

**INTEGRATING MENTAL HEALTH INTO PRIMARY HEALTH CARE  
IN THE CARIBBEAN:  
A DEMONSTRATION PROJECT IN BELIZE AND DOMINICA**

**End-of-Project Report**

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**ABBREVIATIONS used in the course of this report:**

MH: Mental Health

PHC: Primary Health Care

## Introduction

This project was carried out as a collaboration between the Ministries Of Health of Belize and of Dominica, the Montreal (McGill University) WHO-PAHO Collaborating Center in Mental Health, the Departments of Psychiatry and of Family Medicine McGill University and of the University of the West Indies, and the Pan-American Health Organization (PAHO).

### Integrating Mental Health into Primary Health Care in the Caribbean

- **Belize:**
  - Dr. Claudina Cayetano:
  - Dr. Beverley Barnett
  - Dr. Gustavo Vargas
- **Dominica**
  - Dr. Griffin Benjamin
  - Ms. Shirley Augustine
  - Permanent Secretary – Health
- **PAHO/WHO**
  - Dr. Devora Kestel (OCPC)
  - Dr. Tomo Kanda (OCPC)
  - Dr. Jorge Rodríguez
- **Montreal WHO/PAHO Collaborating Centre**
  - Dr. Marc Laporta
  - Dr. Mark Yaffe
  - Julian Xue
- **Jamaica UWI**
  - Dr. Wendel Abel
  - Dr. Aileen Juanita Standard Goldson

The objectives of the project included the following:

1. To train primary care physicians in mental health diagnostic and treatment skills with the aim to improve their ability to care for a variety of mental health problems that could be managed by non-specialized PHC services
2. To train some primary care physicians and nurse practitioners to develop the technical skills to themselves become trainers in the area of Mental Health at the Primary Care level
3. To implement the concept of ‘wholeness’ of care i.e. managing patients’ physical and mental health needs simultaneously, as a means of lowering barriers to mental health care in PHC
4. To evaluate the actual and desired mechanisms for mental health consultations, referrals and support, which PHC physicians would access, while simultaneously defining better those mental health problems that could be management within PHC settings
5. To aid in the establishment of appropriate lines of consultation, supervision, referral and support between primary and secondary care settings for mental health problems
6. To help ensure that mental health is integrated into PHC by establishing a model of ongoing training and supervision

## The actions scheduled to attain the objectives

The following represent the actions undertaken over the course of this project. We will proceed to describe each of these in the next pages of this report in the same order as they appear here, by number.

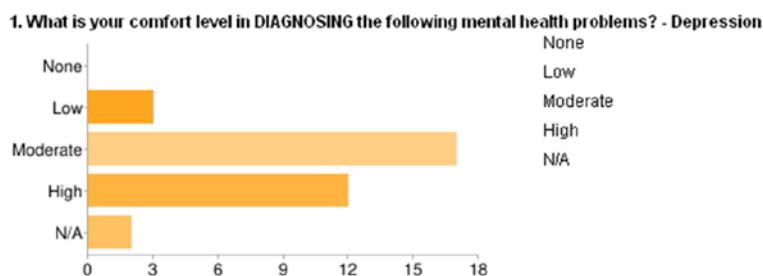
1. Initial web-based survey
2. 2-day training program
3. “training of trainers” with pre-identified local clinicians
4. Follow-up CME sessions promoting access and treatment in PHC settings
5. End web-based survey
6. Wrap-up and local recommendations
7. Overall conclusions and recommendations

### **1. Initial Web-based Survey**

At the beginning of the project, a web-based survey was constructed and distributed to the clinicians taking part in the training program. It was comprised of questions aiming to understand the clinicians’ mental health skills, knowledge, attitudes, experience, perceived needs and barriers. Interestingly, both Belize and Dominica showed similar profiles initially.

The results from this survey were collated and analyzed. Based on the results of the survey, an agenda for the training program was constructed to be adapted to the specific realities of each country’s needs and to the realities of their health care system.

Sample question from the initial survey



### **2. Two-day Training Program**

A two-day training program adapted to the results of the initial survey was put together. Interestingly, both countries had very similar needs and requests for training.

