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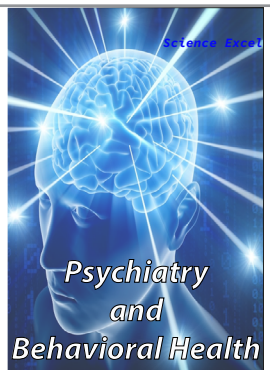

Model for Integrating Mental Health Care in Health Districts in Côte d'Ivoire

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Abstract

The WHO invites countries with limited resources to integrate psychiatric care at the primary level of the health pyramid. For two years now, the Arrah health district in Côte d'Ivoire has been providing psychiatric care at the level of first-contact health establishments. Based on this experience, we want to define a model that can be applied throughout the country. Objective: To describe the model for integrating psychiatric care into the primary health care system in the Arrah health district. Materials and Methods: we conducted a descriptive and analytical cross-sectional study on the integration of mental health care in the Arrah health district. It took place over a one-year period from April 2021 to April 2022 in two sites in the district: the kregbe urban health center (CSU) and the kotobi our lady of charity rural health center (CSR). Results: This study enabled us to describe the organization of psychiatric care in the Arrah health district. We were able to assess the level of collaboration with the health district, community players and the prayer camps on the sites. These two health centers are applying a successful model for integrating mental health care into primary care. However, there is little involvement of the district and community players in patient care. This has led to an increase in the number of patients lost to follow-up, estimated at around 25%. Conclusion: first contact health facilities can provide quality psychiatric care. If this activity is to be sustained at all levels of the health pyramid, it must be integrated into the minimum activity package of these centers.

Keywords

Integration; Community psychiatry; Primary health care.

Introduction

According to the world health organization (who), mental disorders affect 450 million people worldwide. These disorders place a considerable burden on individuals, families, and healthcare systems. It is therefore a real public health problem. Moreover, 35-50% of severe cases in developed countries and 76-85% in developing countries have not received any treatment [1].This means that at least 8 out of 10 people suffering from mental disorders in the West African region do not receive care [2]. In Côte d'Ivoire, access to mental health care is still limited in most parts of the country. The number of mental health professionals is insufficient or almost non-existent in some towns. Psychiatric facilities are very unevenly distributed across the country. According to data from the National Mental Health Program (PNSM), of the 57 health facilities offering psychiatric care, 63% are located in the Abidjan region and 15% in other urban areas. In addition, less than 25% of health districts have facilities offering mental health care [3]. Aware of these difficulties, the government has undertaken several health systems reforms, in particular health development plans. Unfortunately, of all the planning processes that have taken place from 1996 to the present day, it must be said that specialist care systems such as mental health have not found their place in this dynamic. As a result, despite the existence of the health development plan, mental health care has so far remained a matter for psychiatric services. It is only available at national and/or regional reference centers. At the level of First Contact Health Establishments (ESPC), acute cases of mental disorders are systematically referred to specialist structures without any upstream care. In the information and management system (SIG Report), mental health data is collected globally under a single heading «mental disorder». Faced with this alarming mental health situation in the health districts in the interior of the country, since 2018, the psychiatry department of Bouaké University Hospital has taken the initiative to develop and implement a model for integrating

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mental health care into primary care in accordance with WHO recommendations [4] and the institutional support of the National Mental Health Program. Psychiatric activities are developed in the ESPCs of the health districts of Côte d'Ivoire, including Arrah. The aim of this work is to define a model for integrating psychiatric care in health districts based on the experience acquired.

Materials and methods

This research was part of two health centers, namely the Kregbe CSU and the Kotobi CSR

These two centers were included in the study because of the size of their active thread, their remoteness from any specialized psychiatric structure, the quality of the organization of psychiatric care and the interest of the administrative health authorities in these psychiatric care activities. We conducted a descriptive, cross-sectional, evaluative study. The study took place over a period of one year, from April 2021 to April 2022. Several data collection and analysis tools were used. These included a psychiatry and epilepsy clinical information sheet which forms the patient file, a treatment dispensation sheet, a CHW guide, a monthly report sheet for the nurse and the CHW, and a supervision sheet which reviews all the indicators to be monitored. The parameters studied made it possible to describe the organization of psychiatric care in the Arrah health district, to describe the level of collaboration between the actors involved (coordination/supervision team, Departmental Directorate, health centers, non-conventional care centers) and finally to set out the difficulties encountered in integrating care.

Results

Organization of care in the Arrah health district

Administratively, the Arrah health district comprises one department, three sub-prefectures, one commune, nineteen villages and several camps. The population is largely rural, with 77.5% living less than 5 kilometers from a health Centre. The district has 11 public health establishments, including a general hospital, two urban health centers, three rural health centers and five rural dispensaries. There is one doctor for every 1,501 inhabitants, one nurse for every 2,766 inhabitants and one midwife for every 1,334 women of childbearing age.

