_____ Weight: _____	Any seizures since last visit? (*exclude 1st 2wks after med change*) ☐Yes → # ____ ☐No	Missed period or feels pregnant? ☐Yes → check pregnancy test ☐No	Accompanier visiting home every month? ☐Yes ☐No Adherence counseling: ☐Yes ☐No	Any missed doses? ☐Yes → # ____ ☐No Any mild side effects? ☐Yes ☐No Any serious side effects? ☐Yes → _____ ☐No	Medication: ☐PBT ____ mg QHS ☐CBZ ____ mg BID ☐Folic acid 0.5 mg daily ☐Other _____ Any red flags? ☐Yes ☐No	Disposition: ☐ Refer to hospital ☐ Refer to livelihood services ☐ Follow-up visit ___/___/_____ Clinician Signature: _____
Additional comments:						
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Clinical Forms => Access Database

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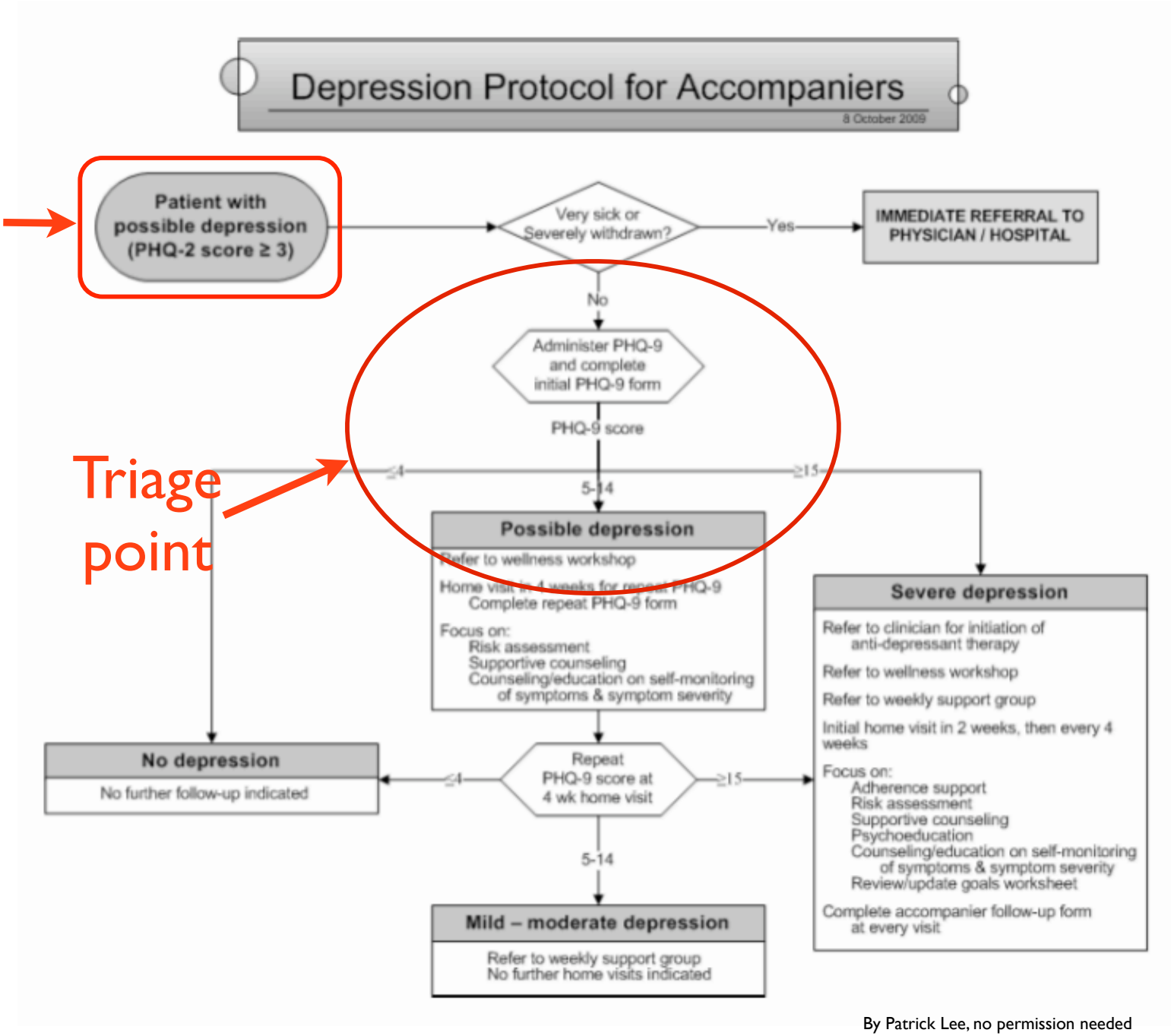
Reviewing the evidence

- All diagnostic instruments perform about as well (and as poorly) in LMICs[1]
- PHQ-9 well validated in other settings and used for 2008 Liberian MH study[2]
- PHQ-2 (ultra-brief instrument) correlates well with PHQ-9 and has good inter-observer reproducibility
- Combination pharmacotherapy + talk therapy effective and affordable in other LMICs[3]

