Integrating mental health into primary health care settings after an emergency: lessons from Haiti

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Following the 2010 Haiti earthquake, there was a need for specialist services for severely mentally ill people who were presenting to the emergency medical clinics set up for displaced people. That need was unmet. Using guidelines drawn up by the Inter-Agency Standing Committee (IASC), and piloting the Health Information System (HIS) of diagnostic categories in mental health, weekly mental health clinics were begun in eight mobile clinics. A psychiatric liaison service was also started in the main casualty hospital. Haitian general practitioners and psychosocial workers, who received on-the-job training and supervision from the authors, ran these services. This integrated mental health/primary health care model was successful in engaging severely mentally ill patients in treatment; however, the scale of the disaster meant that only a relatively small proportion of the displaced population could access help. This limitation raised a number of questions about the practicality and sustainability of the IASC model in resource poor countries, with poorly developed community services, hit by large scale emergencies, which the authors address.

Keywords: earthquake, Haiti, large scale emergencies, mental health services, resource poor countries

The Haitian Government reported that an estimated 220,000 people were killed and 1.5 million displaced in the 2010 Haitian earthquake (United Nations High Commissioner for Refugees (UNHCR), 2010), although a more recent draft report commissioned by the United States Agency for International Development (USAID) has recently claimed that the mortality figures may have been overestimated at least threefold (BBC, 2011). Nevertheless, whatever the final estimate, the scale of the disaster was immense; occurring in a country where four out of five people already lived below the poverty line, and where the health infrastructure was weak. Haiti ranks last for health care spending in the Western Hemisphere (World Bank, 2006) with health provision unregulated and patchy. Only 30% of health facilities were public, mostly in urban areas, and 70% of rural health services were provided by nongovernmental organisations (NGOs), with 40% of the rural population having no access to primary health care (World Bank, 2006; WHO, 2010a). Mental health resources were highly centralised, and consisted of two psychiatric hospitals in Port-au-Prince, both of which were understaffed and in a poor state of repair. There were only 0.2 psychiatrists per 100,000 general population, as compared to 11 per 100,000 in the United Kingdom (WHO, 2005), most working in the capital city. Outside of Port-au-Prince, there was little access to psychosocial support or effective social services. There was, however, a widespread network of traditional religious healers. *Vodou* beliefs are common in Haiti, and these beliefs support a religious health care system that

incorporates healing practices (WHO, 2010a). *Vodou* beliefs are also reflected in the presentation and causal explanation of severe mental illness. This fragile health infrastructure was overwhelmed following the destruction of at least eight hospitals, as well as the deaths and injuries of essential personnel during the earthquake. A massive aid effort was mobilised, which included attempts to meet the needs of those with severe mental illness. This paper describes how one group of mental health professionals undertook this task.

Meeting mental health needs following large scale disasters

WHO guidelines, for providing mental health assistance after disasters, have previously suggested that there are three groups of distressed people, each requiring a different response (WHO, 2007). Those with mild psychological distress that resolves in a few days or weeks, and needs no specific intervention, estimated at 20–40% of the affected population; Those with moderate or severe psychological distress, who would benefit from basic non specialist, psychosocial interventions, such as psychological first aid and interventions that strengthen community and family, are estimated at 30–50% of the affected population. Finally, are those with a mental disorder, the incidence of which appears to temporarily double following a disaster. Within this last group, the prevalence of mild to moderate disorders, such as mild to moderate depression or anxiety, would be expected to increase from a baseline of 10% (WHO, 2004) to 20%, while the prevalence of severe disorders could rise from 2–3% to 3–4%.

