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Evaluation of proactive community case detection to increase help-seeking for mental health care: a pragmatic randomized controlled trial

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Abstract

Objective: The Community Informant Detection Tool (CIDT) is a vignette- and picture-based method of proactive case detection to promote help seeking for persons with depression, psychosis, alcohol use disorder, and epilepsy. The authors evaluated the effectiveness of the CIDT to increase help-seeking behavior in rural Nepal, where a district mental health care plan was being implemented.

Methods: Twenty-four health facilities were randomly assigned to one of two methods for training their all-female cadre of community health volunteers: standard training or standard training that included the CIDT. The authors compared the number of patients with depression, psychosis, alcohol use disorder, and epilepsy who were registered in the routine health information system prior to and 6 months after the training.

Results: At health facilities where volunteers received CIDT training, 309 patients were registered as having depression, psychosis, alcohol use disorder, or epilepsy, compared with 182 patients at facilities where volunteers received standard training. The median number of patients registered was 47% greater at facilities where CIDT training was included (24 patients) than at

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Availability of data

The data supporting the findings will be made available through the PRIME program's website <http://www.prime.uct.ac.za/>.

facilities with standard training (16 patients) ($p=0.04$, $r=0.42$). The difference in the number of registered patients remained significant when the analysis factored in the population catchment (N=18 patients [CIDT] versus N=14 [standard] per 10,000 population; $p=0.05$, $r=0.40$).

Conclusions: The median number of patients registered as having a mental illness was 47% greater at primary care facilities in which community health volunteers used the CIDT than at facilities where volunteers received standard training. Proactive case finding holds promise for increasing help seeking for mental health care.

IRCTN <http://www.isrctn.com/ISRCTN28071919>

Keywords

community health workers; community mental health services; developing countries; help-seeking behavior

Introduction

Recent global efforts to reduce the treatment gap for persons with mental, neurological and substance use disorders in low- and middle-income countries (LMICs) have focused on “supply-side” factors, i.e., increasing availability of primary care providers trained in mental health care (1, 2). However, even when availability of services has increased, there is often low utilization of mental health services due to “demand-side” factors, i.e., factors that determine the level of uptake of care, such as cost of services, social and cultural norms, and knowledge of available services (3–6). LMICs are not dissimilar from high resource settings regarding gaps in help-seeking. In the United States, there is low mental health help-seeking among racial and ethnic minorities (7), members of the military and veterans (8, 9), rural populations (10), and the general public (11, 12). To bridge the ‘access gap’ and increase mental health treatment coverage, supply-side efforts will need to be combined with strategies that increase help-seeking and demand for care (13). Initiatives demonstrated to be successful in LMICs may set the stage for comparable strategies in high resource settings.

An innovative strategy to increase help-seeking is the Community Informant Detection Tool (CIDT). The CIDT has been developed in the context of district-based mental health care plans initiated in five LMICs (14), including Nepal (15). The CIDT is intended to be used by people that are respected and trusted in the community (16), who received a two-day training in community engagement and implementation of the tool. Persons trained on CIDT use the tool in their daily work or interactions, through a process of prototype recognition of people in their surroundings. The strength of the method is that (a) it facilitates reaching the most vulnerable and most isolated people in a community, and (b) it provides a low-cost alternative to universal screening in primary health care. There are a number of risks associated with universal screening for mental, neurological, and substance use disorders in primary care, including time and related primary care provider costs associated with screening, the diverse range of screening tools required, and the risks associated with false positives, including flooding services with clients.

The current study evaluates the effectiveness of CIDT as a community-based case detection and help-seeking promotion strategy in rural Nepal where populations have extremely

limited mental health help-seeking. Prior to implementation of this study, there was low mental health treatment seeking behavior. Based on a community survey of 1,983 adults in the region, only 1 out of 13 persons with depression and 1 out of 20 persons with alcohol use disorder sought mental health care (17). We conducted a pragmatic randomized control trial to test the added benefit of the proactive case detection tool. We hypothesized that there would be more engagement with mental health services in the area where proactive case detection was introduced.

Method

Setting

This study was implemented in Chitwan, a district in the south of Nepal, as part of the multi-year Programme for Improving Mental Health Care (PRIME) that aimed to implement and evaluate a district level-mental health care plan (MHCP), including the integration of the World Health Organization's (WHO) mental health Gap Action Programme Intervention Guide (mhGAP-IG) in primary health care (14, 15). The program include demand-side improvements, specifically training healthcare workers in all primary care facilities to deliver mental health services using the mhGAP-IG (15).