As far as the organization of psychiatric care is concerned, the MORONOU region is a veritable desert when it comes to psychiatric care for patients. There are no public or private inpatient or outpatient psychiatric facilities. No mental health professional (nurse or doctor) is on duty in the entire health region. Since April 2018, health workers in the Arrah district have been trained in the diagnosis and management of 3 priority pathologies using the MHGAP approach advocated by the WHO. We trained two nurses in the management of psychiatric and epilepsy cases. Two of the 11 health centers were chosen to carry out psychiatric activities. These two centers provide psychiatric care, each with its own specific organization.

At the Kotobi Centre, the team in charge of psychiatric activities consists of a nurse responsible for consultations and prescribing medication, two care assistants who provide care and a community health worker who makes home visits. Psychiatric consultations are held every day. Psychiatric patients benefit from the same reception facilities as all other patients. As the center does not have an inpatient ward, care is provided exclusively on an outpatient basis. After the consultation, there are two possible scenarios: either the patient is calm and receives oral treatment and is scheduled for a monthly appointment, or the patient is agitated; parenteral treatment is started and the parents must undertake to bring the patient back every day for three or four days for injectable treatment, or the nurse and care assistant go to the patient's home to provide care. The nurse also provides home consultations when the patient is too agitated to be transported, or during advanced strategies when the patient is a long way from the center, as well as caring for patients living in prayer camps.

The community component consists of home visits and care. In theory, home visits are systematic for all new patients. Their purpose is to identify patients' homes and find out about their living conditions, monitor compliance with treatment, detect any side-effects and look for people who have been lost to follow-up. The community health worker also identifies suspected cases of psychiatric disorders or epilepsy in the community and refers them to the health center.

In Kregbe, the team responsible for psychiatric care consists of a nurse and a community health worker. Consultations are held every day, depending on the availability of the nurse. Patients are welcomed at the admissions office, and once they have been assessed, they are directed to the consultation office. Here, patients can be treated in one of two ways. Either outpatient care or short-term hospitalization for three days. The CHW's activities can be summed up as home visits, the aim of which is to identify patients' homes, assess their living conditions and raise awareness among those around them to avoid any stigmatization. He also identifies suspected cases of psychiatric disorders or epilepsy in the community and refers them to the health center.

The different collaborators

The NGO MCF-CI: The NGO's activities take place at three levels:

Training activities

The project team has organized 2 training sessions:

Training for health-care staff: Health workers were trained in the use of the Practical Guide to Primary Mental Health Care. This tool is a West African adaptation of the MHGAP as proposed by the WHO for countries with limited resources. This training enables trained agents to diagnose and manage the three priority pathologies, namely psychosis, depression and epilepsy, manage psychiatric emergencies, use neuroleptics and antiepileptic's, and recognize and manage the adverse effects of these drugs.

Training for community health workers, enabling them to acquire a basic understanding of mental health and illness, to provide psychosocial support for patients and their families, to recognize suspected cases of mental illness and epilepsy, and to refer these people to the health center where they are affiliated

Supervision activities

Supervision is defined as a process of guiding, assisting and training staff to ensure high-quality care services. In practice, we have opted for two means of supervision: physical supervision and telephone supervision.

Physical supervision: This involves visiting the site to carry out activities with trained staff. This enables us to detect any shortcomings and correct them immediately. To ensure that this task is carried out successfully, we have equipped ourselves with supervision tools for both medical and community activities, with a well-established supervision schedule.

Telephone supervision: It consists of enabling agents at consultation sites to communicate 24 hours a day with a medical specialist. In this way, they can get an immediate response to their various concerns. For this purpose, the NGO has acquired a cell phone dedicated to this activity. For the period from April 2021 to April 2022, we recorded an average of 65 calls for each center. This telephone supervision reassures health workers in their consultation activities and enables us to respond in real time to the expectations of health center workers. It also allows to privileged the different sites for physical supervision

Drug supply

Both health centers obtain their medicines from the NGO MCF-CI. The centers have experienced stock-outs for several reasons, including the unavailability of medicines at the NGO pharmacy, poor estimation of needs by the health center and difficulties in routing orders. The pharmacy of project is working on procedures to improve collaboration. These include the use of order forms and delivery notes, the use of stock sheets, and the management of medicines by the pharmacies of centres

With the health district

At institutional level, psychiatric care is well integrated and accepted as part of primary health care. There is good collaboration between the different agents. However, psychiatric activity is not yet part of the canters' minimum activity package. As a result, monthly activity reports are not transmitted to the district, and psychiatric care is not included in district supervision programs.