As a result, how to undertake psychosocial and mental health work after disasters has long been the subject of debate. For example, there has been no agreement on the public health value of the posttraumatic stress disorder (PTSD) concept and no agreement on the appropriateness of *'vertical'* trauma focused services (van Ommeren et al., 2005). The needs of people with severe mental disorders, in post disaster situations, have also been slow to get recognition. After Hurricane Katrina in 2005, it was estimated that the prevalence of severe mental disorder almost doubled from 6.1 to 11.3% of the affected population, yet psychosocial agencies tended to focus on the immediate traumatic responses (Kessler et al., 2006). This lack of consensus to the approach meant that mental health was only briefly discussed in the first edition of the Sphere guidelines on humanitarian standards, produced by a group of leading international aid organisations in 1998 (published as *The Human Charter and Minimum Standards in Disaster Response*, commonly referred to as the *Sphere Handbook*, currently in its 2011 edition). Controversy continued during the Asian Tsunami, when psychosocial agencies were widely criticised for lack of agreed standards and varying approaches. This experience led directly to the creation of the Inter-Agency Standing Committee (IASC) task force set up to agree guidelines for the practice of mental health and psychosocial work in emergency settings. Representatives from 27 international governmental and nongovernmental organisations worked over two years, in consultation with experts from more than 100 nongovernmental organisations, academic institutions, and professional organisations. The resulting *IASC Guidelines on Mental Health and Psychosocial Support in Emergency Settings* represent an international consensus on the type of care, and care system that is suitable for emergency situations (Inter-Agency Standing Committee, 2007; Wessells & van Ommeren, 2008).

The hierarchy of responses recommended by the IASC guidelines includes: advocacy for equitable and dignified access to basic necessities and protection for the majority; social interventions that reconnect disrupted families and communities, and help them restart their lives; more focused individual psychosocial support for those who suffer more severe non pathological reactions; and clinical interventions for the most severely affected minority. Other authors have emphasised the importance of acknowledging and building on the natural resilience of individuals and communities. Resilience is seen as a process rather than an end point, and is reinforced through strategies such as psychological first aid, and enabling displaced communities to be as self-reliant as possible (Raphael, 2008; Bonanno et al., 2010).

In relation to care for people with severe mental disorders, the IASC guidance recommends integrating mental health provision with primary care clinics (Box 1), which is consistent with the WHO strategy for mental health provision in poor nations (WHO, 2008). This guidance also recommends giving appropriate support to local services and institutions caring for people with severe mental disorders and other mental and neurological disabilities.

Saraceno et al. (2007) have identified a number of barriers to integrating mental health services into primary care. One is the work overload suffered by most primary health care workers, which means they see themselves as having no time for mentally ill patients. The second is providing short, theoretical training courses without follow up supervision. These constraints may result in a failure to distinguish distress from disorder, and consequent overmedicalisation, and overprescribing of psychotropic drugs, for minor complaints. A third barrier can be the lack of psychotropic drugs, so that even trained workers lack the means to treat severe mental disorders.

Box 1: Minimum response actions to address needs of people with severe mental disorders in emergencies (from *IASC Guidelines on Mental Health and Psychosocial Support in Emergency Settings*)

1. Assess situation (including surviving health capacity)
2. Ensure adequate supplies of essential psychiatric drugs
3. Enable at least one member of emergency primary health care (PHC) team to provide frontline mental health care
4. Train and supervise available PHC staff in the frontline care of severe mental disorders
5. Avoid overburdening PHC workers with multiple different training sessions
6. Establish mental health care at additional logical points of access (including emergency rooms)
7. Try to avoid creating parallel mental health services focused on specific diagnoses, or narrow groups
8. Inform population about the availability of mental health care
9. Work with local community structures to discover, visit, and assist people with severe mental disorders
10. Be involved in all inter-agency coordination on mental health

The *IASC Guidelines* address each of these barriers, recommending that theoretical training is always accompanied by supervised on-the-job training, and that primary health care (PHC) staff are assisted and trained in time management to allow dedicated time for mental health work. The guidelines also recommend training in simple psychological interventions for non pathological distress, and rational prescribing. Also important is investment in systems of care, rather than individual staff members, and ensuring that treatment conforms to international standards of care (Cohen, 2001).

The IASC recommended model of integrating mental and physical healthcare in emergency and conflict zone situations is now well established practice (van Ommeren et al., 2005; Budosan et al., 2007; Jones et al., 2009; Rose, 2011; Mueller et al., 2011). However, the scale of the disaster in Haiti and the complete absence of community based mental health care prior to the earthquake provided a challenging opportunity to test the *Guidelines* in an emergency, resource poor setting of immense proportions.

Our response to the Haiti emergency

A rapid assessment of need was done within 12 days after the earthquake. This included coordination with other local and international agencies planning to provide mental health and psychosocial care. Little information was available on Haiti's pre-existing mental health needs, therefore the assessment included visiting both of the national psychiatric hospitals in Port-au-Prince, and talking with surviving staff. Emergency clinics for displaced people, set up by a number of medical aid organisations, were also visited as was the main Emergency Room for Port–au-Prince situated in the grounds of the partly destroyed University Hospital, l'Hopital de l'Université d'Etat d'Haiti (HUEH).