A short training program was opted for because the goal was to have this training be only the initial part of a longer follow-up set of training sessions (see below under “Follow-up CME”).

Topics covered clinical topics, practical consultation and clinical support issues, as well as issues pertaining specifically to practice-changes permitting integrating mental health into primary health care settings represented in the group.

Clinical topics were covered from two complementary perspectives aiming at giving a rich and relevant picture to attendees : the perspective of the general practitioner, and that of the specialist. The former was more complaint-based, and the second was more diagnosis-focused. Interventions were also looked at from both perspectives taking into account, for example,

## 2.1. Agenda for 2-day training program

### Agenda of Training

Mental health from a global perspective  
Approach to the training – Results of Survey  
Pathways and barriers to mental health care  
The GP and the Mental Health Patient  
Presenting complaints - How Do MDs Make Decisions  
Integrating MH into your practice - Current Structure for Mental Health Care  
Engagement and Assessment  
Treatment and Referral  
Normal emotions through the life cycle  
The Common - Depression  
A related problem - BMD  
Suicide risk  
Psychological therapies

### Agenda of Training – cont'd

The Usual - Somatic presentations and MH  
The Silent - Anxiety disorders and their treatment?  
The difficult patient  
Caring for your own mental health  
Psychosis: More subtle than you'd think  
Some useful scales  
Chronic illness and mental illness: relationship  
Integrating MH into your Practice II  
  
Planning for the next 6 months

## 2.2. Materials for the Training Program

### *2.2.1. Slide package:*

A slide set was developed to cover the topics identified in the survey. The slides were delivered keeping in mind the overall objectives of the project to strengthen the provision of mental health care in Primary Health Care (PHC) settings, to strengthening the lines of consultation and referral, and to buttress and help develop efficient supporting mechanisms between PHC and specialized MH care.

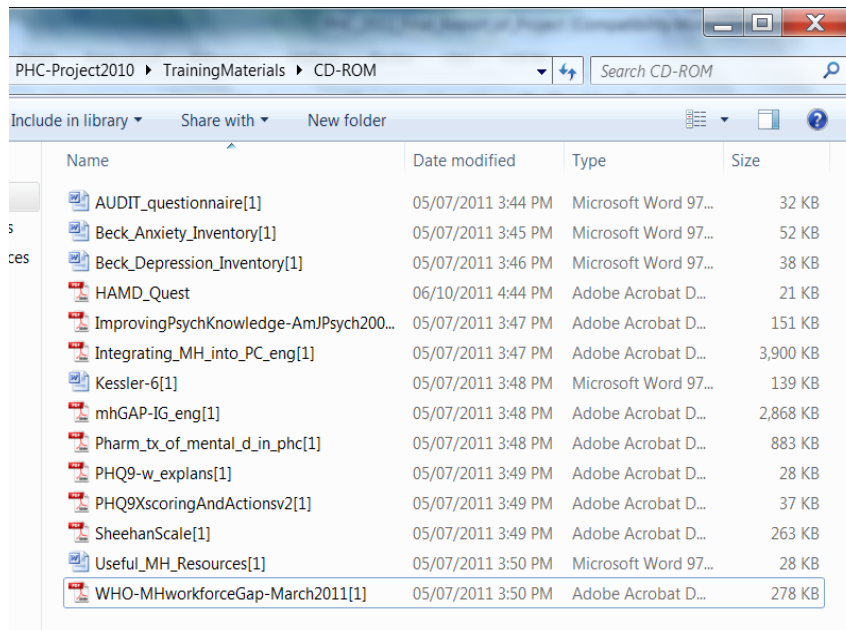
The contents of the training sessions included topics covering the rationale for integrating MH into PHC, diagnosis, therapeutics, and practice integration. The training was given by two trainers - a psychiatrist and a general practitioner – each presenting a different perspective on mental health issues as they arise in practice.

### *2.2.2. mhGAP-IG:*

It should be noted that the topics were all backed by ongoing referral to the newly-published WHO booklet - “mhGAP- IG” - as a primary source of information. Also provided were interview DVDs and MH topics discussions from the Douglas MH Institute’s Mini-Psych school series. We also were able to distribute a number of mhGAP-IG booklets to trainers.

