Interim report on rapid mental health needs assessment in Philippines Typhoon Haiyan/Yolanda Affected Areas: Capiz Province and Southern Leyte[1]

Lynne Jones OBE, FRCPsych. PhD
Mental health Officer
International Medical Corps; Philippines ERT

[1] For a full picture this report should be read in conjunction with the first report from Margriet Blaauw, that covered the first two weeks after the Typhoon.

For more information contact

Dr. Inka Weissbecker, PhD, MPH
Global Mental Health and Psychosocial Advisor
International Medical Corps
Current Location: Addis Ababa, Ethiopia
Current Phone: +251-(0)923-775228
Skype: inka.weissbecker
E Mail: iweissbecker@InternationalMedicalCorps.org
Web: https://internationalmedicalcorps.org/mentalhealth

Acknowledgements: Thanks very much to the entire International Medical Corps emergency response team for their support and assistance. It was only thanks to very well organized site management and logistics that I could do so much in a short time. Thanks to Peter Arcenas and Richard Allandale Villar, my assistants and interpreters on Panay and Leyte respectively. Thanks to all my informants listed below for being so welcoming and helpful at every meeting.

Sources of information

This report based on rapid assessments conducted in Cebu city, Roxas and Tacloban cities and field visits conducted in Capiz province on the island of Panay in the Western Visayas, and in Southern Leyte province on the island of Leyte in the Eastern Visayas.

Information was gathered through:

1. Reading background documents
2. Attending health and protection cluster meetings, MHPSS sub-clusters in both regions
3. Discussions with outgoing international mobile medical unit staff
4. Discussions with, and observation of Philippines mobile medical teams at work
5. Site visits accompanying mobile medical teams in 12 Barangays
6. Psychiatric assessments of 11 patients with severe mental disorders and discussions with their families
7. Site visits accompanying the food security adviser in 2 Barangays
8. Site visits to 5 rural health units
9. Site visit to 1 district health unit (Capiz only)
10. Site visit to one provincial hospital (Capiz only)
11. Site visit to psychiatric out patients at the Eastern Visayas Regional Medical Centre EVRMC
12. Site visit to the OP and inpatient psychiatric ward at the Schistosomiasis hospital
13. Site visit to Cebu Centre for Behavioural Science, the main inpatient referral unit for the Eastern Visayas
14. 5 focus groups with selected age groups in various Barangays (see Annex 1)
15. Individual interviews with the following people:

Cebu

Emily Fernandez, MHPSS focal point in Cebu

Dr. Obra, Psychiatrist, Director of the Centre for Behavioural Sciences

Roxas, Panay

Dr. Samuel Delfin, Director of the provincial Health Office, Capiz

Dr. Leah Del Rosario, Assistant Director, PHO, Capiz

Dr. Leah Agricola Sicad, private psychiatrist, Capiz

Dr. Evelyn Bolido, MHPSS focal point at PHO, Capiz

Dr. Florentia Lucia, director of the provincial hospital, Capiz

Mama Bucay, Albulario (religious healer)

Leyte

Mai Angelina Marquez, focal point for MHPSS at the DOH, Leyte

Dr. Verona, Director of psychiatry, Eastern Visayas Regional Medical Centre, Tacloban

Dr. Benji Go, psychiatrist at the acute intervention unit, Schistosomiasis hospital, Tacloban

Dr. Antonio Ida, Director of provincial health teams in Leyte

Dr. Espina, Director of medical Personnel, EVRMC

At every Barangay visited, in both regions, I talked to the Barangay Captain and if available the midwife. At each Rural Health Unit (RHU) I talked to the medical health officer and on most occasions the public health nurse and midwives there. Contacts are listed in the Contact sheet in annex 3.

EXECUTIVE SUMMARY

- 14 million people have been affected by Typhoon Yolanda which struck the Philippines on November 8, 2012
- The acute emergency phase is coming to an end and humanitarian efforts are now focused on *early recovery* and *building back better*

NEEDS

- Psychosocial and mental health needs are changing. In the first week health agencies and other observers reported high levels of shock, bewilderment and disorientation, as well as many people presenting at clinics with somatic complaints and dizziness.
- Most communities report that they have now recovered from these problems although many acknowledge continuing sleeplessness, fear and anxiety when it rains or it is windy. Children and elderly are particularly sensitive.
- People state that the main sources of stress at this stage are: lack of shelter, livelihoods, financial security, school materials for children and insecurity. These problems are compounded by lack of information as to how and when these needs will be addressed and a perception of unfairness in some of the more neglected Barangays
- International Medical Corps has focused on the needs of people with more severe mental disorders many of whom had problems prior to Yolanda and were particularly vulnerable afterwards
- People with severe mental disorders are to a large extent invisible in the rural disaster affected communities where International Medical Corps is working. Lack of financial resources and stigmatization has meant that they have often never accessed care.
- For example 36 cases were identified by the author in in 13 Barangays in a 10 day period. Of these more than 50% had never received care or only been treated intermittently when violent.
- 11 of these patients were personally assessed by the author and 10 were given or connected to appropriate treatment.