Pro-active case finding strategy: Community-Informant Detection Tool

The CIDT is a method of proactive case detection that enables lay community people to assist in the identification of people with potential depression, psychosis, alcohol use disorder, and epilepsy (See Supplemental Figure S1). The CIDT tool consists of:

- a. context-sensitive vignettes describing prototypes of depression, psychosis, alcohol use disorder, and epilepsy, combined with pictures that are easy to understand for low literacy populations;
- b. one question that asks the community informant to gauge the extent to which a member of their community matches a prototype; and
- c. two additional questions about impaired daily functioning and perceived need for support for an identified individual.

If there is significant prototype matching and a positive response to at least one of the additional part 'c' questions, the community informant will encourage the person to seek help in the health facility where mental health services are being offered (18). Asking the two additional questions (impairment and perceived need for support) and discussing care seeking with the individual or family member requires approximately 10–15 minutes.

A previous study has demonstrated that when lay community members use the CIDT for depression, the accuracy of detection is good (positive predictive value of 0.64) (18) with stronger psychometric properties than the Patient Health Questionnaire (PHQ9) (19). A subsequent study, demonstrated that amongst those detected using the CIDT, two-thirds (67%) accessed services because of that detection (20). These encouraging results prompted the current study to compare help-seeking in primary care settings between regions that were randomized to standard treatment engagement vs. using the CIDT.

The CIDT was developed within the context of the PRIME mental health care package to increase help-seeking and was implemented by female community health volunteers. Female community health volunteers are an existing cadre within Nepal's health care system, present within each village, and these women are often the first point of contact for people needing health services (21). They are residents of the village where they work, and they deliver family planning and maternal and child health services. Within the mental health care package, community health volunteers were also responsible for conducting home-based care for people receiving mental health care to promote treatment adherence.

Study Design

We conducted a pragmatic randomized controlled trial (RCT), comparing utilization of mental health services at primary health care facilities where the CIDT was introduced versus standard practice as the control condition. Female community health volunteers in both arms received equal duration of training on awareness raising activities. This curriculum was 2-days with contents including basic information about mental health, stigma, availability of mental health services in primary care, and making self-referrals. In the CIDT arm, the community health volunteers were taught about proactive community referrals (see Supplemental Table S1 for standard curricula and modifications for CIDT arm). During the training on using the CIDT, time was spent on addressing the potential risks associated with using this approach (e.g., stigmatizing of identified individuals, issues of confidentiality). In this regard, it is important to mention that the community health volunteers are a well-respected group of people in the community with prior health work experience and an ethos for community service. A bi-monthly supervision was conducted for all community health volunteers to oversee the quality of work as well as to discuss challenges and possible ways to overcome it, which included monitoring of the use of CIDT.

This study was implemented in 24 health facilities, (catchment population of intervention arm is 155,114, that of the control arm is 131,724), where the PRIME package was being rolled out. The study is a pragmatic RCT because it was embedded within routine practice. All health facilities in the PRIME scale-up phase with planned integration of mental health services were eligible, excluding only health facilities located in the same village because of risk of contamination and excluding urban centers with overlapping catchment areas (see Supplemental Table S2 for descriptions of health facilities).

Randomization

The eligible health facilities were randomly assigned to the two study arms in a 1:1 ratio. After randomization, community health volunteers attached to the randomized health facilities received: (a) basic training on community outreach for mental health services (community awareness raising) as the control group condition, or (b) the same training on community outreach combined with training on using the CIDT. Randomization sequence generation was done using SPSS (22).

Ethical conduct

Ethics approval for this study was obtained on 7 April 2016 from Nepal Health Research Council (No 1620).

Outcome and analysis

We assessed the number of patients with depression, psychosis, alcohol use disorder, and epilepsy, as well as other mental, neurological and substance use disorders registered in the health facilities' routine patient data collection system. Within each health facility, there is an outpatient department register booklet specifically for care of patients with depression, psychosis, alcohol use disorder, and epilepsy. Primary care providers can also register other mental, neurological, and substance use disorder conditions. This register was provided to all health facilities through PRIME and was routinely reviewed for completion by clinic supervisors and PRIME research staff. Registration reflects patients that have been started treatment for a mental, neurological and substance use disorder. For the baseline, we collected the total number of depression, psychosis, alcohol use disorder, and epilepsy patients recorded over a period of 6 months prior to the community health volunteers training and prior to the implementation of the MHCP. Baseline data were collected to assess between-group comparability in registered depression, psychosis, alcohol use disorder, and epilepsy patients before the start of the program. For the endline, 6 months after the community health volunteers training and start of MHCP service provision, we again collected the total number of mental health cases recorded over the previous 6 months period.