### 2.2.3. Other Materials:

Besides the slides set and mhGAP-IG, we also made reference to several documents included in a CD-ROM which was circulated before the training. Its contents were as follows:



## 2.3. Evaluations of the Training Sessions

The overall evaluation of each of the sessions was very high, between 4 and 5/5 for all issues in both countries. Several clinicians stated that they were not applying interventions for not knowing how to integrate them into their practices, but that the training enabled them now to envisage detecting and treating more persons with MH problems.

## 2.4. Details on training per country: Dates, trainers, trainees

### 2.4.1. Training in Belize

In Belize, the training was attended by 32 participants from the various health facilities across the country of which most were general practitioners (6 were Psychiatric Nurse Practitioners, 2 were Psychiatrists).

Presenters in Belize, the first country where the training took place, were Dr. Marc Laporta, Director, Montreal WHO-PAHO Collaborating Centre for Research and Training in Mental Health; Dr. Mark Yaffe, Associate Professor of Family Medicine, McGill University and St-Mary's Hospital Center, Montreal; Julian Xue, PHD student, McGill University, Montreal; Dr. Claudina Cayetano, Consultant Psychiatrist and Technical advisor in Mental Health, Ministry of Health, Belize.

The regular training sessions took place on April 5<sup>th</sup> and 6<sup>th</sup>, 2011.

### 2.4.2. *Training in Dominica*

In Dominica about 50 PHC practitioners were present from health facilities from around the country; as the structure of health care is comprised of community-based teams, which were represented more by nursing and other professionals, there was a wider range of knowledge and comfort levels, which required more careful adaptation of the topics to the group of attendees. It had been expected training that an inhomogeneous professional group would lead to some difficulties, but nevertheless, this was a decision taken by Dominica and which we decided to respect. This required adapting the training significantly to the roles and functioning of PHC clinicians taking the training in each country.

Presenters in Dominica. For Dominica, it was decided to ask trainers from the subregion to collaborate on the project, hoping to foster further intra-regional collaborations. Dr. Wendel Abel, DM, Director, Department of Psychiatry, and Dr. Aileen Standard Goldson D.M. (Family Medicine), M.P.H., Coordinator - Family Medicine Programme, Dept. of Community Health and Psychiatry, both from the University of the West Indies, Mona Campus, Jamaica, were the main trainers, with Dr. Griffin Benjamin, DM, Psychiatrist-in-chief, Dominica, also taking part.

The regular training sessions took place on July 5<sup>th</sup> and 6<sup>th</sup>, 2011.

## **3. Training of Trainers**

An additional training day was scheduled for the Peer-Trainers identified to ensure continuity of the training over the ensuing months. These days were scheduled on Tuesday, April 7<sup>th</sup>, 2011 in Belize, and Thursday July 7<sup>th</sup> in Dominica. This was a “Training-of-Trainers” series, preparing the next phase of the project.

The goals of this ToT was to prepare trainers to take the responsibility of organizing case discussions and medical education seminars centered on mental health, with the goal of enhancing the integration if such clinical cases into PHC treatment. As support for these peer-trainers, the mental health teams of each country, and the Montreal CC were to be involved and available.

### 3.1. Details on ToT per country: Dates, trainers, trainees

#### *3.1.1. ToT in Belize*

For Belize, the trainers were peer trainers – general practitioners – who were selected based on their interest and experience in mental health. For Dominica, due to the different structure of its healthcare system, the trainers were clinicians working in the area of mental health and posted in different areas of the country.

The presentations in this ToT were highly interactive, and so the topics were constantly being adapted to particular concerns and realities as they were brought up. One particularly

interesting and important recurring remark was that MDs time per patients is pegged generally at about 15 minutes, and so there was much concern about being able to do mental health in that time frame. Discussion revolved around adapting practice of mental health, including diagnosis and treatment actions, into short time frames. Another issue was that of mental health issues in many medical conditions, and the importance of integrating this thinking into practice as well. As well, the ongoing need for support from specialized care, and the roles of MDs, PNPs and Psychiatrists.