EXISTING SERVICES

- The Philippines has 420 psychiatrists for a population of 92 million. There are 3 inpatient units for the country. Access to formal mental health care is very limited in both Roxas and Leyte
- A major barrier to care is the lack of free psychotropic medications. Drugs for mental illness are not covered by health insurance or the department of social welfare. There are almost no psychological services in the public sector.
- To address need the Philippines passed a National Mental health Act (2009) calling for more community based mental health services and the integration of mental health into primary health care. A training programme of rural health unit staff in mental health began last year.
- Post disaster the Department of Health (DOH) has concentrated on providing immediate psychological support to those affected, through fielding teams of people to do psychosocial processing. The Department of Education has worked with teachers in Schools

- The DOH is now asking for help in capacity building of rural health unit staff so that those identified as having mental health problems can more easily access care.

RESPONSE

- The majority of agencies doing MHPSS work are focused on PFA, counselling, supporting children through child friendly spaces, community services, baby tents.
- Only 2 other international agencies: CBM and IOM are currently trying to address the needs of those with more severe disorders. International Medical Corps is working in collaboration and cooperation with both.
- International Medical Corps is beginning a three month mental health capacity building pilot training programme for RHU doctors and public health nurses from 7 municipalities in Southern Leyte in January. This will allow health workers to integrate mental health into primary health care and provide more accessible less stigmatizing care for the mentally ill.
- The programme will use the mhGAP humanitarian curriculum. Training will also allow for the introduction of basic psychological skills to assist patients. They will also train Barangay health workers in de-stigmatisation and case finding.

INTRODUCTION

For background on the disaster and latest updates please see the latest OCHA situation reports.

On December 20th figures were:

- 14 million affected
- 4.1 million displaced
- 1.1 million damaged houses
- 6092 reported dead
- 1779 reported missing

I arrived at moment of transition. The acute emergency phase is coming to an end and "early recovery" is repeatedly pushed in cluster meetings. The DOH requested that mobile medical units be drawn down in order not to undermine local health structures. International Medical Corps teams transitioned out on December 8th, and the Manila volunteers left on December 20th. Cluster meetings in both areas have been scaled back to weekly and most evacuation centres are closing, although large numbers remain camped around the Convention Centre in Tacloban and in other tented sites, or are sharing accommodation with relatives and family.

There are repeated requests in cluster meeting for a shift of emphasis to livelihoods where possible, to provide work for pay to allow people income to get back on feet. There has also been an appeal to NGO's adopt facilities to help rebuild local health structures. However site visits showed that emergency needs still exist and that coverage is patchy and in places appears arbitrary. Many people still lack even basic shelter equipment such as plastic, and have not received non-food items such as hygiene kits, flashlights, water containers, while others in neighbouring areas are fully equipped. This appears to be a particular problem for more isolated agricultural workers not living in settlements

Attendance at MHPSS sub cluster meetings made clear that the majority of agencies are providing community support, children's activities of a variety of kinds and individual counseling services including psychological first aid both training and practice. However only 2 other agencies: CBM and IOM are looking at the mental health needs of those more severely affected and those with pre-existing disorders.

International Medical Corps has received funding for capacity building in health care, including capacity building activities for mental health. This assessment has therefore focused on:

1. Assessing the needs of the more severely affected groups (the upper two levels of the IASC MHPSS intervention pyramid)[2]
2. Assessing the potential for integration of mental health care into the primary health care system
3. Identifying mechanisms for referral

[2] Inter-Agency Standing Committee (IASC) (2007). IASC Guidelines on Mental Health and Psychosocial Support in Emergency Settings. Geneva: IASC

4. Consultation with government partners and all relevant mental health actors on all the above

Details of the assessment can be found in the accompanying annex 4 which provides specific information on individual Barangays, RHUs and discussions with focus groups. Annex 1 has example case details, annex 2 my assessment of Cebu psychiatric unit. Annex 3 contains Philippines National Mental Health Act of 2009.

WHAT ARE THE MAIN MENTAL HEALTH PROBLEMS?

PSYCHOSOCIAL ISSUES

Focus group discussions with various age groups in different areas showed that people's primary concerns are material:

1. **Shelter**: the majority of people interviewed had lost their entire home and were living in small constructions patched together by themselves. Many of these looked very vulnerable and unsafe. People want equipment and funds to rebuild.
2. **Food security**: no one I interviewed is hungry at this moment, but all are worried about the continuity of supply, combined with failed harvest, lack of seeds and fishing boats, no work and no income.
3. **Destruction of their livelihoods**: International Medical Corps is working in primarily agricultural areas. See Michael Yemani's detailed report on this issue. In all areas where I assessed, people had lost the existing harvest, supplies and the plants on which their livelihoods depended. Nipa for straw weaving in Capiz, coconut and rice in Leyte. In the fishing community we assessed, 90% of the Fishermen had lost their boats
4. **Difficulties in paying rent for land:** the majority of farmers tenants and main system of payment is a fixed number of bags of rice, regardless of crop yield (See Michael Yemani's report)
5. School children and teachers complained about **lack of all School materials**- books, paper, writing equipment, uniforms etc.
6. **Lack of information**. This was a major source of stress for everyone I interviewed. People's major source of information is local radio which does not let them know what is happening in their village. Barangay Captains don't always know something is being distributed until the night before. Their main method of communicating a distribution or planned activity is through megaphone, house to house calls, or just word of mouth. This can mean more isolated vulnerable people get left out. Planning is difficult because people have no idea what is going to happen next. In one municipality (Burauen) Barangay Captains met three times a week at municipality to get information. See also the Attached report on this issue in Annex 3
7. **Perceived unfairness**. Barangays feel that because aid comes from private donors with allocated communities- some get more than others. For example the Barangay Captain of St Esteban in Burauen municipality, Southern Leyte, told me *Other Barangays are getting a lot here we only received food but others get shelter, bed nets, and personal hygiene kits. There are 78 Barangays in municipality, 17 are supported by PLAN and get more relief than the others.* International Medical Corps' AOR in Southern Leyte concentrates on agricultural communities that have been severely Storm affected but have not had the heavy NGO presence of the main towns in the coastal region. I was therefore able to witness this discrepancy myself. Thus I interviewed displaced families living in a fragmented rural hamlet who got food

from the DSW once a week but had had NO other support of any kind, whereas a coastal Community was receiving deliveries of various kinds from 6 different NGOS as well as the DSW.

8. **Failure to address the needs of most vulnerable:** the Department of Social Welfare is running cash for work programmes to clear roads and land. However there is no provision for the elderly, sick or those unable to work (see Michael Yemani's report)
9. **Insecurity.** People do not feel their houses are safe. Curfew notices including threats to shoot are visible in many places. On three separate occasions I was told that some people's worst fear was the *Aeta Badjao* coming into town and stealing their things. Aeta Badjao are nomadic indigenous people who live in the highlands on Leyte primarily in conflict affected areas, controlled by the NPA. The needs of this group have not been assessed at time of writing. This raises the question of stigmatization and attacks on marginalized groups.

No one spontaneously mentioned emotional distress or psychological issues as a problem. However when asked specifically about this the majority reported a period of bewilderment, shock and disorientation in the immediate aftermath of Yolanda but most said that this had now gone. The main complaint was of weather related sleeplessness and fear. Heavy rain and wind continues to be very disturbing. *Some people were wandering around bewildered. They needed materials, they were upset and frightened, now they are recovering and moving on. Some school children are still frightened another storm will come*. This was a typical response. A false Tsunami alert via SMS on December 1st caused enormous panic and distress with people running to the hills.

International Medical Corps' AORs both in Capiz and southern Leyte are not in areas with many deaths and I was not told about many grief reactions. The two people I interviewed who had suffered losses were still grieving deeply.

People's main coping methods are community engagement-both to assist others and ask neighbours for help, engaging in rebuilding, and prayer. Some of the communities interviewed have received mass PSP interventions, some not. I was not able to note a difference. The one significantly different community was the fishermen in Sungi Barangay in Dulag, South Leyte. They all reported marked fear about going to sea again and asked directly for more psychological assistance for the Community. The adults had not received any, although SAVE was working with Children. NOTE: This was the only storm surge affected community I assessed, as International Medical Corps is working primarily in inland agricultural areas. It is possible that the coastal communities may have more enduring communal psychological stress and may require more support in this area.

POST YOLANDA MENTAL HEALTH PROBLEMS

Perspective from Mobile Medical Units:

Leyte

The MSF Spain doctor working in Mayorga has seen 15/1500 cases requiring more psychological help: problems are mostly related to lack of sleep and stress.

International Medical Corps MMU teams observed over an initial three week post disaster period, that at least 95% were stressed, which mainly presented as somatic distress or dizziness. They did not see anyone with severe mental disorders.

Roxas

Over the initial 3 weeks post disaster period International Medical Corps MMU doctors in Capiz observed:

- High levels of stress related complaints in clinics, primarily presenting as somatic complaints particularly dizziness. Say things like “my head is turning”, feel overwhelmed: lingin sang uto. Treatment: primarily reassurance
- Trouble sleeping, particularly since the false tsunami alarm December 1
- 1 case of clinical depression- widow living alone, 2 of psychosis: 1 patient was taken by police, because broke down after running out of medication, 1 dementia, 2-3 cases mental retardation

Perspective from Rural Health Units

All reported an initial increase in somatic problems, and dizziness that has now subsided. There are continuing problems with sleeplessness and fear associated with wind and rain, particularly in elderly people.