Given the small sample size of 12 facilities in each arm, we used a non-parametric test (Mann-Whitney U) to compare the median number of depression, psychosis, alcohol use disorder, and epilepsy patients per health facility by study arm as the primary outcome. In addition, we compared the number of patients per health facility based on the population catchment of facility (presented as per 10,000 population catchment), and we compared the number of patients based on the number of community health volunteers trained per health facility. Data collection happened between July 2016 and June 2017. (See supplementary material for completed CONSORT statement.)

Results

Of the 24 eligible health facilities in the Chitwan district, 12 were randomly assigned to each arm (see Supplemental Figure S2). In the intervention arm 105 community health volunteers were trained, compared to 91 in the control arm (see Table 1). At baseline only 2 cases with a mental disorder (both depression) were registered (both in the intervention arm). Six months after the community health volunteers training and after the initiation of the mental health care services, there was a rise in registered mental disorders in both study arms. The health facilities with community health volunteers that used the CIDT registered 309 mental, neurological, and substance use disorder patients compared to 182 patients in facilities in the standard training arm. A Mann-Whitney test indicated that number of patients registered with an mental, neurological and substance use disorder per health facility was greater for health facilities where community health volunteers were trained with CIDT ($Mdn=23.50$) than for health facilities where community health volunteers received standard training ($Mdn=16.00$), $U=36.50$, $p=0.04$, $r=0.42$. This equates to a 46.9% greater median number of depression, psychosis, alcohol use disorder, and epilepsy patients in facilities where CIDT training occurred compared to control facilities. We did not find a significant difference

when analyzing by the number of community health volunteers trained per health facility, but the relationship was significant for the population catchment of health facility (see Table 1). Figure 1 provides breakdown by disorder of the information in the mental health outpatient registry.

Discussion

With increasing attention to reducing the treatment gap for people in need of mental health care both supply- and demand-side factors should be considered (13). The former can, for example, be done by training primary care providers in the diagnosis and treatment of mental disorder. However, health systems may continue to face challenges in improving service access and utilization even after increasing availability of care (23). Demand-side factors refer to strategies that aim to improve service utilization, beyond increasing the availability of services. The CIDT is developed to facilitate identification of persons with potential depression, psychosis, alcohol use disorder, and epilepsy and their engagement with services. Such recognition of 'illness behavior' at the community level is in line with tackling the first of five filters or barriers in Goldberg and Huxley's pathways to psychiatric care model (24).

This study demonstrates that proactive community case detection, using the CIDT, leads to nearly 50% more people being initiated on care compared to community strategies only relying raising awareness and self-referral. Previous studies have demonstrated that approximately two-thirds of the people being detected by community members are accurately detected (18), and that approximately two-thirds of those being detected seek help because of case detection (20). The current study provides evidence for the effectiveness of the CIDT as a strategy to increase relevant help seeking. This finding is particularly pertinent in contexts in which the challenges of routine screening for depression, psychosis, alcohol use disorder, and epilepsy in primary care settings remain unresolved (25). Especially in LMICs where services are scarce and barriers to access abundant, facilitating help seeking is important in reducing the treatment gap (26).

The limitations of this study are mostly related to the pragmatic nature of the design. First, while we randomized assignment to study arms, differences between the areas in the control or intervention arm may explain the between-group differences in service utilization. We conducted an analysis based on population catchment of each facility, and the differences remained significant. However, when analyzing by number of community health volunteers trained, the differences were not significant, although the absolute median difference was 2.6 patients versus 1.9 patients. A larger sample size of health facilities is needed to accurately assess differences per community health volunteer trained. The difference in number of female community health volunteers between study arms was explained by one health facility that had only one female community health volunteer in the control arm.

Second, as we were dependent on the limited data from the routine health information system, we could not evaluate the role of other possible predictors impacting service utilization (e.g., average distance to health facility, socio-economic status of households, and quality of services). Future replication studies should take these variables into account.

Another limitation is that we do not report the specific matching of CIDT prototype to diagnosis made by the primary care provider. This has previously been reported in another CIDT sample (18). Moreover, as the goal is to encourage help-seeking, if the community health volunteer CIDT prototype does not match the exact diagnosis made by a primary care provider but a different mental, neurological and substance use disorder diagnosis is made, we still consider this a successful referral.

