

# Integrating Mental Healthcare into Primary Care: Experience of PRIME and Lessons Learned in Ethiopia

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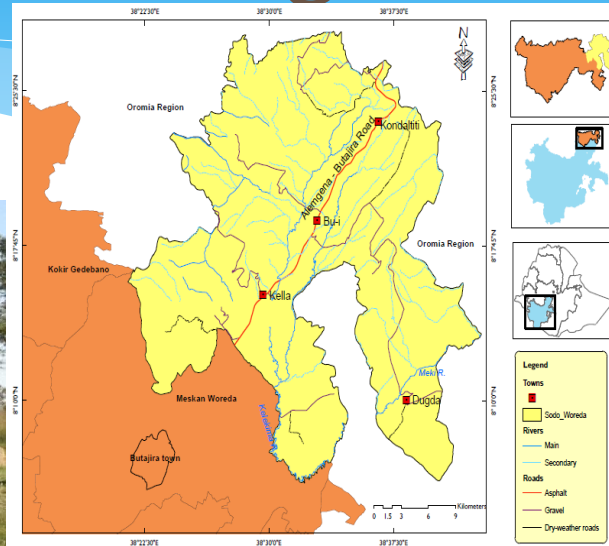
**Providing Sustainable Mental Health Care in Kenya**  
**January 13, 1015**  
**Nairobi, Kenya**



# What will I be talking about?

- \* I will briefly introduce the context in which integrated care is important and what specific issues PRIME addresses
- \* Talk about the methods of PRIME
- \* Will end by sharing preliminary outcomes and overall lessons learned and recommendations for integrating mental health into existing health services

# Ethiopia PRIME Implementation site: Sodo District, Gurage Zone



# What we did ...

- \* We understood the complexity of the challenge...and we took a more complex and deliberate approach
- \* We were convinced that if the plan was to work, it would require for PRIME
  - \* To gain political buy-in (both at the Federal, Regional and Zonal levels)
  - \* To be led by the district and community persons who decide the healthcare agenda
  - \* Need to focus on acceptability and sustainability

# The steps ...

1. Develop interventions collaboratively with all key stakeholders (3 packages at the 3 levels of the health system)
  1. Community (cultivating and supporting champions)
  2. Facility (securing leadership support of facility leaders)
  3. Health Care Organisation (Regional/Zonal Health Bureaus)
2. Piloting
3. Evaluation of impact