### *3.1.2. ToT in Dominica*

Dominica has a well-developed team-based PHC system well distributed into the regions of the country. It is claimed that access to care of all new persons with MH problems is very good, and the triage role played by community nurses is well done. It is also claimed that referral of such persons requiring specialized MH services is efficient, and results in follow-up of most persons with mental illness by the MH team, often bypassing PHC physicians. Thus while the needs of MH training remains real in Dominica, it became clear that PHC doctors did not expect, and were not expected, to be primarily involved in becoming trainers.

There was however the expectation that PHC physicians would, thanks to this project, develop the will, skills and understanding necessary to follow persons with established mental illness who were in a stable clinical state. When this project began the PHC MDs had not yet agreed to do this, and the project was seen as a means of arriving at this agreement, by lowering the barriers there may have been for doctors in PHC to feel comfortable following such patients, and by preparing clinical trainers to offer the ongoing support necessary for this transformation.

The Training of Trainers having been originally structured to train general practitioners as peer-trainers, had to be modified to accommodate to the realities and to the stage of integration which Dominica wants to avail itself of. The trainers chosen for the project were thus (1) clinicians from community teams performing interventions for persons with mental illness, and (2) members of the MH team which remains involved in clinical support of communities-based clinics around Dominica. These professionals were very motivated, and were key representatives from each district forming the core group for follow-up training. There were about 15 trainees for the ToT.

## **4. Follow-up CME sessions - Promoting access and treatment in PHC settings**

Follow-up training was a central aspect of this project. It was based on the common experience highlighting that lecture-style training leads to knowledge which often does not transfer well nor generalize to actual clinical practice. Taken alone, lecture-style teaching rarely leads to changes in practice. Thus continuing training with case-based material was implemented. The leaders of such sessions were the clinicians chosen as peer-trainers (see above).

#### 4.1. Details on follow-up training per country

##### *4.1.1. Belize*

In Belize, there were a series of meetings organized by participating PHC centers within Belize City. Monthly 90-minute case-based discussions within regular pre-scheduled CME meetings were dedicated to MH, and made mandatory by administrators of participating centers. These meetings were co-lead by PHC physicians and a member of the mental health team. The meetings were case-based and prepared by rostered presenters. Guidelines were provided to help structure presentations.

Three clinics within Belize City were involved in these trainings. Two of them met together, and the third held its own CME sessions. In all, 9 CME sessions were held with general practitioners, and were met with success. The results are discussed below (see next sections on “End-of-project web-based survey”, and on “other outcomes”).

##### *4.1.2. Dominica*

As mentioned above, adaptations were made to the physician-led trainings originally conceived for this project, as PHC clinicians were not comfortable with acting as peer-trainers.

From September to October 2011, a series of “Case-Manager Seminars” was scheduled in all districts. Presenters were from the psychiatric team (SW, Couns, 2 docs, 2 senior nurses, psychiatrist) but also included clinicians dealing with mental health issues in the districts. Case discussions were organized about one or two persons with mental illness seen in each PHC setting, in the context mainly of clarifying how to follow stabilized patients and how to refer to mental health services when needed.

One outcome represents a major advance for this country, brought about through this project: a verbal agreement was arrived at by Community Health Clinics of all regions to follow stable psychiatric patients within local district clinics. This was the main avowed goal of the MH team.

## **5. End-of-Project Web-based Survey**

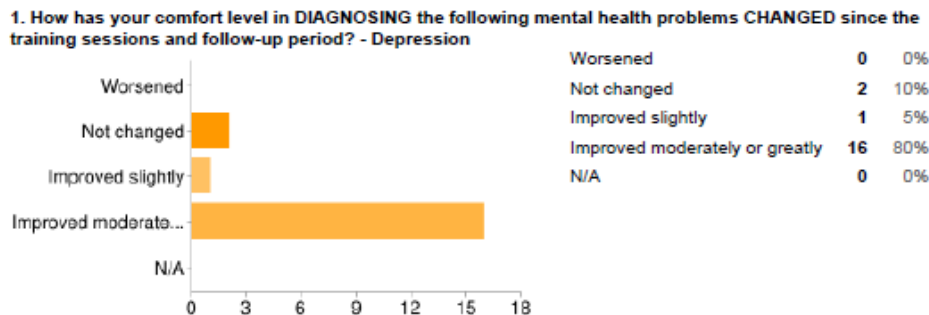
In order to assess the success of the project, we developed an “end-of-project survey”. This second survey was sent out at the end of the project, and aimed to assess changes that accrued from the project in the areas assessed with the initial survey. The same issues were addressed in the second survey as in the first, worded to assess change.

