March 22, 2016

Integrating Mental Healthcare Services in Rural Nepal

Structured notes from focus group discussions

Focus Group 1: Health Assistants (HA)
Total number of participants: 11
Date: November 23rd, 2015

Current situation:

- We refer the patient to a clinician who has received some training in mental health or we refer them to physicians.
- If this is not possible, we will screen the patient based on some training and knowledge we have. Might also start some meds but will ask them to see a psychiatrist in the city.
- We know that most patients will not be able to take the patient to the city to see a psychiatrist.

Desires:

- We agree that we need more training.
- We agree that training is not enough and ongoing consultation is helpful.

Thoughts about a collaborative care model:

- Reviewing all patients could be difficult
- Perhaps prioritize patients to be discussed based on severity rather than trying to discuss all patients at each session.
- It will be critical to train HAs so they are able to understand and follow the recommendations made by the consultants (conveyed by the care coordinators). What if the recommendations seem too complex?
- Care coordinators' skills will be absolutely critical for the success of the program.
- What about turnover? They need to around for long otherwise they will not be able to track patients' progress through time.
- It might be better to have an HA obtain psychosocial counseling (PSC) training rather than bring someone who has only received PSC training.
- The positive is that this might help decrease the load on one MH-trained clinicians with all HAs doing some aspects of MH care (e.g. screening) based on their training and comfort level.
- There will be times when HAs may need urgent consultation and the question may not wait until the Friday consultation. XXXXX has one contact in Nepalgunj who promptly answers the call or returns it within few minutes regardless of the day. This may not necessarily be feasible all the time and certainly won't be a model for other medical specialties.
- The program's success will also depend on HAs actually screening for mental illness because without this, there will be no patients feeding into the system for the care coordinators to discuss with the psychiatrists.
- For the program to be successful, there has to be a concurrent, strong training for all clinicians so they are able to conduct screening, follow recommendations etc. The video lectures were useful, mainly because the delivery used simple language and mnemonics.

- To maintain the knowledge-base, it will be important to integrate the protocols or at least the questions on electronic health record (HER)/make it available as charts on walls. Books and posters were initially suggested but when asked who had actually opened a book/chart when talking to a patient, no one raised their hand.
- Skills training has to be hands-on and with feedback after observation. Role-playing had been useful but would be even better if the person providing feedback was a psychiatrist.

Focus Group 2: Bachelor of Medicine, Bachelor of Surgery (MBBS), staff physicians
Total number of participants: 6
Date: November 25, 2015

Current Situation:

- Refer to psychiatrist in Nepalgunj/Kathmandu. Most patients want to go to India but it is very expensive. Some come back with benzodiazepines only for depression.
- Learn about visiting psychiatrists in the area (once a month) and then refer.
- Discuss cases amongst each other.

Desires:

- Integration will certainly be welcome
- Will allow primary care providers (PCP) to screen and then refer to the counselor.
- Will help PCPs with time-management because patients with mental illness usually require more time and having a dedicated counselor will free up PCPs' time.

Concerns/unknowns:

- Counselors should be able to assess for severity of illness and potentially refer back to the PCP if the patient is worsening or turns out to have severe illness and will need medications.
- Counselors will need a private space so that patients can be taken there and not be interviewed/counseled in the busy outpatient department (OPD).
- This is not specific to mental health, but HAs are not allowed to prescribe several medications on their own. In practice, this is rarely enforced but we need to think about this in case there is some concern about, for example, benzodiazepine abuse in the future.
- If many patients will need 1:1 time, the counselors will be quickly overwhelmed. So they should consider group therapy and also consider scheduling future visits for non-acute cases.
- What will happen when PSCs leave? What if they have set up several groups and have individual therapy cases etc and they have to leave? What to do with the patients then? Consider employing younger counselors and having them join the groups as well so that when the senior PSCs leave, the juniors will be able to take over. Also make sure that they counseling sessions are manualized and evidence-based and have good documentation so that someone else can pick it up when the senior person leaves.
- Consultants should have a reliable schedule. Better to work with someone who is in a university setting than in private practice so that we can have few hours set aside each week for consultation session.

Other suggestions:

- If the load of patients who need consultation is high, this can be managed by having a case discussion just among the PCPs and then deciding which cases need input from the psychiatrist.
- PSCs must have clinical background (e.g. HA) to be able to communicate with other HAs and with physicians.
- Consider hiring a highly trained/experienced counselor and a newly trained counselor/HA. Perhaps the highly trained person cannot be retained but they can guide the HAs, who are likely to be retained/long-term employees.
- Therapy/counseling should be seen as an add-on rather than a "referral out", meaning PCPs will continue to follow-up with the patients while counselors continue to see them

in parallel. This would be analogous to referring the patients to the community health program.

- All PCPs should be provided with a screening tool for depression and other illnesses so they can conduct this on all patients and then refer positive patients to the PSCs.

Focus Group 3: Community Medical Assistant (CMAs; also known as Auxiliary Health Workers or AHWs)
Total number of participants: 7
Date: November 27, 2015

Current situation:

- "I've heard that about 20% of women have mental illness, and many will never be diagnosed so having a mental health program will be very good"
- Currently, many people are being referred to the private specialists and it is not necessary: people in the city are doing head CT for mild mental illness. They do this multiple times in multiple hospitals.
- Lot of patients with aches and pains are being told they have "other anxiety" because we do not know what is going on

Recommendations:

- Train own staff (e.g. HA/CMA) to become psychosocial counselors because they will know the system and will be able to integrate back into the clinic.
- Train all clinicians in the hospital and outpatient clinic on screening for illness so they can feed into the system.
- Therapy will be helpful and is a skill they want to learn.

Caveat: this was the final focus group and some of the repeated recommendations are not included.