Other views

The PHO in Capiz reported a *big increase in traumatic distress that requires counseling*

The DHU head at Bailan, Capiz thought there were *not many- some anxiety reactions and panic because of tsunami alert*

Psychiatrist: Dr. Sicad in Roxas reported an increase in anxiety cases and acute stress at her private clinic.

…Most people reacted relatively well because everyone was affected, so everyone has to bear the hardships. Unfortunately the Dec. 1st tidal wave scare lowered the threshold and created more stress. I had a sudden surge of anxiety patients who had been well after the Typhoon. The other group was old bipolar patients who had been lost to follow up for years and had a manic response, disrupting their communities

SEVERE MENTAL DISORDERS

I was informed by regional and provincial offices that little specific data was available for the affected regions. For example the DHU director in Pontevedra, Capiz, said there were *a lot of people with severe disorders but we have nothing to do with them, they go directly to Ilo Ilo*. There were also many homeless people in town and problems with alcohol intoxication.

…In the past they had some emergency psychiatric drugs but not now. The mentally ill just roam around. There are at least 5-6 in town. No one cares for them. The cost of medication is the major issue.

Questions about baby blues and maternal depression were similarly unrevealing: all six midwives interviewed in Roxas said that they never observed maternal depression or baby blues. There was a similar response in Leyte, all four midwives interviewed stated they had never encountered either 'baby blues' (their term), or depression.

I therefore decided to engage in systematic case finding.

Case Finding

At each, DHU RHU, and in each Barangay that I visited I enquired if the Barangay Captain or the available health staff knew of anyone in the area with a severe mental disorder- someone who had 'lost their mind', behaved strangely, talked to themselves, or was mentally retarded or had convulsions or spent time alone. If possible I asked to see them. Full details are in the **case finding report** attached in annex 1. This process was very revealing. The initial response was, on many occasions *No,* and then after some discussion people did identify cases. Most Barangays with a population of at least 200 families could identify 2- 3 people. The majority of these people had never received treatment, or treatment had lapsed. In all cases this was because of lack of resources.

In total 36 cases were verbally identified and described in 13 Barangays. Of these:

- 4 were currently receiving treatment
- 3 had been referred to hospital
- 6 were receiving intermittent treatment, only when they became violent
- 15 had never had treatment
- 7 there was no information

The suspected diagnoses were psychosis: acute and chronic schizophrenia and bipolar disorder; catatonia; substance abuse; dementia; mental retardation and autism; severe grief reaction; and epilepsy

I was able to personally see and assess 11 cases:

- 2 of these were already receiving care from the local psychiatrist.
- 1 patient with dementia: the family was given psycho-education
- 1 patient with an organic illness was referred to the DHU
- 1 boy with mental retardation was referred to social services
- 5 patients were referred to a local psychiatrist, or doctor with mental health training, who had been given the psychotropic drug supply from the interagency emergency drug kit
- 1 patient refused treatment

In addition I connected 2 patients I was unable to assess personally, but who had never been assessed or treated, to the nearest doctor with psychiatric training, to whom I had donated drugs. They both sounded as if they had psychosis.

Information from the Rural Health Units

The numbers of cases reported by public health nurses and the medical officers bore a direct relationship to the amount of training the medical officer had received in mental health. 2 out of the 5 interviewed had received a one week training course. One of them had had 2 weeks training. Two of these medical officers were doing 20 mental health consultations a month. The other was referring cases to EVRMC. However the other two untrained RHU doctors denied that mental disorders were a problem, and stated that the few cases there were went direct to the hospital. Case Vignettes are attached in appendix 1.

WHAT IS THE EXISTING SITUATION REGARDING THE PROVISION OF MENTAL HEALTH SERVICES?

Psychosocial Processing (PSP)/Debriefing/Counselling/Psychological First Aid (PFA)

PSP has been the major intervention organized by the DOH to address post Yolanda needs. The DOH in Cebu, Roxas and Leyte have all fielded teams of psychosocial processors, particularly to the evacuation centres. The Assistant head of Cebu DOH announced at the Health Cluster, on December 6th that she wanted *no families left un-served in terms of psychosocial debriefing.*

Although the DOH agreed to use PFA instead of psychosocial processing after the presentation of Mark Van Ommeren of WHO, on 5 December, this message has not filtered down to communities.

The DOH in Cebu was also planning training of trainers for teachers to assist children in School. Similarly the DOE in provided some training for teachers to do “activities with children”. The DOH also did one day training for health workers in Capiz.

IS PSP THE SAME AS CRITICAL INCIDENT DEBRIEFING?

The midwife at RHU Panay in Capiz province Western Visayas gave me an example of doing psychosocial processing: She has held 3 PSP meetings for 100 people each: *I get people together to express how they feel and to share their experiences in the Typhoon. They liked it. For example- some could not sleep because of their trauma and house destruction. Almost all the fishermen cannot make a living because their boats are destroyed. By sharing the problems they have- so people can share resources for example their fellow citizens can assist them with a boat.* This makes clear that it combines elements of CID: retelling trauma story and sharing feelings, and PFA, in terms of mobilizing resources and social support.