At this stage, the International Medical Corps was responsible for providing 15 community clinics, as well as Emergency Room services at HUEH. The assessment revealed that the majority of people attending the emergency services reported feeling shocked and afraid, with common complaints of palpitations and a persistent feeling that the *'ground was moving'*. People were also being seen with severe mood disorder and psychotic illness, clinical problems that the medical teams were poorly equipped to manage.

The majority of the affected population were living in overcrowded makeshift shelters and/or crowded camps for displaced people. They were frustrated and angry at the difficulties of obtaining basic necessities, and at the lack of security. Therefore, advocacy to change these conditions was a psychosocial priority from the start. Most people had suffered losses of some kind. Some individuals had been trapped under the rubble for long periods. A child patient of one of the authors had been discovered after nine days for example. Because of the rapid disposal of bodies in mass graves and the persistent problem of uncleared rubble, many had been unable to find or identify the remains of their loved ones, which made mourning difficult. Added to this, fear and stress was generated by continuing government warnings of the likelihood of new quakes. Given these conditions, the resilience of the population and the degree to which they were helping themselves was remarkable. Markets appeared in the makeshift camps in the first days after the disaster, as did small enterprises such as phone charging, hair dressing and the

sale of prostheses, crutches and wheel chairs.

Assessment of the two psychiatric institutions revealed a particularly disturbing situation. In the acute psychiatric hospital near the city centre, 11 of the original 100 inpatients lived in degraded and insanitary conditions with no running water, no power, filthy accommodation, no bedding, and no clothes.

Many of the staff were understandably preoccupied with their own affairs, because they were bereaved, or their homes were destroyed, and did not return to work for weeks. Those who did come to work had to care for at least 150 outpatients a day in a tent surrounded by an encampment of 120 displaced families that had taken refuge in the hospital yard.

In the long stay hospital on the outskirts of Port-au-Prince, many patients had run away when the wall collapsed and the remainder slept in the open-air as the rooms were considered unsafe.

At least 90 international and local agencies were offering psychosocial support after the earthquake. Coordination took place through the UN led mental health and psychosocial support sub-cluster, which met twice a week. A representative from the Haitian Ministry of Health was joint chair of this meeting. Mapping of agency activities made it clear that very few of them were providing psychiatric services for the more severely affected section of the population, either in the community or in existing psychiatric institutions. Only two agencies, apart from our own, were providing psychiatric care through clinics in Port-au-Prince. In the earthquake affected areas outside the city, there were no psychiatric services available. The International Medical Corps then made the development of accessible psychiatric support and services for this group a priority.

Interventions to support the acute psychiatric hospital included: the provision of a staff transport vehicle, a generator, bedding, patient clothes, hygiene kits, cleaning materials and essential medication. At the request of staff, a series of twice weekly training seminars was organised for three months. Also at their request, these seminars were then extended for eight weeks. These aimed to support staff in evaluating and developing their care and treatment practices. A generator was also provided for the second hospital, which cared for longer stay patients. Other organisations provided food and tents. However, in light of the continued functioning of both hospitals, albeit at a reduced level, we decided that further support of the two institutions required resources beyond the capacity of an emergency health agency. In line with the *IASC Guidelines*, we therefore prioritised the rapid development of community based mental health services that would both serve emergency needs and decrease the demand for institutional care. Since a large number of people with mental health problems were being seen in the Emergency Room following the earthquake, it was also decided to provide a temporary psychiatric liaison service for the University Hospital, HUEH.

A psychiatric liaison service at the University Hospital started two weeks after the earthquake. In consultation with the hospital's Haitian medical director and the Government's Department of Health, it was agreed that a Haitian psychosocial worker would be employed to triage referrals, supervised by an international or Haitian psychiatrist. The psychologist provided both group and individual therapy, and a psychiatrist was available daily to see complex cases, as well as patients who might

need psychotropic medication. After six months, as earthquake related problems diminished, the medical and psychiatric liaison services were gradually withdrawn.

Community based mental health services began within a month of the earthquake in locations with the greatest concentration of displaced people. The model used followed *IASC Guidelines* and was supported by Ministry of Health officials. Mental health clinics were integrated into eight busy primary healthcare centres, each serving a displaced population of between 10 and 15,000. Most took place under canvass since many surviving buildings remained unsafe, and staff and patients understandably felt safer in the open. The clinics were located in the western suburbs of Port-au-Prince, and in the earthquake damaged South West and Southern provinces.

