EVALUATION AND COSTING OF THE PILOT PROGRAMME ON PROMOTION OF ADOLESCENT MENTAL HEALTH AND PREVENTION OF SUICIDE IN KYZYLORDA OBLAST, KAZAKHSTAN

To assess viability of the UNICEF’s pilot as a cost-effective intervention for adolescents’ suicide prevention and mental health promotion, and to document the Kazakhstani experience in customizing methodologies and approaches with possible use by other countries.

Background

Globally, adolescent suicide and self-harm has continued to climb the agenda of governments and development organisations (McKinnon et al., 2016). Suicide is the second and fifth leading cause of death for females and males aged 10-19 years respectively, with roughly 67,000 adolescent suicides each year (WHO, 2017a). Between 1990 and 2009, the World Health Organization (WHO) had identified the Republic of Kazakhstan as having some of the world’s highest suicide rates for young adults, adolescents and younger children (WHO, 2014). UNICEF in Kazakhstan has developed, piloted and is bringing to national scale an innovative project which seeks to reduce the risk of adolescent suicide and improve their mental health and well-being. The pilot used schools-based training and awareness-raising to identify, refer and treat adolescents with mental health problems and at risk of suicide. The issue is highly sensitive and stigmatized, which has acted as a barrier to raising the profile of the issue and implementing potential solutions.

Methodology

The overall approach to this evaluation revolves around a theory-based design, which involved reconstructing a Theory of Change (ToC) of the programme, and developing an evaluation framework and Key Evaluation Questions (KEQs). This approach was further complemented by a mix of quantitative and qualitative methods: key document reviews, qualitative data analysis, qualitative data collection and analysis through: KIs, FGDs, with 120 respondents interviewed across 16 sites in Kyzylorda Oblast; and a cost analysis of the ASP pilot. In the context of this sensitive evaluation, all respondents agreed to take part in the interviews and signed an informed consent form. All interviews with students at risk were conducted off the school grounds and in the Kyzylorda Youth Health Centre (YHC) on appointment. This allowed students at risk to remain anonymous in regards to their peers and to access the YHC’s mental health services before and/or after the interviews if they desired to do so.

The initial assessment of adolescent mental health in Kazakhstan, funded by UNICEF, found alarmingly high rates of mental ill-health and risk factors for suicide. The study found that:

- 26.5% of adolescents were considered at risk
- 3.3% were considered at high risk of suicide
- 4.4% had moderate or severe depression
- Access to health services was low – only 15.4% of cases in a psychological autopsy had had contact with a general practitioner

Source: Wasserman et al 2014

Conclusions/Impact

By validating the results of the pilot, the evaluation confirmed the value of the model and of the effective multi-sectoral collaboration. This validation in turn enabled UNICEF and partners to speak with confidence about strategies to promote the mental health and well-being of adolescents. At the same time, the evaluation reinforced national support for the pilot initiative, with the Government of Kazakhstan dedicating national resources to the nationwide scale up of the model. AMH is now firmly on the national agenda in Kazakhstan, and mental health and its integration into PHC is receiving greater attention and resources. The evaluation also sparked the spread of the programme to other countries in the region. The diffusion of the policy to other countries in the region can be attributed to the 1st International Conference on Promoting the Mental Health and Wellbeing of Children and Adolescents held in Almaty in January 2018. UNICEF supports the Government of Kazakhstan to provide technical and financial resources to promote the model in 3 countries in Central Asia.

Recommendations

The recommendations are focused around 3 core areas: i) capturing learning, ii) improving programme components and iii) scaling and replication.

- Strengthen evidence generation for piloting of innovative approaches, particularly in health systems, and to test what works; to continue improving the use of evidence and data;
- Enhance training for GPs and, to a lesser extent, school psychologists; Enhance the curriculum for pre- and in-service training of educational psychologists;
- Enhance training for GPs and, to a lesser extent, school psychologists; Enhance the curriculum for pre- and in-service training of educational psychologists;
- Improving treatment options for those with complex needs and improve access to pharmacological treatment; Develop more differentiated screening models which can identify complex needs;
- Provide a mechanism for debriefing to carers of those at risk of suicide, so that they can receive professional support;
- Improve understanding of the gender-based norms which affect incidence of self-directed violence, and further develop a gender differentiated approach;
- Strengthen engagement with policy-makers and decision-makers to ensure that the mental and PHC systems are adequately resourced to meet demand.

10 Main Lessons Learned

Lessons 1 & 2: Over-coming stigma related to mental health & The importance of leveraging political will
Lessons 3 & 4: Use a multi-disciplinary approach to awareness and identification of those at risk & Engage with parents
Lessons 5 & 6: Expand treatment options for those with high and complex needs & Improve access to pharmacological treatment
Lessons 7 & 8: Adequately resourcing frontline providers & Using evidence and data
Lessons 9 & 10: Developing sustainable models & Using a gender and equity focus