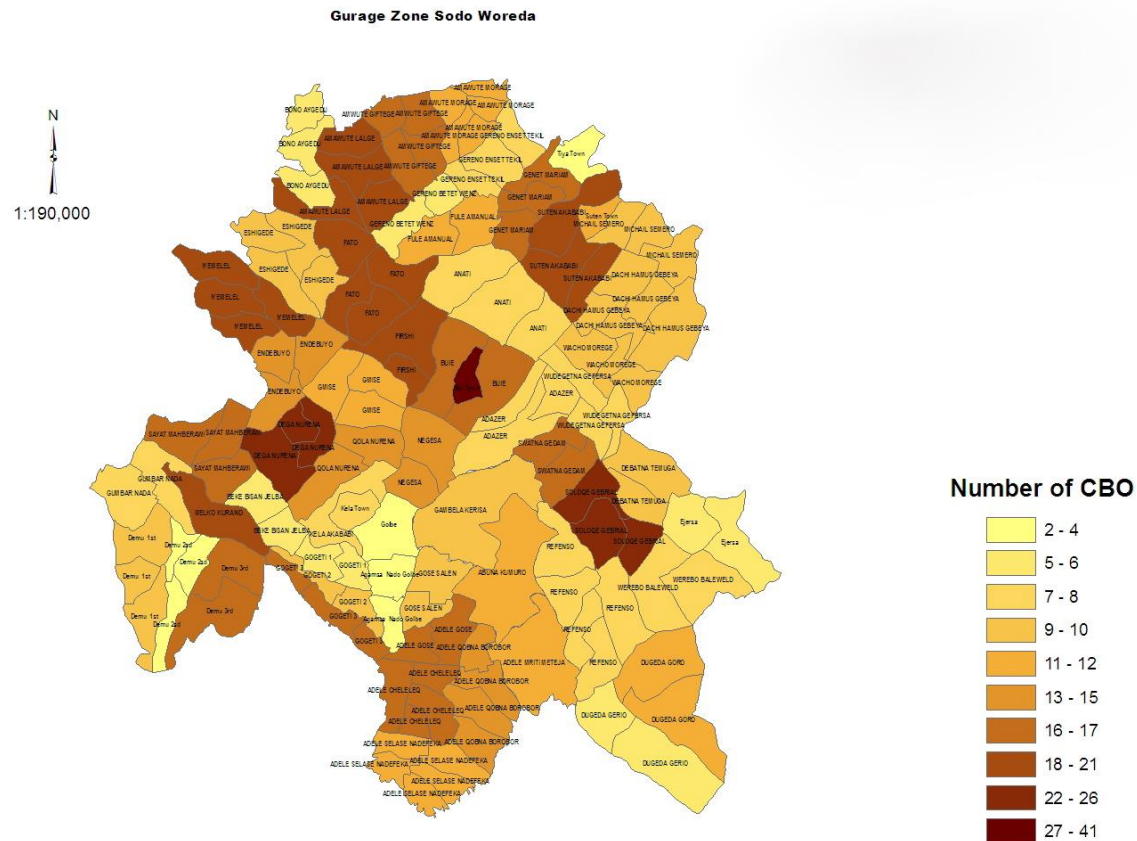
# Used mhGAP Intervention Guide (mhGAP) for Training

- \* The mhGAP-IG is an excellent template for integrating mental healthcare into primary care
- \* But the mhGAP does not provide explicit instruction on how integration should occur (primarily treatment approaches for various diagnosis at the primary health facilities)
- \* Integration is a much more complex process than could be addressed through the mhGAP-IG
- \* PRIME aims to address these gaps and more

# The steps

1. Engagement with the district and community: top down approach won't work
2. Attempted to understand the district context
  1. Situational appraisal
  2. Cross sectional survey
  3. Understanding resources (Asset mapping)
  4. Evaluation of feasibility and acceptability (Qualitative)

# Context-community assets



Sources: CSA 2007.  
 Caution: all boundaries in the maps do not  
 have any official regional or federal endorsements



# What has been accomplished so far:

## Engagement



Meeting of the Advisory Board



Meeting with SNNPR Health Bureau

- \* MoH is a key leader in PRIME
- \* Engagement through consultation, community advisory board and country management group

# Context: Broad psychosocial status

Characteristics		Number (%)
Number of stressful life events* (N = 1449)	None	801 (55.3)
	<b>1 or 2</b>	<b>415 (28.6)</b>
	<b>3 and above</b>	<b>233 (16.1)</b>
Social support (N = 1412)	<b>Poor</b>	<b>590 (41.8)</b>
	Moderate	654 (46.3)
	Strong	168 (11.9)
Common Mental Disorder (N = 1475)	Likely well	1064 (72.1)
	Mild disorder	205 (13.9)
	<b>Moderate disorder</b>	<b>132 (8.9)</b>
	<b>Severe disorder</b>	<b>74 (5.0)</b>
Hazardous use of alcohol (N = 1382)	None	1070 (77.4)
	<b>Yes</b>	<b>312 (22.6)</b>
Suicidality (in previous 30 days)	Wish to die (N = 1491)	306 (20.5)
	Suicidal ideation (N = 1497)	202 (13.5)
	Persistent death wish (N = 1444)	47(3.3)
	<b>Suicide attempt (N = 1493)</b>	<b>21 (1.4)</b>

Fekadu A, Medhin G, Selamu M et al. Population level mental distress in rural Ethiopia. BMC Psychiatry 2014, 14: 194