To address the time management problem, we suggested that mental health care be organised in a manner similar to antenatal care, by providing a '*mental health*' clinic once a week. At each primary health care clinic, a Haitian general practitioner was therefore released from general duties for half a day a week to run this service. Thus, rather than seeing such cases as a time consuming interruption, the practitioner could give them additional time, and more dedicated attention. It also allowed for concentrated periods of on-the-job supervision by an international psychiatrist (one of the authors), or a Haitian psychiatrist learning to become a workplace trainer. Each mental health clinic, including the one attached to the emergency room, was co-ordinated by a community psychosocial worker, usually a previously unemployed Haitian psychologist or nurse. These were recruited as full time mental health staff working with patients on a daily basis. As well as their service coordination role therefore, they were able to undertake preliminary assessments, provide individual and group therapeutic activities, liaise with other community resources such as local leaders, aid organisations, and traditional healers, and act as the point of referral for victims of sexual and gender based violence. Each psychosocial worker also had the task of recruiting and supervising a dozen local community volunteers who could promote good mental health, support appropriate mourning processes, identify people suffering from severe mental illness in their neighbourhood, engage them in treatment, and help them access local resources. Psychosocial workers liaised closely with the general practitioner in charge of their weekly mental health clinic, and were clinically supervised by the visiting international or local psychiatrist. In addition, a senior psychosocial worker, who organised a separate training programme to support and develop the activities and skills of the psychosocial workers, managed them.

A patient file system was established to record demographic, clinical and trauma related information. In addition, team members were taught to use the mental health categories and case definitions newly developed in the Health Information System (HIS) of the UNHCR, for use by primary care staff working in refugee camps (UNHCR, 2010). We used a pilot version, which included case definitions, loaned to us by UNHCR, as yet unpublished. The categories are based on a recommendation in *IASC Guidelines* (2007), and are designed to simplify the diagnosis of mental distress and disorders by primary health care workers, so that they can identify probable psychiatric cases. The prior failure to include anything but the most gross mental health diagnostic categories in HIS systems, in many low and middle income countries,

has added to the difficulties of primary health care workers giving these patients attention and care. The categories used (Table 1) are straightforward, and easily recognised by health workers. They also, to a large degree, match the newly created mental health Gap Action programme (mhGAP) priority conditions (WHO, 2010b). Establishing the community service in Haiti provided an opportunity to informally field test these definitions. Essential psychotropic medication, included in the WHO essential medicine list, The Inter-Agency Health Kit (WHO, 2006) was made available in all clinics.

Training played a central role in clinic activities. For the general practitioners, the aim was for them to be able to clinically manage most people presenting with severe mental illness within three months. This was done through workplace training and attending a weekly half day teaching programme. Assessment involved a combination of workplace Assessed Clinical Encounters, Case Based Discussions, and an end-of-training examination consisting of Objective Structured Clinical Examinations (OSCEs) and an oral exam.

The curriculum of the teaching programme was based on the textbook '*Where There Is No Psychiatrist*' (Patel, 2003), *IASC Guidelines*, and a draft of the *mhGAP Intervention Guide* (WHO, 2010b). Psychosocial workers also attended the half-day teaching programme, and were supervised in providing basic, individual and group interventions focused mainly on anxiety management and problem solving. Two part time Haitian psychiatrists were recruited to train as workplace supervisors and assessors of the general practitioners, so that the programme could become independent of international staff, and therefore more sustainable.

Patients seen

During the first five months of the community clinics, a total of 431 patients were assessed on eight sites. Assessments included a supervising psychiatrist in 65% of cases. Of the patients seen, 22% had experienced the loss of a first-degree relative in the earthquake, and 74% had suffered serious damage or collapse of their dwelling (Table 2). About half of those assessed had seen a traditional healer for their complaint, often at great expense. By far the most

Table 1. Health Information System (UNHCR, 2010)

Health Information System (HIS) for use in humanitarian settings: Mental Health Categories	
HIS 1	Epilepsy/seizures
HIS 2	Alcohol or other substance use disorder
HIS 3	Mental retardation/ intellectual disability
HIS 4	Psychotic disorder
HIS 5	Severe emotional disorder
HIS 6	Other psychological complaints (including anxiety) not resulting in major day-to-day dysfunction
HIS 7	Medically unexplained somatic complaint
No HIS category for:	Dementia
	Other, for psychiatric disorders not covered in the seven categories
	No psychiatric disorder present

