Mental Health and Poverty Project (HD6)

Case Study 3:
The development and evaluation of a pilot community-based intervention for common mental disorders (CMDs) in a rural district in South Africa

The purpose of the Mental Health and Poverty Project is to develop, implement and evaluate mental health policy in poor countries, in order to provide new knowledge regarding comprehensive multi-sectoral approaches to breaking the negative cycle of poverty and mental ill-health. MHaPP is based in 4 African countries: Ghana, South Africa, Uganda and Zambia.

Summary of success:
This novel intervention study aims to close the treatment gap for depression and evaluates the use of community-based health care workers (CHWs) to deliver a group-based counselling service to alleviate depression. As there are inadequate numbers of trained nurses in this remote rural district, the service is delivered by locally trained CHWs under the supervision of a mental health counsellor (MHC) with a four-year training (Bachelor of Psychology) based at the PHC clinic level.

The intervention includes the development and adaptation of manulaised version of Interpersonal Therapy (IPT) for use by CHWs in treating depression in order to increase accessibility and affordability of the service.

Mental health counsellors trained in psychological work over four years provide:
- basic counselling in individual form;
- a referral system for individuals in need of immediate care who are suffering from depression; and,
- support and training to CHWs in providing a counselling service for those with depression.

Who has already benefited and how?
CHWs have benefitted on a technical and emotional level through the manualised training and once monthly support meetings provided by the mental health counsellor. Service users have gained through the alleviation of depressive symptoms through strengthened social connections and increased coping skills resulting in greater personal agency.

Description of the project and main findings
There is strong evidence for the benefits of integration of treatment of depression into primary health care in well-resourced settings. In middle and low income contexts there is a need to harness other strategies for the delivery of care for CMDs because of human resource constraints. Evidence suggests that counselling provided by trained community-based workers can be effective.

The development of peer facilitated group interventions for people with depression using a manualised adapted version of Interpersonal Therapy proved feasible with good retention and all participants experiencing significantly reduced depression scores at 12 and 24 weeks compared to controls. The findings suggest that the intervention has the potential to close the treatment gap for depression at a district level at substantially reduced costs compared to models that do not embrace a task shifting approach.

The prevalence of common mental disorders (CMDs) such as depression, PTSD and other anxiety disorders is estimated to be high in South Africa at 16.5%\(^1\) Among pregnant women, the prevalence rates in South Africa are particularly high ranging between 34 and 41%, with most of these being untreated.\(^2,3\)

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\(^3\) Among pregnant women, the prevalence rates in South Africa are particularly high ranging between 34 and 41%, with most of these being untreated.\(^2,3\)
The potential benefit is the incorporation of the training model into the suite of services offered to patients at outpatient clinics who suffer from common mental disorders, and the adoption of a referral system that integrates mental health into the primary health care system.

The potential benefits for such an intervention include the vast majority of patients at outpatient clinics presenting with depression who are currently untreated. The establishment of a low cost mental health system that utilises CHWs and a MHC may well address the need for greater treatment access to patients suffering from depression and other common mental disorders.

The effects of the depression programme not only alleviated depression, but improved cognition which in turn led to better coping strategies as the following extracts from participants in the programme suggest:

"I was just so terribly sad, just down all the time. When I meet with this group, my mind becomes lighter."

"I feel free, I no longer have that feeling of being tied up and trapped that I used to have before. I just feel free, even if another problem comes up when I'm alone I feel like I can still go on, it doesn't depress me."

"I've become brave...you know, if you want to beat something, you have to take the position of being brave. Now, I am able to do that – really the group has helped."

"Everybody was leaving me, first my father, then my step mother. Everybody that was close to me was leaving me. I even thought I was worthless, but by coming here I realized that by going out and meeting other people, many of the bad thoughts can be removed from my head."

**What made your research successful?**

- A detailed situation analysis of mental health needs and service provision in the district, in Phase 1 of MHaPP.
- The research has been made possible through a partnership with the Department of Health sub-directorate on mental health and local health officials. This augurs well for buy-in to the treatment approach in the future.
- The successful translation and adaptation of a basic counselling manual as well as group-based counselling manual based on Interpersonal Group Psychotherapy principles. Specifically the method of drawing on vignettes in the manual provided a basis for users to identify and feel acknowledged and understood in their problems.
- Using CHWs to deliver the programme made it more culturally congruent and meaningful for people. In addition, it helped that the care workers were not professional and made users feels more at ease.
**Lead researchers and organisations**

| Ghana: Kintampo Health Research Centre; University of Ghana Medical School; Ministry of Health |
| South Africa: University of Cape Town; University of Kwazulu Natal; Human Sciences Research Council; Department of Health |
| Uganda: Makerere University/Butabika National Mental Hospital; Ministry of Health |
| Zambia: University of Zambia; Ministry of Health |

**Lead partners:** UCT; UKZN/HSRC; WHO (Geneva); WHO (AFRO); University of Leeds (Nuffield Centre for Health and International Development)

**DFID Involvement**

| Dates of RPC: | 2005-2010 (Note: Phase 2 Interventions are from August 2008 to July 2010) |
| Financial spend to date: | £2,198,552 (2005/6-2010/11) – total RPC budget, across the four countries. |

**Detailed protocol of the intervention study is available on request.**

Reference List