# Context: acceptability of integrated care (Qualitative)

- \* Integration feasible and acceptable with the right preconditions fulfilled
  - \* Access to adequate staffing and training
  - \* Access to sustained availability of medications
  - \* Providing ongoing supportive supervision to clinical staff (compensates for short-term training and increases case detection and timely referral)
  - \* Focus on recovery and the basic needs of patients in relation to food, shelter and clothing (holistic)

# Facility packages

1. Training of clinical staff: used (modified) mhGAP-Intervention Guide
  - \* 5 days theoretical training
  - \* 5 days practical training
2. Sensitisation of all staff (using patient testimonial)
3. Training of pharmacy staff
4. Decision support: supervision +
5. Health professional wellbeing



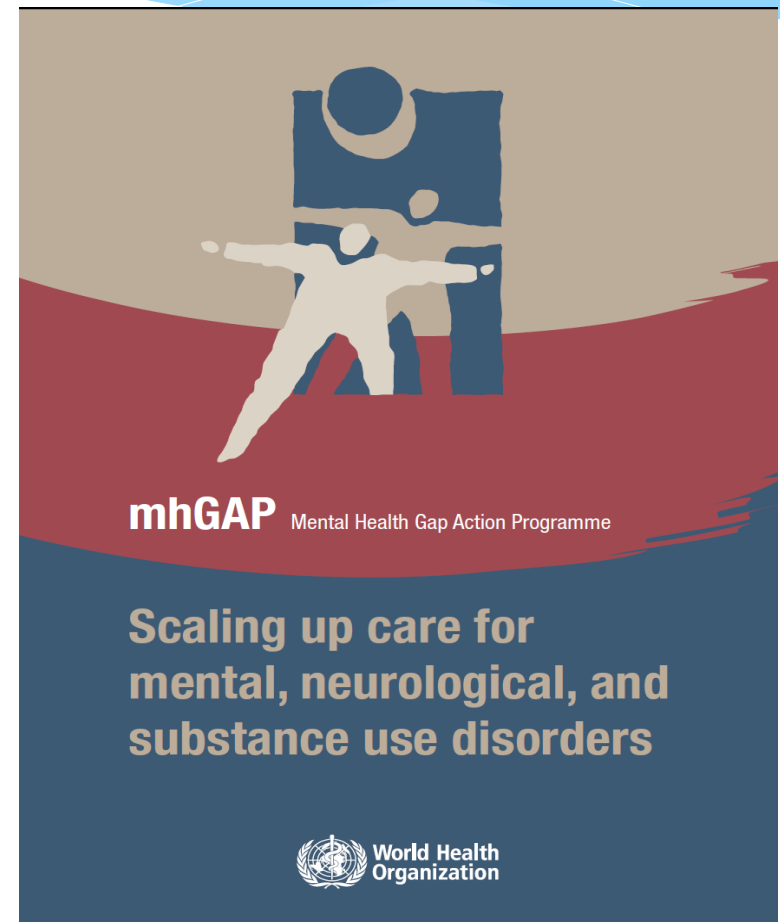
# Community packages (core component)

- \* Community awareness raising and stigma reduction
- \* Community case detection (using community key informants...campaigns)
- \* Continuing care and community-based rehabilitation

*Integrating mental health services into primary health care is not a one time effort, it is and should be a continuous, multipronged and sustained struggle until it takes root!*

# Phase 1 interventions

In the first phase, PRIME implemented interventions for which contextualised evidence is available or success is more assured: **psychosis, epilepsy, and depression**



# Phase 2 Interventions

- \* Require further development work and include:
  - \* Maternal mental health
  - \* Stepped care interventions for alcohol use disorder
  - \* Supporting staff wellbeing
  - \* Engagement with traditional providers
  - \* Community-based rehabilitation