Dr. Obra told me he was trained in CID and was using it. I shared information regarding WHO guidelines and PFA. He appeared very interested. This was a very small part of our discussion which was mainly on services for severe mental disorders

I was able to witness mass psychosocial processing in action at Patoc Barangay in Dagani Municipality. The Archdiocese had a local team come in from Saviour University as part of a big relief delivery day including a medical mission and direct distribution of food. People from 16 Barangays were in the yard waiting for relief.

The PSP team consisted of a psychologist, a counselor and two lay workers from the Church. They also had a team of approximately 10 volunteers. The idea was that each volunteer would work with 10 people in age divided groups.

The Team met with me and explained their process to me. They are using the 'Agreed Filipino Framework' and gave me a one page handout which includes instructions, in Phase 1, to

A. Tell people we are here to listen to your stories
B. Get the facts of the Narrative (regarding the traumatic event)
C. Get reactions and feelings: What did you think and how were you feeling when it was happening

I suggested that this was very similar to CISD and they agreed. I then asked if I could share some reservations I had about this part of the process and they were extremely interested, and for two of them it appeared to be completely new information. The psychologist then assured me that they did not use that bit of the handout and only concentrated on *the Here and Now.* They use a drawing to identify strengths, resources and connections and to instill hope. The handout does go on to say Facilitation is NOT probing or asking too much. It then discusses coping, surviving, planning and rebuilding.

They had asked the Barangay Captains to select those who "wanted psychological debriefing" (unexplained). No means of selection was given. Unfortunately because of the mass distribution, there were at least 2000 people in the church yard and many people queuing and waiting outside the PSP spaces thought they were queuing for food or medicine.

I watched the Volunteers working with large groups of children and they were doing standard animation activities and then planned to move on to drawing, concentrating on the present situation. The large size of the group, and pressure from others outside the room wanting to come in, meant that at least three children were separated from their mothers and crying bitterly, without any counselor noticing (we did some reunification). Otherwise the rest were enjoying themselves.

The same church had free booklets available in large numbers called: *Emotional First Aid Kit, Psychospiritual Model* by Leo Deux Fils Mijares Dela Cruz. As I imagine these books are being given out in many Churches I will summarise the main thrust: This booklet combines spiritual advice with a form of CISD. It has some good points such as *one does not need to be a counselor or psychologist to be able to do Emotional First Aid* with more worrying ones such as *Traumatic experiences must go through ' emotional processing';* using the metaphor of the *'Dental Approach:*

- *Finding the Cavity*
- *Drilling it*
- *Making the cavity bigger*
- *Making the cavity deeper*
- *Disinfecting the Site*
- *Then and only then can we close the Cavity*

The main idea is that one must have full awareness of the traumatic experience and feelings aroused in order to become aware of God's creativity and purpose in order to become a better person. The second part of the book goes through activities very similar to a one session CISD model.

OPENING A DISCUSSION

At the Child protection Cluster 17/12 in Leyte Dr. Joop de Jong, visiting at the invitation of psychiatric association and WHO, gave a presentation outlining the likely overall responses and means to address them. This was very much in line with IASC and WHO guidelines. In particular he emphasized:

- Not everyone will be traumatised. He had been asked to 'debrief' all government staff. Although the government thought that all exposed to the storm needed treatment, he explained that this was not the case.
- Importance of identifying those really in need including those with severe disorders
- Apparently various psychologists are coming specifically to train in PFA and EMDR
- There is a lack of connection between psychosocial sector and clinical services run by DOH
- The need for referral parties

As Margriet points out in her report, Filipinos know very well how to do PFA without being taught. It is important that in explaining the problems with CISD and advocating PFA we do not sell it as another intervention which you cannot do unless you are trained. The emphasis should be on reinforcing the numerous natural coping skills that exist here. I conducted two discussions with national staff on both approaches and in both cases, prior to introducing PFA; they identified a list of helpful activities that they would choose to do themselves. These were almost identical to what is laid out in the manual.

Existing mental health services

The Philippines has 420 psychiatrists for a population of 92 million. Access to mental health care is limited in both Roxas and Leyte. Patients access to care is through an RHU doctor, or they may go direct to a psychiatric OP department themselves, or through the Department of Social Welfare (particularly if they are victims of sexual violence). Alternatively if they are causing a disturbance and are violent the Police may refer them to an OPD.