The “end-of-project survey” was also built to inform us as to the interest in pursuing further training, and the topics considered most relevant.



The results of the survey were collated and analyzed, in order to be reported back to the participating groups at the Wrap-up Sessions, and to use for this report and for planning of an extension project if funding is available.

An illustration of the type of questions posed follows:



## 5.1.Details on end-of-project survey per country

### *5.1.1. Dominica*

The final survey was completed by 12 project participants. This was helped by making available an on-site computer enabling attendees to fill it out in situ.

Answers revealed an increased comfort with diagnosing more than with treating mental disorders. Improvements were greatest for depression, anxiety, non-medically based somatic complaints, suicidal behavior, acute psychosis, and mental health problems in the context of medical illness. Changes in comfort with treating was lesser, but were present for suicidal behaviors and psychosis. It is interesting that the most positive changes were greater comfort in approaching patients and in exploring emotional issues with them.

All responders requested to have further training. The areas prioritized included: Depression, non-medically based somatic complaints, suicidal risk, and practical ways to integrate mental health into practice.

### *5.1.2. Belize*

There were 20 responses from the Belize group, which we assume to be representative of the group of clinicians present for the wrap-up.

There was a clear improvement in respondents' comfort in diagnosing as well as treating depression and anxiety, with Bipolar disorders and Psychoses being the least improved. There was also a greater comfort in approaching and discussing emotional issues with patients

generally. On the topic of suicidal behavior, it is interesting to note that participants improved most on their comfort in approaching patients and asking questions, followed by diagnosing, and trailed by treating suicide risk.

Comments attest to a much improved integration of mental health into the thinking of clinicians, and of their ability to ask questions leading to mental health decision-making.

Respondents want to learn more, in particular about depression, anxiety, suicidal risk, mental health issues in medical and chronic illnesses, alcohol and drug abuse, as well as specific strategies for integrating mental health into their practices.

## 5.2. Other Assessments of the Outcomes of this Project

### *5.2.1. Verbal comments on the End-of-Project Survey*

There were a number of telling verbal comments written by participants on the survey form. Here is a sampling of positive and (all of the) less positive comments.

#### Positive

<< Since the workshop I have gained much more confidence in diagnosing mental diseases>>;  
<<My knowledge has increased therefore increasing my confidence level. I now address not only the physical, but also the mental issues>>;  
<<generally diagnosing mentally ill clients has become easier now that (I am) recognizing the problems and able to manage the conditions.>>  
<<I spend more time listening and that makes a difference. I feel more comfortable in approaching the clients...>>  
<<I am now able to have a more holistic view of the client.>>  
<<We have had significant improvement in determining that there is a mental health component to many patients complaints>>  
<<Aspects changed in my approach are: I interact and dialogue with my patients more freely since I feel more confident of my knowledge about the condition; I try use my time adequately to discusses difficult question with my patients too; I feel good in using the drugs available>>  
<<I am more confident in prescribing existing drugs>>;

#### Less positive:

<<I have gained some confidence, but have not been able to make use of the knowledge gained.>>;  
<<Very little has changed in treatment except trying to get the patient to be more aware of mental affectation and to let them know that help exists. From there, further treatment will be offered.>>

<<(I) wish I were more familiar with the most recent drugs.>>

### 5.2.2. *Number of Visits for Mental Health Problems - Belize*

In Belize, available information indicates that the number of persons visiting one of the 3 participating PHC clinics who were diagnosed with mental disorders, increased threefold (X3). This was seen as a positive indication of the effect of this program.

We are not yet able to produce these data for the deadline of this report, but they are available from Dr. Claudina Cayetano in Belize.