[1] *Patel V et al. Psychological Medicine 2008.*
[2] *Johnston K et al. JAMA 2008.*
[3] *Patel V et al. PLoS Medicine 2009.*



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Triage by PHQ-9

- ≤4 – no depression – no further follow-up
- ≥18 – severe depression – PA initiates amitryptilline + assigns patient to support group
- 5-17 – possible depression – repeat PHQ-9 at 1mo home visit and retriage; if again 5-17, assign to support group

Accompanier roles

- Triage / diagnosis
- Lead support groups
  - Trained in "modified CBT" by TH Director of Mental Health
- Home visits
  - Adherence support, education, reduce stigma, monitor high-risk patients, and drug side effects

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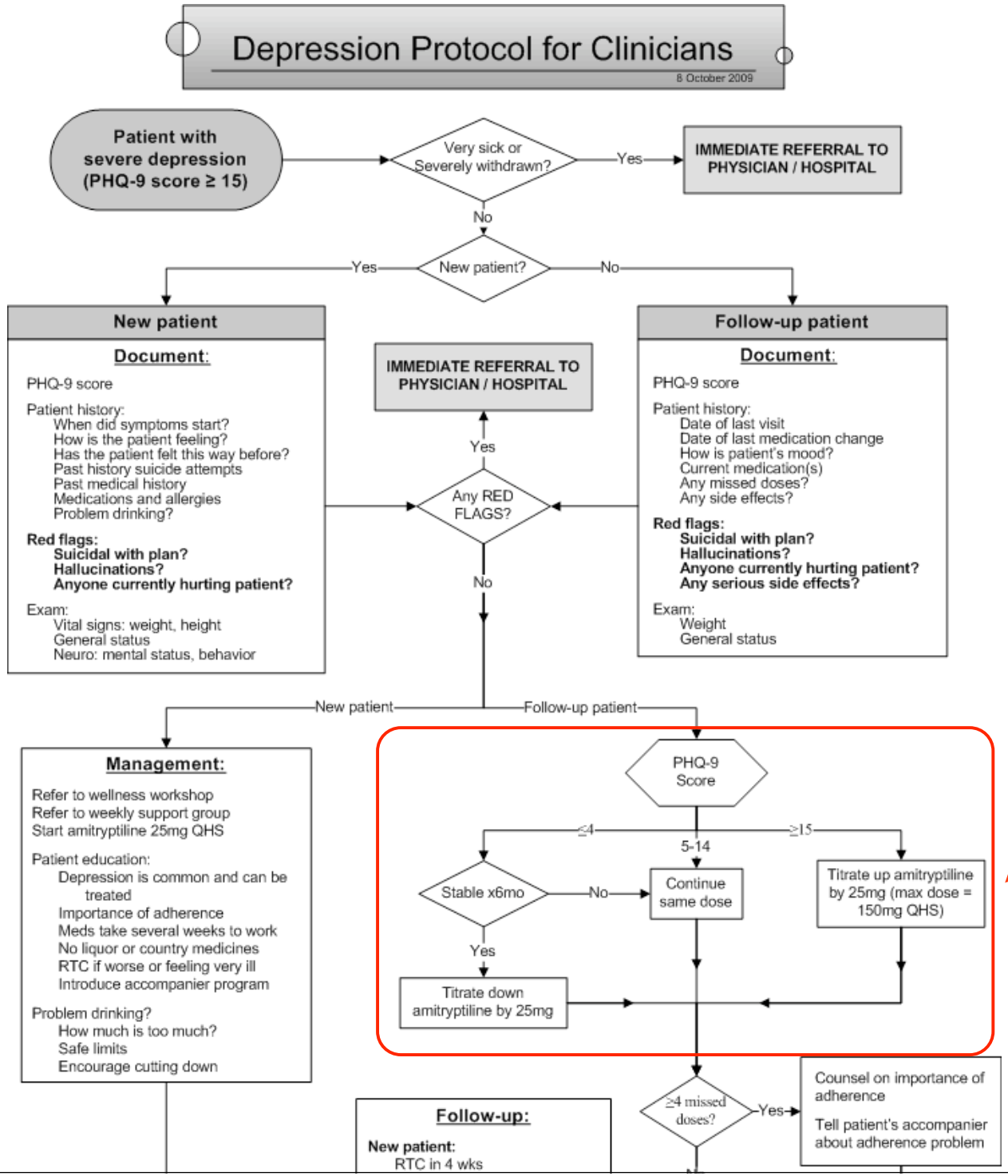

Med titration driven by PHQ-9 score

Closing thoughts (I)

- MH is a major neglected epidemic with important consequences for global health, development, and security
- Poor, post-conflict settings are especially vulnerable – effective delivery will require sustained focus on primary care systems

Closing thoughts (II)

- Liberia has placed MH firmly on its national health agenda, has developed a strong national mental health policy, and aims to become an international model for post-conflict recovery
- Within this framework, TH operates as a change agent and partner, pioneering community-based models of primary care delivery

Thank you!

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