Leyte

Leyte region with a population of approximately 1.9 million, has 8 psychiatrists, all based in the city of Tacloban:

- 3 in Eastern Visayas regional medical Centre: Outpatients only
- 1 in the Schistosomiasis hospital, out-patient and in-patient
- 1 providing drug rehabilitation
- 3 working privately

Dr. Verona explained she has 5 main tasks

1. Consultations with patients from all parts of the region. There are 2 ambulances available and, for example 20 patients attend monthly from Ormoc. Cases are the full range of psychiatric disorders. They also see children with ADHD, autism, epilepsy, and physically and sexually abused children
2. Court orders, the evaluation of violent patients. There are no specialist forensic facilities
3. Training: they are asked to be lecturers in the basic training of RHU doctors and provincial doctors
4. She is the referral point for violence against women and children
5. After hours, teaching at the medical school

There are no beds but *if a patient needs rapid tranquillisation they sleep on a bench until they are fit to go home.*

Before Yolanda she was conducting 400 consultations per month. There has not been a big increase post Yolanda. She thinks this is largely because many patients have transport problems.

The service is free and since Yolanda, medications have also been free because of the quantities of donations.

The OP department is very dilapidated and Dr. Verona feels unsafe. She has used her own money to knock a door into one wall to create a second exit if she feels threatened by a patient but has no money for a door. She also needs a computer.

At the Schistosomiasis hospital Dr. Benji Go runs a crisis intervention service. He has an inpatient ward with 25 beds but it normally has 70 patients. There are no specialized psychiatric nurses. Outpatient consultations are done by a medical resident under his supervision and Dr. Go also does private practice. Currently the Ward is damaged and only 2 patients were saying in a downstairs room. One was tied by her feet to the bed to prevent her wandering.

Roxas

There are 2 psychiatrists, for a population of more than 700,000. Both work privately: Dr. Leah Agricola Sicad and Dr. Lourdes Ignacio. Dr. Sicad feels she *is a guard on a boiler*. She sees at least 20 cases a week just from the Roxas area. She inherited 60 impoverished patients from her predecessor for whom she tries to provide care for through providing occasional mental health clinics for provincial hospital, approximately 3 x a year. She will also see

patients on request. However the Provincial hospital provides no psychiatric medications, not even depots although she has requested them.

…It is political; there is no reason why they cannot.

…Only the most resourceful families get to see me. If patients don't have resources they won't get to me

The nearest child psychiatrist is in Ilo Ilo. Epilepsy is treated by neurologists. There is one school for special needs.

There are no psychiatric beds available in Roxas Provincial hospital. Municipal doctors refer to Dr. Sicad, or patients go to Ilo Ilo Psychiatric Hospital, but they are only accepted for admissions if have family who can take care of them. This is also the case with disruptive and violent patients. Dr. Sicad told me: *Police prefer to stay out of it if they are psychotic or manic. So the Barangay Captain will bring them to me. The Barangay pays half and DSW the other half and they will be sent to Ilo Ilo, admission is free, but they are still only accepted if they have family carers*. *…we have a lot of vagrant patients as a consequence.*

The Department of Social Welfare (Roxas) explained that patients may come direct to them. If a person is mentally ill they may go first to a social worker who will interview and assess their social circumstances, then refer them directly to a psychiatrist or the hospital. However the municipality usually does not cover hospital admission expenses so they are quickly discharged. Maximum financial assistance available is 3000.

…Local government is much more concerned with public health; nobody is interested in this problem.

…Patients from our Barangay may go there but if they don't have enough money they get discharged because there is no insurance (Barangay Captain, Banga)

Cebu

Dr. Renato Obra is Director of Cebu Centre for Behavioural Sciences. A detailed description of Cebu City inpatient psychiatric can be found in Annex 2. This is the main in patient unit for the Eastern Visayas

ARE TRADITIONAL HEALERS IMPORTANT?

Many people go to Albularios but they are not so important in mental health. They are now illegal and we don't tolerate them (PHO Roxas).

Yes people go, none here but they help with body pain through massage (Barangay Captain, Banga)

Many people go to Albularios (Psychiatrist, Roxas)

Interview with Albulario in Lodugan, Capiz province: Mama Bucay

A patient who had seen her took us. He had consulted doctors for pain and inflammation in his side with no result. MB cured it, with rituals. His father in law is also an Albulario. He had a cousin with stomach problem who was also cured by Albulario.

What do you treat?
Cancers, inflammation, dystonia, people who have 'lost their minds'- *too many to count*, 5 a month. Treats people as far away as Canada

Treatment methods?
Herbs, plants and prayer, massage, giving advice. Tell people to take care of themselves.
If someone comes who has lost their mind- for example they complain of whispering in their ears that won't stop, or one patient came who was going wild, taking off their clothes and attacking others. I take their pulse and check their eyes. I treat them with healing using plants, I cured both.

What causes people to lose their minds?
Feeling hopeless, having lots of problems, losing loved ones. They get depressed. It can be caused by spirits. Or by other people. For example evil spirits can cause a patient to lose consciousness and start shaking.