## **6. Wrap-up Meeting**

A wrap-up meeting was scheduled in each country, with the following main objectives:

1. To review the overall outcomes of the project;
2. to discuss recommendations derived from this project;
3. to meet decision-makers to discuss this project and the way forward

### 6.1. *Dominica*

In Dominica, the meeting was held at the Crazy Coconut Convention Center, on November 17<sup>th</sup> 2011.

#### *6.1.1. Attendance:*

But for a few exceptions, it was attended by the same persons who attended the initial training. There were about 50 attendees, of which about 7 or 8 were MD General Practitioners. Again I have not received the complete list by this deadline, as the meeting was 6 workdays ago... The list will be available from Dr. Griffin Benjamin in Dominica.

#### *6.1.2. Agenda:*

The agenda included the following main items:

1. Opening Remarks - Drs. Martin Christmas (Director of Primary Care Services), Marc Laporta, and Tomo Kanda (CNCD Advisor PAHO ECC)
2. WHO views on Integrating Mental Health into PHC (Drs. Laporta and Kanda)
3. Brief overview of the project (Dr. Laporta)
4. Clinical case presentation (Dr. Laura Esprit)
5. Group discussion: 3 questions toward recommendations about integrating MH into PHC
6. Statistical trends in mental health in Dominica (Ms. Lesley-Ann Waldron)
7. A report on the outcomes of the project (Dr Benjamin)
8. Reviewing the results of the end-of-project survey (Dr. Laporta)
9. Final open discussion about recommendations relating to the Integration of MH into PHC

### 6.1.3. Highlights and attendees' recommendations:

Discussion was around determining which persons with MH problems should be followed in PHC or by the MH team.

Access: There is adequate access to care for persons with MH complaints in each region (Castlebruce, Marigot, St-Joseph, Portsmouth, RoseauX4, Grandbay). Each district has 1-2 community nurses who were present for the training and who felt it had been very useful in improving their skills and comfort.

→ Earlier access to care of persons with MH complaints could be improved by screening at-risk groups in any given community. It was suggested that screening family members of patients with mental illness would be a feasible starting point.

→ Access would be improved if community resources contributed to identifying and ensuring persons needing care access services. Non-medical community resources – police, pharmacist, priests, schools, employers, etc - could be trained in dealing with behavioral changes on an ongoing basis.

→ Regional clinics require skills in acute sedation of behaviorally agitated persons; they also need adequate spaces to deal with such problems.

→ Local teams need agents capable to giving families and carers more support once a person has been identified. Once again, this could provide a better ability to keep patients within their communities.

Referral : Referral to and interaction with the mental health services is done with ease, seemingly to clinicians' overall satisfaction. However, treatment of persons with MH problems is often done in parallel to the PHC system.

1. → Persons with stabilized MH problems are identified by the MH team as a group that could be followed in non-psychiatric services. In fact, the MH services have obtained verbal agreement from all districts to follow more persons with a psychiatric diagnosis who are stabilized. An chronic care model adapted to these patients would have to be developed, to permit effectively following persons with little insight. In-country MH resources are able to support the PHC system the follow-up of stabilized patients with psychiatric disorders.

→ Community health nurses play a central role in maintaining persons with MH problems in their communities. Their knowledge and comfort in dealing with persons with MH problems has improved with this project, and should continue to be optimized through ongoing CME. Also, social services at the PHC level would have to take on the roles befalling them if more follow-ups are done within PHC settings.

→ If clinicians are to follow more stabilized patients, they would require treatment algorithms and standards.

Adolescents have become a high-risk group requiring more admissions over the past few years. Suicidal, parasuicidal, and substance abuse behaviors were frequent.

→ Clinicians require more knowledge around interventions for such problems.

Substance abuse is a significant diagnosis at hospitalization in all age groups, but it may represent acute presentation superimposed on more long-term MH diagnoses.

→ better training in identifying and brief interventions for such problems is requested.

Information about MH in the population in general is poor, and makes decision-making about areas of greater need more difficult.

→ A plea was made to develop an information system that would capture MH indicators to permit ongoing situation analyses for MH.

→ Future training that would aim to integrate MH into PHC should be targeted to the professional groups involved with the functions identified as priorities (eg access, referral, pharmacological treatment, psychosocial treatments, community rehabilitation, etc)

Medical illness: → PHC clinicians express an interest in learning to integrate MH into their interventions for medical illness including the common CNCDS.

