Mental Health Integration in General Health Care: a Step-Wise Approach
Background
Mental disorders are common in settings where populations are affected by disasters or conflict, they result in significant distress and impairment of day to day functioning and are key barriers to accessing essential services and support. Offering mental health services through existing primary health centers (PHC) at the community level is an accessible, non-stigmatizing, cost-effective and potentially sustainable way to provide mental health care making use of already available health care personnel. This report summarizes our experience in three humanitarian settings.

The Settings

THE PHILIPPINES
International Medical Corps (IMC) Mental Health and Psychosocial Services (MHPSS) program began in January 2014 (and ended in March 2015) as an emergency response to the devastation wrought by Typhoon Yolanda in the Province of Leyte.

SOUTH SUDAN
The MHPSS program began in August 2014 (and is currently ongoing) in four States that were severely affected by the escalation of violence in December 2013 leading to millions of internally displaced people.

CENTRAL AFRICAN REPUBLIC (CAR)
The mental health program is being implemented since February 2015 in Bria located in the northeastern prefecture of Haute-Kotto. Significant mental health needs have been identified due to the widespread exposure to violence that had worsened during end 2013.

The Process of Mental Health PHC Integration
Mental health Primary Health Care (PHC) integration occurs in incremental steps and includes the important element of sustainability:

**Phase 1:** Stakeholder engagement; baseline situational analysis of common mental health problems and resources

**Phase 2:** Training of PHC staff and initiation of PHC based services; community outreach activities include mental health awareness raising and referral

**Phase 3:** Strengthening of PHC services and initiation of community based psychosocial services; quality enhancement
1. STAKEHOLDER ENGAGEMENT AND BASELINE SITUATIONAL ANALYSIS

This involved semi-structured interviews and focus group discussions with key informants and desktop reviews to obtain a comprehensive understanding of mental health and psychosocial needs, perceptions and ways of coping of the community information about mental health policy and legislation and mapping of MHPSS resources.

2. CAPACITY BUILDING AND INITIATION OF MENTAL HEALTH PHC SERVICES

2.1. Adapting the mhGAP material to the local context

<table>
<thead>
<tr>
<th>Adaptations</th>
<th>Examples</th>
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| A) Simplification of material so that it was more accessible to some of the PHC staff with limited skills and qualifications | Restricting medication information to 1-2 drugs per priority condition in CAR  
Reduced emphasis on psychological interventions in S Sudan and CAR  
Limiting the number of priority conditions to those most relevant in each setting |
| B) Addition of material based on identified needs in the community | Inclusion of stress and anxiety module in all 3 settings and greater emphasis on PTSD in CAR  
Addition of a module on insomnia in the Philippines since it was a common complaint in the PHCs  
Conducted a session on record keeping and documentation as well as procedure to access medicines via the Medicines Access Program in Philippines  
Use of videos to demonstrate clinical phenomena such as seizures  
In the Philippines, case presentations were used to illustrate advanced psychosocial treatments |
| C) Local cultural modifications | Use of local case examples from the participants’ experience  
In the alcohol and drug abuse module, details and alcohol content of local brew ‘tuba’ in the Philippines  
Epilepsy module - under safety risks, the phrase advising people “not to take bath or wash clothes inside rivers alone” was added in S Sudan |
| D) Duration of training     | Reduced hours of training in S Sudan due to work pressures. Training was limited to the afternoon after clinical responsibilities were completed |

2.2 Training and supervising general health care staff

All sites conducted the mhGAP base course training for the PHC staff adapted as described above.

<table>
<thead>
<tr>
<th>Country</th>
<th>Challenges and solutions</th>
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| PHILIPPINES | Staff had difficulty in scheduling the mhGAP training due to numerous trainings organized by the Ministry of Health (MoH) and partners in the post typhoon emergency period and conflicting work pressures, climate conditions (2 typhoons in Dec 2015) and cultural factors (Christmas season and the Pope’s visit to Tacloban).  
Engagement and close collaboration with local administration was useful in ensuring participation of health care staff in training. Flexible training schedules were another method to overcome logistical barriers. |
| S SUDAN  | Security constraints, staff work pressures and large number as well a difficulty-to-access sites meant that the training duration had to be shortened and training conducted in a staggered manner. High PHC staff turnover necessitated training for new staff and varying staff qualifications meant that the training level had to be adjusted for all. |
| CAR      | Apart from security constraints and very low staff skills and qualifications, the biggest challenge was specialist recruitment and continued engagement. After a delayed start, the funds were insufficient to support a psychiatrist beyond 3 months. This has made it necessary for the team to identify alternate sources of funding to enable recruitment of specialist to provide support and supervision to the PHC team as well as refresher training and building capacity of national staff to take on the training/supervision role over time. |

MHGAP TRAINING SUMMARY

<table>
<thead>
<tr>
<th></th>
<th>Health Care Providers (out of total targetted clinics) trained using mhGAP</th>
<th>Average Pre-test score</th>
<th>Average Post-test score</th>
<th>Trainees who found training useful to improve practice</th>
</tr>
</thead>
<tbody>
<tr>
<td>Philippines (6 workshops, avg duration 3 days)</td>
<td>24</td>
<td>70</td>
<td>94</td>
<td>80</td>
</tr>
<tr>
<td>South Sudan (14 workshops, avg duration 4 days)</td>
<td>38</td>
<td>55</td>
<td>69</td>
<td>88</td>
</tr>
<tr>
<td>CAR (2 workshops, avg duration 4 days)</td>
<td>22</td>
<td>46</td>
<td>59</td>
<td>100</td>
</tr>
</tbody>
</table>

Challenges and how these were addressed:

“We have learnt a lot but there is still much to learn”