Table 2. Clinic activity (data February–June 2010)

	General hospital	Primary care clinics (8 sites)
Number of new patients seen	201	431
Total clinical consultations	356	722
Mean age	30 (range 3–75)	32 (range 0.5–88)
Number of females seen	59%	64%
Children seen (under 16)	13%	13%
Loss of 1st degree relative	29%	22%
Loss of non 1st degree relative	12%	13%
Housing destroyed by earthquake	27%	58%
Housing damaged, but habitable	15%	16%
Seen by traditional healer	15%	47%
Assessment by GP or psychosocial worker supervised by a psychiatrist	55%	65%
Assessment only	5%	1%
Main intervention:		
Medication	20%	20%
Psycho education	11%	40%
Counselling	6%	5%
Psychosocial support	57%	34%

common mental health category was '*other psychological complaints*' (HIS 6) which accounted for 55% of all patients seen (Table 3). These complaints were overwhelmingly of anxiety, usually focused on a fear of buildings falling, or of losing people close to them. Psychosis (HIS 4) accounted for 13% of patients seen and epilepsy (HIS 1) for 11%. Surprisingly only 3% of patients had severe emotional disorder (bipolar or severe depression) and only five cases of alcohol or other substance use disorder were diagnosed. Symptoms of grief were common, and it was often hard to disentangle what was culturally normal, from what was morbid. Concerning treatment, 40% received psycho education, which included anxiety management; 34% psychosocial support, usually in the form of help in solving basic needs related problems; and 5% focused counselling. Only 20% were prescribed medication.

Comparing diagnoses made in community clinics during the first five months after the earthquake (February–June), with the next five months (July–November), there was a 10-fold reduction of patients presenting with minor disorders as recorded under the HIS category 6 of '*other psychological complaints*' (Table 3). By contrast, severe emotional disorders increased from 3% to 21%, and medically unexplained complaints increased from 1% to 15%. Dementia also presented more frequently during this later period, although there was little change in the referral pattern of other severe and chronic disorders, such as people with psychosis, learning difficulties or epilepsy.

The general hospital clinic appeared to pick up a similar range of clinical problems as

Table 3. Diagnosis of newly assessed patients (data February–November 2010)

Health Information System (HIS) diagnosis for use in humanitarian settings: Mental health categories (probable cases)	General hospital Feb–June	Primary care clinics Feb–June	Primary care clinics July-Nov	Total
No psychiatric diagnosis	0	27 (6%)	5 (1%)	27 (3%)
HIS 1 Epilepsy	5 (3%)	47 (11%)	78 (16%)	130 (12%)
HIS 2 Alcohol/substance misuse	0	5 (1%)	11 (2%)	16 (1%)
HIS 3 Learning disability	0	21 (5%)	27 (6%)	48 (4%)
HIS 4 Psychotic disorder	29 (17%)	58 (13%)	92 (19%)	179 (17%)
HIS 5 Severe emotional disorder	30 (18%)	15 (3%)	98 (21%)	143 (13%)
HIS 6 Other psychological complaint	80 (47%)	239 (55%)	23 (5%)	342 (32%)
HIS 7 Medically unexplained somatic complaint	5 (3%)	4 (1%)	72 (15%)	81 (8%)
Dementia	1 (1%)	5 (1%)	29 (6%)	35 (3%)
Other	21 (12%)	10 (2%)	44 (9%)	75 (7%)
Total number of assessments	171	431	474	1076

the community clinics. This probably reflected the fact that large numbers of displaced people in nearby city centre camps used the hospital for primary care. However, there was a six-fold increase in the number of patients seen with severe emotional disorders at the hospital, as compared to primary care, during the same period after the earthquake. Many of these patients had life threatening depressive disorders, and were often in a state of extreme physical neglect requiring medical intervention. The general hospital emergency room received many cases of severe gender based violence, sometimes with children as the victims. Poor security and lighting in many of the camps, as well as disrupted community links, may have aggravated this problem. Four particularly severely affected victims of sexual abuse were assessed and followed up by the hospital psychosocial worker.