With the community

Parents spontaneously bring their patients to psychiatric consultations, even those living in prayer camps or cared for by traditional therapists. However, we note a low level of community involvement, especially in community awareness-raising activities, and a lack of initiative on the part of community leaders, local councillors, traditional chiefs and religious guides for the rehabilitation and socio-professional integration of psychiatric patients.

With prayer camps

Both centers collaborate with prayer camps in the region. Even CSR of Kotobi includes prayer camps in its advanced strategies program. The prayer camps systematically refer the agitated patients to the health center. This population is characterized by a high drop-out rate once the patient has stabilized. The majority of those who got lost are patients coming from the prayer camps. Steps are currently being taken to formalize collaboration with the prayer camps and thus improve the care of patients residing there

Discussion

The organisation of psychiatric care in the Arrah health district

The results of our study showed that the Arrah health district is a veritable health desert in terms of care for people living with mental illness or epilepsy. Overall, the practitioners trained had a good command of diagnostic and therapeutic tools. Indeed, this was the objective in the first year. All the supervisions were for training purposes, and the players organized mobile consultations where consultations were carried out jointly by a psychiatrist and a trained nurse. The main clinical difficulties were monitoring treatment and managing side-effects. As far as the professionals are concerned, regular monitoring and supervision simply must be maintained in order not only to ensure that what has been learnt is sustained but also to correct bad practice, as recommended by the WHO in its guide [4]. Our study showed that in the two health centers, apart from the two trained nurses, no other prescribers were interested in psychiatric activity. The long-term future of the psychiatric consultation therefore depends on the availability of its staff. It would be necessary to train other prescribers to replace them in this task. Our study showed that community health workers were not very involved in the various activities, despite the training they had received. However, capacity-building is needed so that they can better understand their role in the scheme and feel the effects of this training in future activity reports. It should be borne in mind that CHWs are volunteers, and thought should be given to a means of remuneration, as in India, where the role of CHW was defined for the first time [5].

The different collaborators or levels of collaboration

The results of our survey showed that the Arrah health district was in favor of integrating psychiatric care into primary care. However, it must be said that the reports on psychiatric care are not yet taken into account in the PMA. The role of the district is to supervise and ensure that the tasks of the PMA are carried out properly at the level of the ESPCs [6]. We can draw inspiration from the Ugandan integration model, which is the first successful integration model in Africa and has been successfully adopted in Nigeria [7] and Niger [8]. This model is applied as follows: The content of the LDC is decided during the PDS, so the district's role will be to transmit the most accurate information and reliable statistics to the secondary and tertiary levels of the administrative chain. The latter will then have a real idea of the needs and resources required and will be able to decide how to integrate the PMA. Using this method, Uganda succeeded in integrating psychiatric care into all ESPCs and psychiatric inpatient beds into all general and regional hospitals between 1996 and 2008. According to YAMIEN [8], if this integration model is to succeed, it is essential to improve the quality of health information, systematically transmit the data recorded to the entire management chain (PNSM, DR, DS, etc.) and, lastly, designate a mental health focal point in the health district and the regional directorate, whose role will be to ensure that the mental health aspect is included in the terms of reference for district supervision.

But this is not the only integration model. In South Africa, for example, they have relied on a large network of community clinics and have scheduled a day of consultation for a nurse specializing in psychiatry. Doctors and clinic staff are then trained to detect mental disorders and systematically refer them to the nurse for consultation [9]. These examples of good practice show that it is possible to integrate mental health into primary care in a variety of situations and in different economic and political contexts. As a result, the models they have adopted for integrating mental health into primary care vary widely. Although these models of integration differed, what they had in common was a well-established policy and action plan [9]. Therefore, the WHO recommends that, prior to any integration of care, a mental health policy with a national action plan should be defined, a drugs policy should be defined, which will involve including psychotropic drugs in the list of essential medicines and thus making them accessible to PHCs, and a budget and method of funding psychiatric care should be drawn up [10].

Conclusion

This descriptive evaluative study carried out in the Kregbe Urban Health Centre and the Notre Dame de Charité Rural Health Centre in Kotobi enabled us to understand the system for integrating psychiatric care into the health system in the Arrah health district. This initial work enabled us to describe the organization of psychiatric care in these two centers, and the level of collaboration with psychiatrists and non-conventional health centers. It shows that the organization of psychiatric care in these centers is satisfactory in terms of patient management and collaboration with psychiatrists. However, the weak involvement of the health district, which is the management body of the first contact establishments, and the inadequacy of actions involving the community, particularly the prayer camps, in the approach, have been real obstacles to the process of integrating mental health care into primary health care.

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