Even More Mountains: Challenges to Implementing Mental Health Services in Resource-Limited Settings

David J. Grelotti, M.D.

Mwen te swe anpil (''I sweat a lot'') when I moved to Haiti after child and adolescent psychiatry training for a global mental health fellowship at Partners In Health (PIH). The blazing Caribbean sun was certainly a cause, but so, too, was the task at hand. Together, Haitian clinicians and I worked to improve mental health services for patients and families that hitherto had little access to psychiatric care. While on the ground, I learned ways to address the challenges of providing mental health care in a resource-limited setting culturally quite distinct from that in the United States.

Before the earthquake on January 12, 2010, the 1.2 million people in the rural catchment area served by Zanmi Lasante (ZL), PIH's sister organization in Haiti, had little access to mental health care. Public sector services were centralized in Port-au-Prince, and the majority of Haiti's mental health budget, less than 1% of the total health budget, went to the capital's two psychiatric hospitals.[1] Although Paul Farmer, cofounder of PIH and the subject of Tracy Kidder's book *Mountains Beyond Mountains*,[2] and his colleagues at PIH and ZL started building a health system in rural Haiti 25 years ago, ZL's *ekip sante mantal* (''mental health team'') was created only a few years before the earthquake and mostly supported patients and families affected by the human immunodeficiency virus (HIV) and tuberculosis.[3] It seemed that Haiti differed little from other resource-limited areas, where approximately 76% to 85% of patients with serious psychiatric conditions do not receive adequate treatment.[4]

The earthquake brought change. In the wake of the disaster, national and international concerns for earthquake-related mental distress mounted. Recognizing the need to address the acute and chronic mental health needs of the people, PIH and ZL committed to building a comprehensive, community-based mental health service by integrating mental health into the ZL primary care system, using task shifting to train nonspecialist, Haitian college graduates to staff clinics as psychologists and creating a fellowship to enable a psychiatrist to accompany ZL's mental health team.[3]

As the first fellow, I trained psychologists in psychotherapy, pharmacotherapy, and consultation-liaison psychiatry as we jointly evaluated adults and children. To treat the psychiatric and neurologic conditions that commonly presented, I managed a small, flexible formulary of 11 generic medications: fluoxetine, amitriptyline, risperidone, haloperidol, valproic acid, carbamazepine, phenobarbital, gabapentin, diphenhydramine, lorazepam, and diazepam. I also participated in community education initiatives, didactic training (including adding psychiatry and neurology components to a nascent family medicine residency program), and collaborations with researchers and policy makers to improve service delivery.

Resource-limited areas desperately need strategies to decrease the growing burden of disease and disability caused by mental disorders.[5] We developed resource-conscientious approaches to raise the standard of care. Many of these are avenues for research and may be generalizable to other contexts (Table 1).

Different factors influenced our choices, including local notions of illness, unfamiliarity with mental health treatments, and the realities of obtaining medical care in Haiti. With unemployment over 36%,[1] the inability to pay for medical care and medications was one of Haiti's harshest realities. We minimized costs to keep our services and medications free. Although many who did not work could not afford care outside of our free services, many who did work could not afford to miss work to obtain care. Traveling considerable distances on foot to reach ''public'' transportation, patients could spend

TABLE 1 Implementation Challenges in the Delivery of Community-Based Mental Health Services in Rural Haiti and Strategies to Address Them

Implementation Challenge	Observation From the Field	Proposed Solutions
Determining local needs	Few if any epidemiologic or other systematic investigations to characterize needs of the community	Engage local knowledge to identify relevant mental health problems and psychosocial stressors and account for this when planning clinical services and resource allocation
		Use clinic data to determine burden of illness and match resources to burden
Reaching patients	Passive case finding (where the patient is self-referred) misses many people who cannot or do not seek care	Provide education about mental disorders to the community and clinical staff to increase referrals and to community health workers to encourage active case finding
		Develop a regular mobile clinic to service remote areas
Evaluation and diagnosis	Cultural variations in description and manifestation of illness	Create and locally validate screening tools
	Ambiguous and sometimes misleading chief complaints	Conduct systematic interviews and expand reviews of systems to assess for comorbid illness
	Limited availability of laboratory tests	Train local providers in a standard diagnostic approach and classification system
		Rule out mental disorders secondary to medical conditions using commonly available laboratory tests (for HIV, syphilis, anemia, etc.), history, and physical examination
		Provide ongoing supervision to local clinicians with specialist
Assessing cognitive and academic problems	No standardized or validated tools in Haiti or in Haitian Creole to assess for cognitive problems, learning disorders, and intellectual disability	Improvise psychological and achievement tests and use local expectations of educational attainment to judge performance
		Adapt existing psychological and cognitive tests for use in the clinic that patients and clinicians may find less language-dependent
Characterizing substance abuse	Rare admission of alcohol or drug use	Obtain collateral information
		Work with local clinicians and patients on importance of issue and how to phrase interview questions
Addressing neurologic problems	Psychiatrists are expected to treat neurologic illness	Expand review of systems and perform neurologic exam
		Create algorithms to treat epilepsy
		Consult with specialists for complicated patients
Accounting for local notions of mental illness	Patients may have beliefs about the nature of their illness such as Vodou, religion, or personal failings	Psychoeducation and the biopsychosocial model may incorporate important beliefs of illness where appropriate and challenge others that may be harmful
Providing therapy	Limited formal training in evidence-based therapies	Provide training and supervision in evidence-based therapies or parts of evidence-based therapies
	Patients unable to make regular appointments	Expand access to care through task shifting and organizing nonspecialists to deliver certain therapeutic services and meet community need/demand
	Limited number of clinicians	