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POLICY NOTES

Community-based mental health project in Davao Region: policy notes

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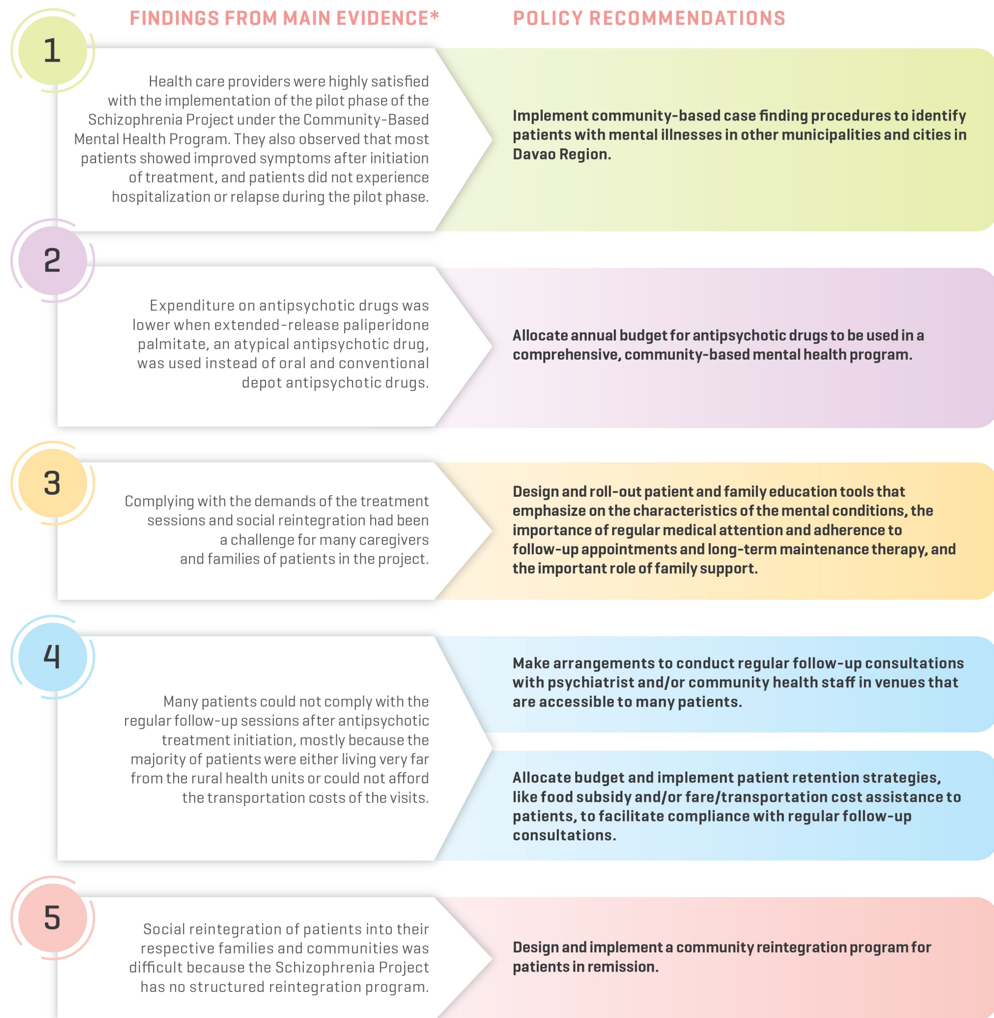

INTRODUCTION

In accordance with the Republic Act (RA) 11036, also known as the Mental Health Act of 2017, the Department of Health (DOH) was tasked to "establish a balanced system of community-based and hospital-based mental health services at all levels of the public health care system from the barangay, municipal, city, provincial, regional to the national level." It is also expected that the Local Government Units (LGUs) "promote deinstitutionalization and other recovery-based approaches to the delivery of mental health care services."[1] Even before RA 11036 was enacted, the Davao Center for Health Development (DCHD) had already

facilitated the establishment of several Community-Based Mental Health Programs (CBMHPs) in rural health units (RHUs) within the region since 2015. These programs are guided by six principles–coordinated level of referral system for better patient care, optimizing the expertise of the regional mental hub to guarantee rational use of drugs, community-based patient care for a more cost-effective treatment, capitalizing family and patient's support groups for better patient outcomes, optimizing innovative long-acting injections for better compliance and decreased relapse, and neutralizing the stigma against schizophrenia to improve mental health.[2]

The aim of this article is to recommend health care policies based on the report on observations and lessons learned from the implementation of the CBMHPs by the DCHD in four municipalities in Davao Region.