It is important to note that the outcome as assessed in this study is dependent on the primary care providers' diagnostic skills. It is possible that the results presented here are an underestimation of the true effect of the CIDT, if we take into account the rate of false negatives, i.e., missed diagnosed by primary care providers. Our study of primary care providers' detection rates of depression and alcohol use disorder would support that the CIDT is actually more effective than demonstrated here because some primary care providers fail to diagnose some cases of depression and alcohol use disorder (27), and the current study only captures those patients who received a mental, neurological and substance use disorder diagnosis from a primary care provider. Therefore, patients seeking care because of the CIDT who were not diagnosed and registered by the primary care worker would not have been captured in the current study design.

Moreover, future use of the CIDT in other settings should take into account the risks associated with applying the approach (as was the case in the current study), ensuring that there is sufficient social capital in the communities where it is introduced, is implemented by community members that are respected and trusted, and explicitly addresses the risk for stigmatization.

Although the current study does not include treatment outcomes for these specific patients, our prior evaluation in other health facilities in this project has shown that patients referred using CIDT had positive treatment outcomes (28): at 6-months post-treatment initiation, provision of minimally adequate treatment subsequent to diagnosis for depression was 93.9% and for alcohol use disorder was 95.1%. Effect sizes for treatment outcomes in this program were 0.58 for depression, 0.34 for alcohol use disorder, 0.43 for psychosis (28). Regarding whether those most in need of treatment were receiving care, routine monitoring of healthcare utilization data demonstrated an increase in contact coverage from 0% at baseline to 7.5% for alcohol use disorder after initiation of the district mental health plan including CIDT; results for other disorders 0% to 12.2% for depression, 1.3% to 11.7% for epilepsy, and 3.2% to 50.2% for psychosis (28).

Efforts to scale up mental health care services to achieve adequate treatment coverage currently involves the integration of WHO's mhGAP-IG within primary health care systems in over 80 countries (29). In order to capitalize on governments' investments to make mental health care available, a demand-side intervention such as case detection using the CIDT should be part-and-parcel of these programs, in order to optimize service utilization (30). Furthermore, we recommend developing, evaluating and comparing other low-cost demand generating strategies, for example stigma reduction (31), systematic awareness raising (32), or invitation cards (23), alongside efforts to scale up mental health care in LMICs. A combination of strategies may be needed to facilitate uptake of mental health services,

especially for the most vulnerable and hard to reach. Moreover, given that similar gaps in help-seeking are observed in high-resource settings, such as North America and Western Europe (7–12, 33), it will also be important to explore how lessons learned in LMICs can benefit strategies in high-income countries. The existence of community networks among immigrant families, military families, and rural populations suggest that the CIDT could contribute to reducing the access gap in mental health care.

Conclusion

In an effort to close the treatment gap for people with mental health problems in LMICs, supply-side strategies need to be combined with demand-side strategies. The CIDT is a methods of proactive case detection, using context-sensitive vignettes describing prototypes of mental disorders, in order to increase help-seeking for available mental health services. This study demonstrates that using the CIDT, at district level, was associated with 47% greater median numbers of primary care patients registered as having depression, psychosis, alcohol use disorder, or epilepsy compared to primary care facilities with standard training of community health volunteers. Proactive case finding holds promise for increasing help-seeking for mental health care.

Supplementary Material

Refer to Web version on PubMed Central for supplementary material.

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Highlights:

1. The Community Informant Detection Tool (CIDT) is a proactive case finding tool to promote mental help-seeking that can be used by community members without formal mental health training.
2. CIDT used by community health volunteers results in greater help-seeking compared to awareness raising approaches relying on self-referral.
3. CIDT has the potential to increase help-seeking in low- and middle-income countries as well as among rural, immigrant, and other vulnerable populations in high-income countries.