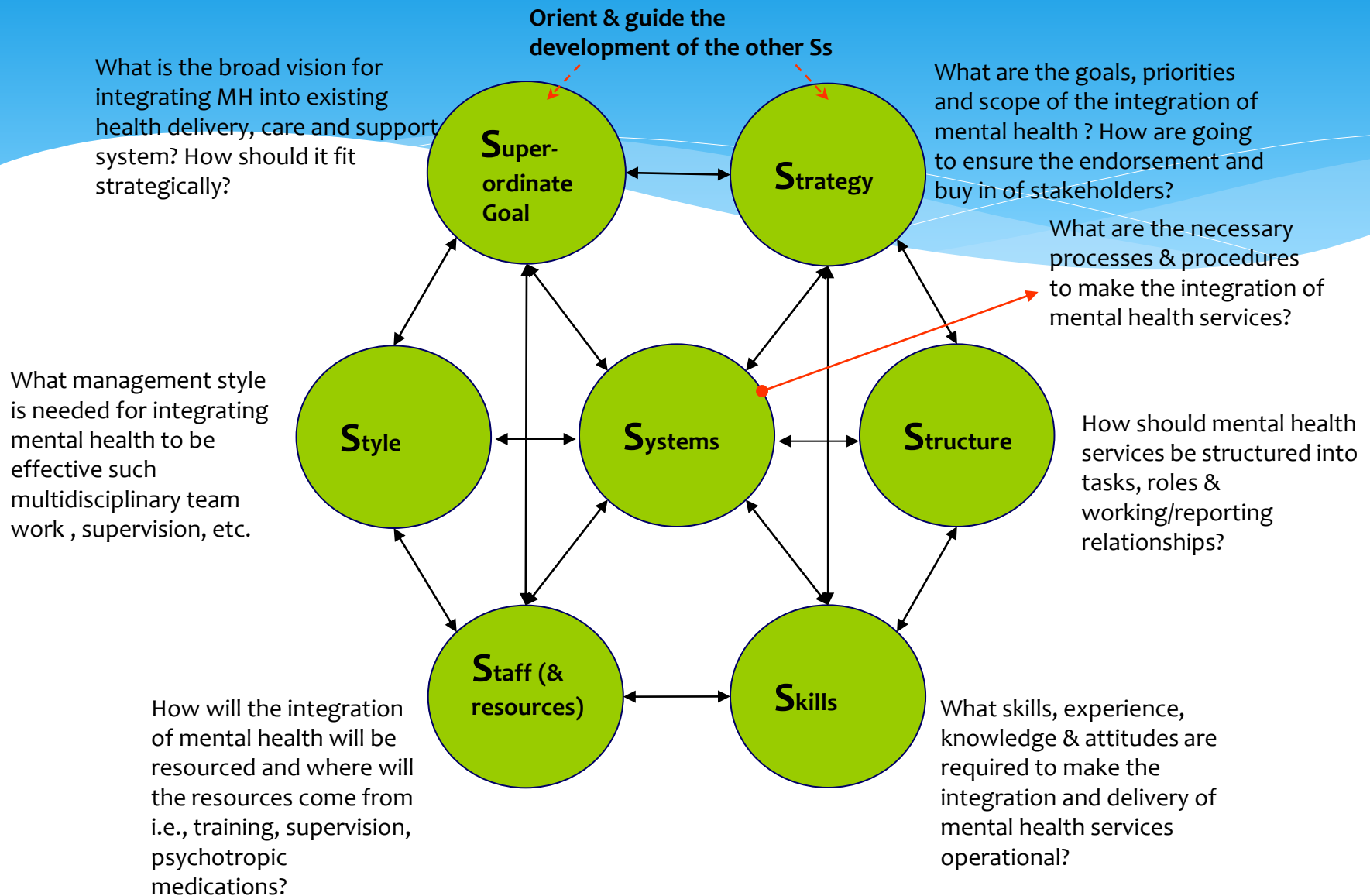


# Pilot data: acceptability of training

- \* mhGAP-IG had very good acceptability
- \* Particularly useful components: case scenarios, role plays and video clips (multipronged)
- \* The additional practical training: very good acceptability (provided confidence)



# 7s Considerations for Integration



# Additional key questions?

- \* What is the acceptability of integrated mental healthcare?
- \* What kind of capacity strengthening is required for PHC staff to provide safe, effective and inclusive care?
- \* What approaches to improve accessibility of care for people living in remote villages?
- \* What kind of organisational support needed?