She had seen a general increase in cases since Yolanda. But not particularly mental health

Do you charge?
Only what people can afford

Training?
Gift from God when 13 years old. *God just came and told me to do healing.* She discovered that God gave her instructions as to what to do, including what herbal remedies to prepare. *I hear God speaking to me, I only do what comes into my mind.*

How regarded by others?
Church respects me. Barangay Officials respect me, Doctors also. I go to the hospital to do healing. Some doctors refer, although they would not say. Sometimes a patient comes directly. Some politicians came here and I gave them good luck. But now they are rich they don't remember me

Are there any cases you cannot treat?
There are some. If I fail I send them to a doctor, but I can cure everything.

At the end Mama Bucay thanked us for coming. She would be interested in further discussion on mental health
Thank you! I am very pleased you came. .Because you came and tried to learn.

Unfortunately this was the only healer I was able to visit to date but at least 3 of the 11 patients I assessed had seen one and I suspect it is more

ARE PSYCHIATRIC MEDICATIONS AVAILABLE?

Psychotropic Drug Supply

Drug supply is THE major problem for patients with severe mental disorders. There is a social insurance scheme for the poorest people (4Ps) that provides some free medications for some non-communicable diseases including hypertension and diabetes. Mental illness is not included in this. Therefore even if the DSW provides some support for a psychiatric consultation, it does not provide financial support for medication.

Unlike for hypertension, there are apparently no cheap generics for psychotropic drugs and they are not made in the Country.

The actual availability of psychotropic medication varies enormously and depends to some degree on the will and interest of the doctors involved and the local authority. Mai Marquez, focal point for MHPSS at the DOH Leyte told me there was a DOH plan to purchase more drugs over the next years. She also explained that if RHU doctors ordered them for their units they could be given free. The S2 licence they need to prescribe some of the psychotropic drugs can be obtained simply by asking for it.

Hospitals

Roxas Provincial hospital director told me there was no insurance for mental patients not admitted to Ilo Ilo. Drugs had to be paid for.

…We are hesitant to pay for those drugs as we don't see a result. Also they are expensive, they are not made locally and there are no cheap Indian or Chinese generics. It is not a profitable drug for business. Solution? We need Obama for President

Patients should appeal to local mayor or DSW for financial support. E.g. one patient reported receiving 1500 pesos a year in terms of financial support but this did not cover medication costs

In Leyte the psychiatric outpatients department at Eastern Visayas Medical Centre used to charge people for medication but since the Typhoon had been prescribing free medications because of donations. Dr. Verona was unsure how long this situation could be sustained.

DHUs

The one DHU I investigated in Capiz had no medications and did not wish to engage with psychiatric patients

RHUs

In the municipalities the two medical officers who had some mental health training and were seeing patients ordered psychotropic drugs as part of their standard supply and prescribed them for free, thus demonstrating that where there is knowledge and awareness of need it is possible to provide some medications.

There is also some confusion as to who can prescribe psychotropic medications. Most RHU doctors believe they cannot prescribe ANY psychotropic drugs so if they do not have an S2 certificate. This apparently is not difficult to obtain

Dr. Nemia Sangrano, the medical officer with mental health training from the Centre for Mental Health explained that this certificate is only necessary for the prescribing of sedatives and tranquillisers such as Diazepam. Antipsychotic medications and antidepressants can be prescribed by any doctor although some pharmacies also ask for it for antidepressants

International Medical Corps provision

The IEHKS DOES contain psychotropic medications

Our initial supply: 6 IEHKS.
Each kit has 10 basic boxes and **1 supplementary kit.**
This contains

Amitriptyline tablets 25 mg	4000
Biperiden Tablets 2 mg	400
Haloperidol injections 5mg/ml, 1 ml ampoule	20
Haloperidol tablets 5 mg	1300

There is NO PHENOBARBITONE OR DIAZEPAM because of customs restrictions.

In Panay I donated drugs to Dr. Sicad who accepted patients whom I referred for free treatment. In Leyte I donated the drugs to Dagani RHU where the medical officer had mental health training and could also take referrals

HOW MUCH TRAINING DO HEALTH STAFF RECEIVE IN MENTAL HEALTH IN PHILIPPINES?

Cebu

Medical students going to Cebu Hospital get one month internship in fourth year including 2 weeks OPD and 2 weeks inpatient – many other students only get 2 weeks I am told. Students interviewed in Cebu OPD were enjoying it but slightly scared of inpatient work.

Roxas

Discussion with Philippines mobile medical team from Manila revealed that

- 3 GPs all received approximately 200 hours theoretical training as medical students and 2 weeks practical training on a psychiatric ward. None had had further psychiatric training.
- I specialist in O and G had had approximately one month on specialist unit and some one day workshops
- Nurses had received one semester of theory as student and 2 weeks on a psychiatric ward.

Most doctors in RHUs had had the same amount as above except for the 3 who had been on additional courses.

WHAT IS THE STRUCTURE OF THE PRIMARY HEALTH CARE SERVICE AND WHERE IS THE BEST POINT FOR MENTAL HEALTH CAPACITY BUILDING AND SERVICE DELIVERY

Health care is organized in the following way- for examples of staffing and size see RHU sheet in annex 4.