Concerning staff training, over the five-month period starting from February 2010, 140 health workers attended one of six programmes of mental health seminars, each held on a different site. Of these, 73 were nurses and 31 medical practitioners. The rest included psychologists, health assistants and a small number of translators. Twelve medical practitioners completed the combined seminar and work place training programme, and successfully passed the assessment programme.

Discussion

The patient information, recorded in Tables 2 and 3, represent an audit of who presented at the mental health clinics, but cannot give an accurate picture of needs

within the community. The data does, however, give a snapshot of what people will bring to primary health care clinics in an emergency situation, and how that picture changes over time. The significant presence of epilepsy and psychosis justified the attention given by the programme in providing services for those with severe mental disorders, and is consistent with experiences in other emergencies (Jones et al., 2009). The 10-fold drop in incidence of HIS category 6, from 55% during the first five months after the earthquake to 5% in the subsequent five-month period, almost certainly reflects the temporary nature of the surge of anxiety following the disaster. These cases appear to have been partly replaced by cases of severe emotional disorders, for the most part depression, enduring grief reactions, and somatic complaints. This may reflect the enduring problems of loss, and the stress of daily life in temporary and inadequate shelters.

In terms of setting up the mental health clinical and training programme, the IASC model proved to be a useful operational framework. In fluid and insecure circumstances, with enormous logistical challenges, it was possible to integrate a mental health service into at least half of the emergency mobile primary care clinics set up by the International Medical Corps within the disaster hit areas. The UNHCR HIS system also proved to be a useful tool for training staff, and related neatly to the mhGAP curriculum. However we had to add three new HIS categories: no psychiatric disorder, dementia, and *'other'* for psychiatric conditions not covered under the seven headings.

Dilemmas encountered

Of the many dilemmas faced in developing and running the programme, three related dilemmas stood out: the sustainability of the integrated mental health/primary care model, post emergency in a country with poorly developed primary health infrastructure, and no history of community psychiatry; the possibility of unintended bad consequences; and whether it was wise to invest in community mental health services, rather than reinforcing already established central ones.

The moral case for providing local emergency clinics after the earthquake is clear, but should a mass disaster be used as an opportunity for Western agencies to promote community mental health services, particularly when central services are so underdeveloped? Additionally, is it reasonable to set up a model that may prove unsustainable, since it is so dependent on the continuing flow of foreign aid, and the future preparedness and capacity of the Haitian government to take over responsibility? As far the model of care was concerned, we felt that this was something on which there was an international consensus, rather than being western imposed clinical practice (WHO, 2009). Also, the patchily provided medical system in Haiti, with its heavy dependence on private, urban based services did not provide an ideal structure in which to integrate community based mental health care. As far as donor commitment goes, although this has been maintained to date, it remains something to be advocated for in these uncertain economic times. It will need expensive long term institution building if the model is to be rolled out nationally. At the very least, we hoped to demonstrate to the Haitian government the benefit of free services provided through the innumerable mobile clinics that were running during the emergency, and to model how mental health care could be integrated into primary care. We were involved in discussions about

the possibility of setting up publically funded primary health care, but there was no guarantee that this would happen. So the question arises as to the value of training primary healthcare workers for a service that may not be sustained, and the ethics of providing care free of charge when that too may not last. Recognising that we could not predict the long term direction of planning with elections about to happen, we reasoned that it was worth training a cadre of primary care staff and psychosocial workers who could be a resource for the country in the longer term.

All humanitarian interventions risk unintended bad consequences. For example, providing services to hundreds of tented camps inevitably creates dependency, although the continuing failure to clear rubble and build effective new homes has meant such services have remained essential. Another important consequence is that the presence of a competent outside agency providing free medical services may undermine local incentives to manage problems with local resources. There was certainly no shortage of Haitian doctors in the country, many having run small private practices before the earthquake. Indeed, the mobile emergency clinics set up by the International Medical Corps were staffed by doctors easily recruited from the private sector whose own clinics were out of action, as well as a small number of ministry of health (MOH) staff out of work because their clinics had been destroyed. So, although we avoided recruiting from functioning MOH services to prevent undermining public services, we may have inadvertently undermined the private sector. Another consequence of providing free services, which included free medication, was that drugs donated to Haiti found their way onto the market place. We had direct evidence, for example, of donated psychotropic drugs being sold to patients. All of these unintended consequences of intervention need further evaluation to inform future practice.