# Ethiopia -- significant achievement in promoting mental health ...

- ✓ Developed a fully funded National Mental Health Strategy (2013/14 – 2015/16) –
- ✓ Implemented mhGAP throughout Ethiopia (approximately 80 health centers)
- ✓ Scaling up of mhGAP in 120 health centers in 2015 (the plan is to integrate into 400 health centers next year) – issue of stigma has to be addressed if we want to assure utilization of these services
- ✓ Established three masters program for mental health practitioners (prescribers)
- ✓ Established four bachelors program in mental health (nurse prescribers)
- ✓ Established a psychiatric residency program
- ✓ Established a Ph.D. psychiatric epidemiology program
- ✓ Established inpatient psychiatric emergency stabilization beds in all major hospitals – also just completed a new 270 tertiary general hosp.
- ✓ Integrated mental health in the 38,000 Rural and Urban Health Extension Program

***Our approach is at the grassroots, multipronged, sustained and full integration!***

# Lessons Learned

**Continuous Buy-in:** From the “*Federal*” and “*Local*” *Governments* is important for sustainability – e.g., EMERALD).

**Training and Supervision:** While initial short training works, continuous and systematic supervision is essential (specially to ensure symptom detection, timely referral and effective treatment).

**Psychotropic Medications:** Ensuring continuous drug supply and inclusion of essential psychotropic medications on essential drug lists is critical.

**Referral systems:** Referral systems need to be developed to deal with conditions requiring more specialized attention.

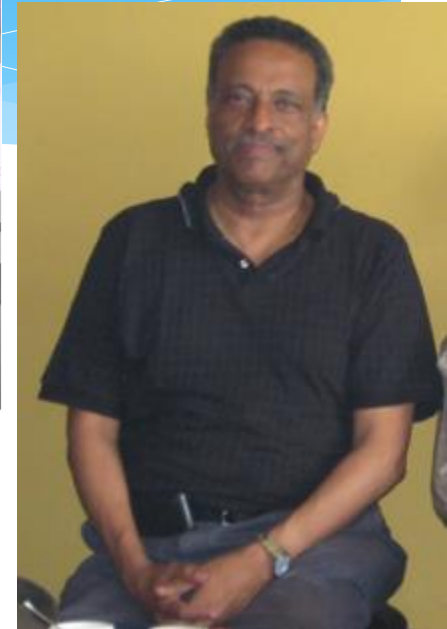
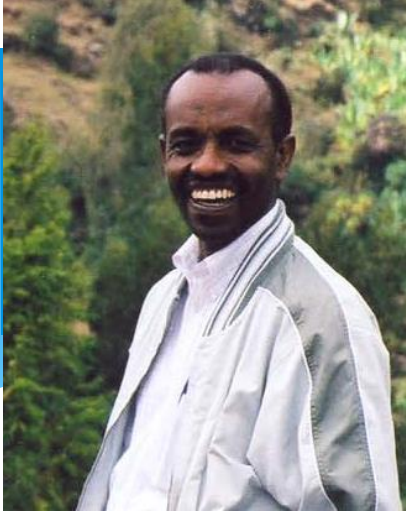
# Lessons Learned contd.

**Support for health practitioners:** It is important to build in peer support, supervision, mentoring, and skills-building activities to ensure quality and prevent burn-out – lowering turnover.

**Funding:** Financial resources are needed to cover the cost of drug supplies, human resources, facilities, training and supervision, printing of materials and guidelines, etc.

**Human resource development:** Development of a model human resource strategy for mental health interface in the various diseases such as malaria, TB, HIV/AIDS, maternal child health care -- is a critical step in the integration process.

# Acknowledgment





**Thank you.**