CTGH Session 3 — Mental Health Care in Rural Liberia

Slide	Presentation Notes
1	Tiyatien Health accompanier with patient and governance circle.
2	Overview — rationale, design, model
3	Huge burden of mental health in Liberia; far greater than global burden of disease estimates. Highlights problem of missing data, and risk of designing centralized policies based on available data. This degree of mental health burden is probably not atypical for countries with similar economic challenges and recent conflict, like Liberia.
4	Under President Ellen Johnson Sirleaf, Liberia has taken a very progressive stance on primary health care. The national policy for essential health services has six main focus areas, and as you can see, mental health makes the short list!
5	Less than a year later, and in collaboration with local organizations (including Tiyatien Health) and consultants from the MGH Department of International Psychiatry, Liberia formalized a national mental health policy – a landmark for a country so recently emerging from conflict
6	Key findings and recommendations of that policy include: …
7	But what are the core drivers of poor mental health in Liberia? Recall our earlier discussion on social determinants of health (from session 1 – primary health care talk)
8	A closer look at the JAMA 2008 study, published and unpublished data, as well as our experience in Tiyatien Health's depression clinic
9	You cannot treat poverty with antidepressants
10-13	Instead, you need an integrated approach to poverty and health. From care in the clinic, to home visits in the community, to a range of poverty-reduction strategies such as agricultural support and training, to political and economic empowerment of our patients. At Tiyatien Health, for example, our patients are full participants in the governance and direction of the organization.
14	Why focus on MH in Liberia?
15	Narrate slide.
16	Shifting from rationale to program design.
17	The major challenge is delivery, in setting with zero trained psychiatrists, only one physician on staff serving population of 50,000, need to aggressively task-share and apply what we have learned from delivery of HIV care in rural resource-limited settings. Essential feature of chronic disease is its chronicity (not whether communicable). Requires system capable of delivering continuous care over extended periods.
18	6 principles of chronic disease care in developing contexts. Pause for 5-10min on this slide to allow for healthy discussion with class.
19	What are some of the challenges? Again, pause for discussion.
20	The goal then is to…
21	Here were some of the design parameters we used.
22	For depression…
23	We learned from Vikram Patel and colleague's experience in Goa. Direct response to resource-limitations, not enough health workers, and dispersed rural populations = task-shift and decentralize services. In our case, needed to shift one step further down health workforce pyramid.
24	Narrate design elements. Special emphasis on the importance of monitoring

	and evaluation, despite the relative resource constraints and other challenges of working in this setting.
25	An example of our simplified forms, designed to match clinical algorithm, facilitate care, and enter directly into our database for prospective interim analyses. Also saves paper – 4 separate follow-up visits fit on a single page.
26	Mark Siedner, one of our research and M&E gurus, training three of our accompanier leaders in data entry.
27	We did a thorough search of the literature. Takeaways included… (LMIC = low and middle income country; PHQ-9 = patient health questionnaire, 9- and 2-item versions)
28	Depression protocol for community health workers. At intake point, PHQ-2 is administered to all patients in our care, as well as 1st 20-30 patients who present to outpatient department. If PHQ-2 is positive (≥3 on 0-6 range), they are referred to our clinic where they receive the full PHQ-9 by CHW leader who triages to "no depression" (≤4), "possible depression" (5-17), or severe depression (≥18). Note upper cutoff revised since original rollout of program. Again, our uncertainties about these cut-off points...
29	Notice the physician assistant's only role is to dispense amitryptilline. The CHWs manage all aspects of clinical care, including triage, diagnosis, follow-up, and counseling.
30	Accompanier roles include…
31	This is the protocol for clinicians. At follow-up, dosing decision is made according to repeat PHQ-9: ≥18 increase dose; 5-17 no change; ≤4 x6mo, titrate down
32-33	Closing thoughts…
34	Thank you.