“Difficult” patients, it is agreed, require secondary care by MH services. They are defined thus: (1) frequent admissions; (2) Prolonged hospital admissions; (3) Poor social supports; (4) Poor treatment adherence; (5) lack of insight.

#### Other recommendations

To submit the revised MH Policy to Parliament, and to subsequently develop an Action Plan. The MH Policy Draft was submitted to Government in 2009.

## 6.2. Belize

The meeting was scheduled at the Fort George Hotel, on November 23<sup>rd</sup> 2011.

### *6.2.1. Attendance:*

The meeting was attended by 30 persons. There were twenty-seven general practitioners, 23 of whom had taken the initial training; there were also 3 psychiatric nurses. All persons invited attended. Also present also for the opening were: Gustavo Vargas (Focal point for mental health, PAHO), Gerardo De Cosio (PAHO PWR for Belize), Alberto Barcelò (regional advisor, NCD, PAHO), and Maristela Monteiro, senior advisor in alcohol and substance abuse, PAHO.

### *6.2.2. Agenda: The agenda was as follows*

Opening remarks - Drs Claudina Cayetano and Marc Laporta.

Brief interventions for alcohol disorders – Dr. M Monteiro

WHO position on integrating MH into PHC – Dr. Laporta

Review of the project – Dr. Cayetano

Review of the 6-month follow-up phase – Dr. Cayetano

Analysis of the end-of-project survey – Dr. Laporta

Analysis of BHIS indicators over the course of the project – Dr. Cayetano

Group discussions:

Practice changes made in the course of the project

Role of PHC in detection of new MH disorders

Role of PHC in the follow-up of persons with mental health disorders in general

Role of PHC in integrating MH in the management of medical illnesses (and CNCDS)

## Recommendations

Depression : A review of pharmacological treatment options (Dr. Cayetano).

### 6.2.3. *Highlight and attendees' recommendations:*

Two lectures were given on topics considered to be very relevant to the clinicians present – treatments of depression, and brief interventions for alcohol abuse.

The Mental Health Division of the Ministry of Health of Belize considers that, with this project, mental health has been successfully integrated into 3 PHC centers in Belize City, which were the Centers involved in this project. It was clear that the project was quite successful in Belize, as evidenced by the results of the End-of-Project Survey as well as by other data (see section 5.2.2.).

Detection and access to care for persons with new-onset MH problems is seen to befall PHC clinicians. There were many recommendations regarding this made by attendees.

→ Use of screening/diagnostic and treatment tools would be useful

→ Supplemental training in certain diagnoses, and access to MH consultation and referral are essential. The main themes identified include: Depression, Anxiety, MH issues in Medical illness, Addictions, Suicidal risk, Integrating MH into practices (including shared-care models) / Integrating community support-group participation into PHC.

→ Several formats were discussed which were innovative and relevant to the specific situation of Belize. Formats could include a combination of lectures / case-discussions / discussions with community support groups (including cultural subgroups such as the Garifuna, Maya, Mennonite, Mestizos) / shared-care exercises / use of clinical tools.

→ Short-term shared care between PHC settings and the MH services must be worked out and available

Follow-up of persons with MH problems in PHC settings.

→ For this to improve, support systems are required, which must be developed – access to referral and feedback, a shared-care model if needed, and family- and consumer-support groups to participate in the effective active treatment of such patients with less insight requiring proactive approaches.

MH interventions in the management of medical illness: There is a desire to improve this integrative approach, along the bio-psycho-social model espoused by most, but difficult to apply in clinical practice.

→ Learning to understand interactions between medical (and CNCDS) and MH problems

→ Learning about models of care that would improve this integration

→ Including community support groups to facilitate this integration – HIV, diabetes, cancer, kidney and MH groups

Other recommendations considered to be priority for Belize at this juncture are:

1. BHIS: Develop the MH indicators and markers that would be useful to include on the BHIS. The BHIS could also receive treatment modules accessible by clinicians around the country.

2. Duplicate this project on Integration by organizing peer-training sessions in other areas of Belize, to be led by local trainees who participated in this project.