Almost all trainees in the 3 sites reported the need for further refresher training and ongoing clinical supervision which was challenging due to limited funding, specialist time constraints and security issues restricting travel to project sites. In addition, site-specific challenges were:

This is what the trainees had to say:

“I learnt about mental illness…that stress following a typhoon can cause mental health problems, because for me, I used think ...it as quite absurd for one to become mentally ill after experiencing a typhoon” Midwife, Philippines

“Earlier I used to get angry with these patients...when the patient yells, I would yell back. Now I try to understand the patient and look for a solution to their problem” Nurse Assistant, CAR

“I used to think that mental illness was due to people’s own failures. Now I know they can still be useful – can be treated and go back to normal.....and contribute to the community” CHW, Juba, S Sudan

2.3. Delivering clinical interventions to people with mental illness

The interventions provided by the trained PHC staff in all facilities consisted of: i) Assessment and diagnosis; ii) Psychoeducation to patient and family members; and iii) Psychotropic medication, if needed. iv) Additional psychosocial activities e.g. activity groups for children v) Community awareness/education and individual supportive counseling by psychosocial workers. The prevention & promotion activities consisted of: mental health education sessions in PHC waiting area, house-to-house visits, radio shows, distribution of IEC material, community awareness raising sessions.

The majority of patients and family members in all 3 sites reported satisfaction with services and improved functioning as shown in figures below.

"I can now cook for my children, bring water from the river, go to the forest to collect wood...Earlier I never used to do this... when I was sick. I had thoughts about killing my children.....” -Woman with depression, on treatment since 4 months, Akobo, S Sudan.

“I can go to work now as my child is better- her fits are under control” - Mother of a child with epilepsy, Bria, CAR

1. Measured using the International Medical Corps Patient Satisfaction Questionnaire and is an aggregate of responses (those who agreed/somewhat agreed) to 13 statements e.g. staff accessibility, confidentiality, information provided about health condition and treatment, etc.

2. Measured using a 5-point Likert scale at each follow-up visit and represents the perception of the PHC service provider based on patient/family report and assessment of symptoms. The results represent the change from first visit to last visit in Philippines and CAR and for each follow up consultation in S Sudan.
Solutions management teams in Bria, in particular the chief of the district In CAR, developed and monitored activities with health district Regional national guidelines and policies. sub-cluster meetings and contribution towards development of Active and regular participation at the National level MHPSS National These were conducted at different levels:

### ADVOCACY ACTIVITIES

4. NETWORKING, COORDINATION AND AD vocacy ACTIVITIES

These were conducted at different levels:

#### National

Active and regular participation at the National level MHPSS sub-cluster meetings and contribution towards development of national guidelines and policies.

#### Regional

In CAR, developed and monitored activities with health district management teams in Bria, in particular the chief of the district

and with the hospital management to support their efforts in MH integration.

The Philippines, participated in MH sub cluster meetings and in the Regional Mental Health Technical Working Group. At the municipal level, mental health teams were constituted to provide avenues to discuss mental health issues in the locality and to serve as coordination groups.

In South Sudan, while mental health sub-clusters do not exist, the team attends Health and Protection cluster meetings to share information and discuss linkages with other organisations.

### Community

Conducted workshops with community leaders (including religious leaders) and community members in all sites to increase mental health literacy and address stigma and violation of human rights of people with mental illness.

Conducted community awareness raising activities with over 10,000 community members in the Philippines who were then empowered and /or informed to be able to access services within their municipalities.

### Organizational

Coordination between different International Medical Corps programs (i.e. Nutrition, GBV, Protection programs) was an important component and was addressed by sharing information with other program managers during senior management team meetings (S Sudan), and involving these other program staff in PFA and mhGAP trainings.

In S Sudan, organization level advocacy activities aimed to persuade program managers to create opportunities for professionals to meet donors and advocate for mental health.

5. ENSURING SUSTAINABILITY OF MENTAL HEALTH SERVICES INTEGRATED IN GENERAL HEALTH CARE

Different methods were used in the 3 sites:

In Philippines, training was provided to government health care staff. In addition, multidisciplinary Mental Health Teams were instituted at the community level to coordinate mental health services. The teams were encouraged to develop TORs and obtain Mayors’ agreements in order to formalise them.

In S Sudan, recruitment of large number of national health care staff such as clinical officers and midwives from the local community and providing them with training and supervision to build skills and competencies.

In CAR, working in partnership with local government authorities from the start, locating services within government facilities and building the local capacity of MoH staff through formal training and on-the-job supervision.
A mother with post-partum psychotic depression in the Protection of Civilians site, Juba, South Sudan

A mother who delivered a premature infant (birth weight=1.3kg) was seen by the midwife to be neglecting her baby, saying: “why has God given me this child who cannot survive? I do not want this child”. Evaluation by the clinic staff revealed that she was severely depressed with some psychotic features. Following discussion with the specialist, the mother was provided medication and seen regularly by the counsellor. The baby girl was noticed to be poorly responsive to external stimuli. She was started on F-75 milk by the nutrition assistant. After 10 days of treatment, the mother showed dramatic clinical response and began to hold her baby and smile and croon to her. After a month, both mother and baby were in good condition and discharged from the ward. At discharge, the baby weighed 2.8 kg and the mother was fully engaged in caring for her with minimal support from other family members and regular home visits by the IMC counsellor and nutrition assistant.

The mother had two previous episodes for which she was admitted to psychiatric hospitals in Khartoum, Sudan and Kampala, Uganda where she was treated with ECT and discharged. The husband of the woman is living in a refugee camp in Uganda and her sister was the only supportive family member taking care of the patient. Efforts were under way to link her with the husband through phone.

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