MAIN EVIDENCE

In Davao Region, the Schizophrenia Project has been carried out since March 2020 by RHUs in collaboration with DCHD, several psychiatrists, and Johnson & Johnson Philippines as part of the CBMHPs. The project was started in order to make mental health services accessible and antipsychotic medications readily available in municipalities with the highest burden of schizophrenia. A one-year pilot phase of the project was implemented in four sites–Boston in Davao Oriental, Santo Tomas in Davao del Norte, Sta Cruz in Davao del Sur, and Jose Abad Santos in Davao Occidental. Since July 2020, a total of 49 patients—9 from Boston, 10 from Santo Tomas, 11 from Sta. Cruz, and 19 from Jose Abad Santos—were enrolled into the program. Diagnosis, treatment, and monitoring of the enrolled patients have been done by the collaborating psychiatrists and RHU physicians. Johnson & Johnson trains health workers involved in the program, the RHUs coordinate the events in the diagnosis, treatment and monitoring processes, while DCHD gives technical assistance to the RHUs and finances the project. During the implementation review of the Schizophrenia Project, the stakeholders pointed out several challenges and good practices, for which policies can be recommended to improve future implementation of the project.[3] An outline of the policy recommendations based on the review of the project's implementation is presented in the evidence-to-policy diagram below.

In the evidence-to-policy diagram, we enumerate important findings described in the infographic and program profile articles, and outline our policy recommendations based on these findings.

RELATED EVIDENCE

The World Health Organization's Mental Health Action Plan emphasizes the "provision of comprehensive, integrated mental health and social care services in community-based settings."[4] There is increasing evidence on the effectiveness of mental health interventions into primary care services in promoting mental health and social equity,[5] especially in communities in low- to middle-income countries (LMICs).[6]

Community case finding has been proven to be effective in increasing access to mental health care, especially in LMICs.[7] This is especially true in countries like India and Nigeria, where active case finding for mental disorders played a vital part in increasing the demand for and access to care.[8 9] In Nepal, increasing help-seeking for mental health care through the use of a structured tool, e.g., the use of pictorial vignettes[10] by community informants, helps identify people with priority mental disorders.[11] Data from several quantitative studies done in Asia showed that the rates of formal help-seeking behaviors in Filipinos ranged from 2.2%[12] to 17.5%.[13] Community-based studies among Filipinos showed negative attitudes (e.g., stigma, prejudice, and discrimination) towards formal help-seeking.[14]

With only 3% to 5% of the total health budget spent on mental health,[15] looking for cost-effective measures to deliver mental health services is an important strategy in community-based mental health programs.[2] The priorities and policy goals on community-based mental health for each country would largely depend on its financial resources. For LMICs, policy considerations on mental health would include improving services within primary care settings, including community-based care.[16] In high-income countries, mental health services conducted in the community had lower costs compared to those conducted in hospital settings.[17 18]

Managing appointment adherence, despite the integration of behavioral health programs, has still remained a great challenge especially in low-income settings.

Patients with serious mental illnesses are more likely to miss appointments and are less adherent to the prescribed mental health treatment plan.[19] Consequently, patients with poor appointment adherence will have suboptimal outcomes and higher rates of hospitalization.[20] The use of an inexpensive bundle of interventions—consisting of simple educational materials, warm patient hand-offs, and follow-up phone calls—that are applied in low-income clinics and low-resource settings, has led to an improved adherence to mental health treatment.[21] The ability to keep clinic appointments may also be improved by offering incentives, such transportation and monetary assistance, to patients in underserved and low-income communities.[22]

Psychoeducational interventions—i.e., lectures, therapy sessions, monthly gatherings—have been developed to help improve the clinical and social outcomes of patients with schizophrenia, and to meet the information needs of the patients' families.[23] Several studies conducting psychoeducational interventions among patients and their families/caregivers showed improvement on patients' compliance to treatment, clinical status, and social functioning.[24-29] Patients' families and caregivers also reported a lessening of perceived burden in taking care of patients with schizophrenia after experiencing some form of psychoeducational interventions.[24]

Reintegration into family life and the community is the end-goal of treatment programs for patients with mental illness. The resources needed for coordinating reentry and managing the behavioral health problems in the community may be compounded by complex social problems that stems from poverty,[30] especially in geographically isolated and disadvantaged areas. Multidisciplinary reintegration programs—including employment services, financial management counseling, cognitive remediation, and social skills training—have been found to be effective in reintegrating patients with schizophrenia into the society.[31] [32] Efforts to implement a community reintegration program for patients with mental illness should therefore involve not only the medical sector, but also those sectors that can contribute to a holistic approach to the program.

Based on the review of the implementation of the Schizophrenia Project, a community-based approach is an effective strategy for identifying, diagnosing, treating, and possibly rehabilitating persons with mental illness. However, such an approach also demands great efforts from the part of the program staff to consolidate and efficiently manage available financial, social, and human resources, to coordinate all stakeholders, and to oversee all activities within the program. When backed by health policies and carried out well, all these endeavors can lead to the successful treatment and social reintegration of patients with mental illness.

Contributors
CMPA, RCR, CLM contributed to the conceptualization of this article. All authors wrote the original draft, performed the subsequent revisions, approved the final version, and agreed to be accountable for all aspects of this report.

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