3. Meetings were also held with the PAHO representatives to discuss the outcomes of the project. There is a will to continue this project, and to include MH issues as they relate to chronic non-communicable diseases as a focus.

## **7. Overall Conclusions and Recommendations**

### 7.1. Did the project attain its objectives?

Overall, this project entitled “Integrating Mental Health into Primary Care in the Caribbean: A Demonstration Project in Belize and Dominica” has attained its objectives.

Different objectives arose for Dominica as the project evolved, which required adaptations. This country’s MH division decided to change the focus of training from PHC doctors to MH personnel, and the integration goal for its PHC settings from assessment and treatment of emergent cases to following up stable diagnosed patients. These changes were based on the structure of PHC settings and availability of clinicians.

### 7.2. Can the project be adapted to different settings?

The project has shown itself to be adaptable and relevant, and could be adapted with ease to other countries in the region.

The program was implemented in its original conceptualization in one country, and was adaptations with success for the other. The content of trainings was adaptable, and indeed needs to be made easy to adapt to different professional groups. The adaptations also of the follow-up CME was adapted, and requires the ability to be so adapted in future settings.

Normally, the initial survey should have informed us of all the necessary adaptations. In our case, some changes to the local needs and requirements were made after the fact, and adaptations also had to be made more quickly.

### 7.3. Should the project be prolonged ?

All trainees answering the survey requested that training continue, and identified areas of greatest relevance. We see this as an indication of its usefulness and acceptability for PHC settings. Prolongation fits well with the concept of this program based on ongoing exposure and integration of MH into practices.

In Belize, prolongation is seen as priority by the MH division of the MoH. In Dominica, despite requests by trainees for more training, the division of MH prefers next to emphasize the parliamentary acceptance of a new MH policy, and the development of an information system integrating MH indicators.

The point was made that great benefit would be derived from training in certain areas outlined above, including the diagnosis and management of mental health components of medical problems encountered on a daily basis by the clinicians in PHC settings - for example, maternal care, HIV clinics, diabetes clinics, etc.

#### 7.4. What should be done differently?

In a follow-up training, both the target population(s) and the professional body of PHC clinicians should be identified at the outset who are to integrate MH into their practices. The training could then be adapted to the stage and professional group mostly involved. In some countries, nurses will need to be included more than physicians.

A subsequent project would gain by having funding dedicated to a local project assistant able to ensure the smooth flow of steps involved, and obtaining information on outcomes.

The mhGAP-IG was perceived as most useful in follow-up training, where specific interventions for specific patients was required. Its use in the initial training was considered as much more detailed than most PHC clinicians are comfortable with at first.

#### 7.5. What was most useful and should be done the same way?

Surveys: The use of a survey at the beginning did help focus training appropriately. The end-of-project survey was a very useful tool, as were the Wrap-up Meetings. These helped target relevant topics and approaches. Other outcome measures of diagnostic patterns and medication use will strengthen the evaluation of outcomes (available in Belize).

Content of training: The initial training sessions advantageously integrated primary care, specialized MH, and administrative (practice change and integration) perspectives. Comments point to the fact all three perspectives were appreciated, and would be requested again in a continuation project.

Trainers: Part of the success of this project came from having trainers who are perceived as peers of the clinical groups targeted for implementing changes to their practices. The language used, the approaches, the clinical time frames and settings are better understood by peers, and trainings were accordingly well adapted.



Follow-up CME: The formula of targeted training sessions followed by well-organized follow-up case-based training was said to have had a powerful effect in enhancing integration, reinforcing and maintaining competence. The project went beyond simple knowledge transfer to become one of practice changes. The follow-up CME training represented, overall, a powerful means of generalizing knowledge transfer, a strong incentive to continue integration work, and permitted this project to be adapted to actual clinical practices.

#### 7.6. Other important features

Other features of the project which were reported as useful in increasing comfort and integration, included:

- Adapting interventions to the short time frames available in PHC practice;
- Gaining knowledge on the use of a small number of locally available psychoactive medications;
- Comfort in asking questions and exploring emotional issues;
- Increased contact with the MH specialists for consultation;
- Specific and practical ways of integrating MH into practices.