The final dilemma arose from the decision to focus mainly on creating new community services, rather developing the two existing psychiatric institutions. This decision was made partly in line with the principles incorporated in the IASC guidance, and partly on pragmatic grounds. We had limited resources, and were unable to provide a service to both displaced people, and large psychiatric institutions. We also calculated that since the institutions were providing at least some level of service, our priority should be to reach displaced people with severe mental health problems who would otherwise have no access to treatment. Our concern, in retrospect, was whether we could have detected a larger number of severely ill new patients by using our resources to improve access to the two established psychiatric hospitals. Certainly, community services are good at engaging people in treatment because of better accessibility, but there were insufficient resources to scale them up across a metropolitan population of 3.5 million people, let alone a country the size of Wales. Additionally, there are economies of scale in centralising, even if some will not access the treatment. So the dilemma was, with scarce resources, could we have done more for the severely mentally ill population as a whole by reinforcing the capacity of a centralist approach, rather than setting up a newly created integration of specialist mental health and primary care as recommended by the IASC? Lacking hard evidence, our impression was that few of the patients seen in the community clinics would have attended hospital, particularly in the more distant clinics, where we saw

patients who had not been able to access care before. A hospital centred approach may have helped to improve both psychiatric out patient and inpatient care quality, but may not have attracted many extra new patients.

What lessons were learnt from our intervention?

Some things went well, and we would repeat them in similar circumstances. Others went less well, and pose real questions for future interventions.

What worked well was the ability of the clinics to rapidly identify and treat severely ill people in the camps, providing a service that complemented the psychosocial activities provided by other less specialist organisations. Integrating a specialist service with the emergency mobile clinics undoubtedly helped with this. The supervised Haitian general practitioners were often already aware of untreated psychiatric cases on their patch, and with the help of the psychosocial worker, were able to get them to attend the specialist clinic. In addition, partly because the clinics were so accessible (moving within the city was extremely difficult and time consuming), patients almost always came with family or concerned neighbours. So even quite disturbed patients could be managed with this community support. Of course, given the level of social disruption caused by the disaster, some patients had no support and did not seek help. However, in time, the psychosocial worker's ability to network within the camps led to many of these more isolated individuals being engaged in treatment.

The second thing that seemed to work really well was on-the-job training. Although this was often difficult logistically, because of security or transport problems, it did mean that supervisors had regular first hand experience of a wide range of clinics and were able to become more attuned to the cultural and contextual differences inherent in their work, something particularly important for the international supervisors. Trainees also valued the immediacy and personal relevance of feedback, and felt more confident to manage complex cases. Significantly, this training model proved resilient enough to cope with busy and often chaotic emergency clinics.

We did, however, have reservations about one key aspect of the *IASC Guidelines*. Given the scale of the disaster, it proved unrealistic to provide mental health care in every emergency primary health care location, as recommended in the guidelines. Even if the on-the-job training component had been diluted, the specialist resources needed to scale up the integrated mental health/primary care model for all the emergency clinics serving a displaced population of well over a million people would have been considerable, and beyond the capacity of all existing medical aid organisations put together. We were also opposed to weakening the amount of on-the-job supervision provided, viewing this as an essential part of the training. Recognising this, we tried wherever possible to place mental health clinics in central locations. Two were in tents within the grounds of district hospitals providing primary and secondary general medical care, while others were in locations convenient enough to allow referrals from a number of nearby primary care clinics. This still left the vast majority of displaced people with limited, or no, access to mental health care. In future disasters, we should pay greater attention to the setting up of carefully situated integrated clinics operating as referral hubs, serving clusters of emergency primary care clinics. We would also employ psychosocial workers to develop

and support this more, dispersed way of working.

Building an effective health service for the long term remains an enormous challenge for Haiti, not least because of the extent of institution building required to increase the capacity of the Department of Health, and to train an appropriate national workforce. At present there are few resources to train community mental health nurses, or to create a new cadre of community mental health worker. There is some cause for optimism though. Following negotiations with the Haitian Department of Health by the International Medical Corps, together with Partners in Health, *Médecins Sans Frontières* and *Médecins du Monde*, community mental health was included in the draft Haitian National Health Strategy (2010). However even if long term resources were available to the government, mental health services may not be prioritised in a country with a long history of undeveloped basic public services, which is going to be pre-occupied for years to come with the political, economic and social repercussions of the earthquake.

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