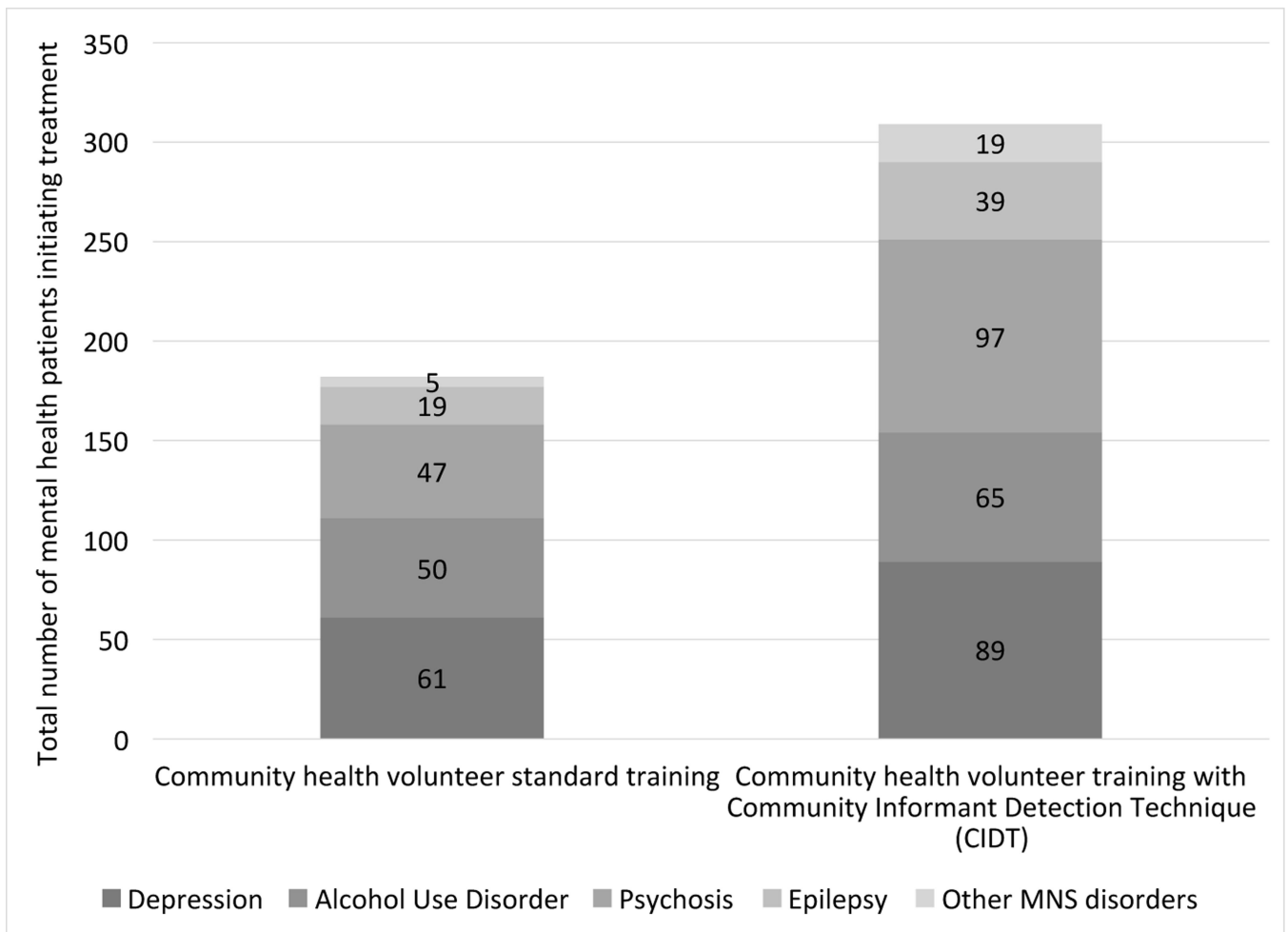


Figure 1. Number patients initiated on treatment in primary care facilities comparing facilities where female community health volunteers received standard awareness-raising and referral content (n=12 facilities, 91 community health volunteers) vs. female community health volunteers trained in the Community Informant Detection Tool (CIDT), (n=12 facilities, 105 community health volunteers). Abbreviations: mental, neurological, and substance use disorders (MNS).

Table 1.

Depression, psychosis, alcohol use disorder, and epilepsy patients initiating treatment in health facilities with standard training (n=12) versus training that included the Community Informant Detection Tool (CIDT, n=12) six months after training

Outcome variable	Total (n)	Median	Interquartile Range	Mann-Whitney <i>U</i>	<i>p</i> -value	Effect size (<i>r</i>)
Number of mental health patients per primary care facility				36.50	0.04	0.42
Control	182	16.00	9.50, 20.00			
Intervention (CIDT)	309	23.50	16.00, 38.25			
Number of mental health patients per community health volunteer trained per primary care facility				52.00	0.25	0.24
Control	91 [*]	1.88	1.15, 2.89			
Intervention (CIDT)	105 [*]	2.61	1.78, 4.70			
Number of mental health patients per 10,000 population catchment per health facility				38.00	0.05	0.40
Control	131.71	14.14	11.40, 16.09			
Intervention (CIDT)	155.11	17.72	13.29, 26.49			

Note. CIDT= community informant detection tool

^{*} this refers to the number of community health volunteers that have been trained.