REGIONAL SPECIALIST CENTRE: specialist clinics, in and out-patient facilities

PROVINCIAL HOSPITAL: smaller version of above

DISTRICT HEALTH UNIT: inpatient beds: surgeons, internal medicine, O and G

RURAL HEALTH UNIT: Medical officer, public health nurse(s), midwives, technician pharmacist, other nurses
Size varies enormously- see annex 4.

BARANGAY HEALTH POST: midwives covering between 5 and 12 Barangays; and visiting health team from RHU on occasion. Barangay Health workers (volunteer); Community health teams (1: 20 Mothers- focus on pre and post natal care)

The DOH has already decided that the best point of entry is the RHU, and has begun training RHU staff. The impact of this training is discussed above. The example of the trained RHU doctors shows that it is feasible to train at this level and will have an impact. If training is combined with training Barangay health workers in case finding, support, follow up and advocacy the reach of the programme may be even greater.

ARE THERE PLANS TO INCREASE MENTAL HEALTH CAPACITY?

The Philippines National Mental Health Act of 2009 stated the need for increased training at all levels including the reorientation of psychiatry towards the community and the development and integration of mental health into primary health care. To that end plans had been made in all three regions to start capacity building. (See annex 3)

Leyte

Leyte region have already begun on mental health training of RHU doctors. To date 90 have been trained for 5 days and further training was planned for next year in 6 provinces

At the MHPSS sub-cluster meeting 17/12, the DOH representative from Manila, Thelma Barrera, emphasized the following points:

- More training in mental health at the local level is needed
- The previous training of three days duration was not long enough
- Training needs to include better diagnostics training for Community Health Workers
- Those people trained at the municipal and Barangay level need better supervision
- There are only 8 psychiatrists in the region and even before the storm their capacity was taxed
- There is a need for clear guidelines and structure how the psychiatrists and the community health workers will function
- The Psychiatrist Association of the Philippines is willing and wanting to provide training for community health workers

Also at the meeting, there was a major discussion on the structure of a referral system: how to identify cases and where to refer them[3]. NGOs doing counseling are starting to identify cases and need somewhere to refer.

Cebu

MHPSS cluster lead Emily Fernandez says they have a plan to have community based mental health services. Initial training was planned pre Yolanda in cooperation with Dr. Michelin Visayas, private psychiatrist.

Roxas

One doctor and one nurse have already received 5 days training from DOH. The trained Doctor is an infectious disease specialist at the PHO and has had no time to train others or use skills. There is a further plan to train 17 doctors and 17 nurses from RHUs. With 5 days plus follow up trainings using DOH guidelines. Dr. Sicad was going to assist.

Dr. Sicad says her *dream is a free mental health ward at DHU level which has 6-7 beds*. She was very supportive and interested in idea of treating community based doctors. She would like to help in training.
…the stigma is very great. People still go to the Albulario, there is one who keeps them in a compound. Most GPs are afraid of these patients and don't want to associate with me.

CAN INTERNATIONAL MEDICAL CORPS ASSIST IN CAPACITY BUILDING IN MHPSS?

Leyte

The DOH is very enthusiastic about International Medical Corps doing a pilot capacity building programme in Southern Leyte. They are open to the idea of using mhGAP Curriculum. Discussions as to the practicalities are ongoing

[3] These notes come from minutes taken by Tom Gerhardt as I was not present

Note: Dr. Verona thinks training RHU doctors is a good idea and completely supports it. She welcomes RHU doctors being able to diagnose and prescribe. However she did not feel she or her staff could be involved at present: *we need stress debriefing ourselves. One of our staff has lost three relatives, I have no roof and the other is homeless*

Dr. Benji Go psychiatrist at the schistosomiasis hospital said he could assist

Dr. Jose Baranda, medical officer Julita who has had some training pointed out: *doctors who don't have training wont prioritise mental health*

Cebu

International Medical Corps is not working in Cebu.

Roxas

The RHU doctor, PHO director and Hospital director all welcome idea of capacity building. The Provincial hospital can provide a training room. IOM is working in this region and we have discussed them covering this as International Medical Corps is no longer working in this area

ARE ANY OTHER INTERNATIONAL AGENCIES DOING SIMILAR PROGRAMMES?

Leyte

World Vision, Merlin/Save, MSF France, Spain and Holland, ACF, the Salvation Army and UNICEF are all providing psychosocial programming across the province. Most activities are concentrated in the most damaged urban and coastal municipalities

Current activities include community mobilization and self-help; recreational activities, peer support, psycho-education, child friendly spaces; child protection; baby friendly spaces and improved child care practices; individual counseling; training DOH staff in basic psychosocial support; art therapy and play therapy

SAVE were administering the SRQ 20 to identify those in need of support. The feeling of the MHPSS meeting (17/12) was that it would take too long to use and that it was important to take action and provide treatment to identified cases ASAP

The Philippines Salvation army was only agency specifically offering stress debriefing at Dec. 17th MHPSS meeting. SAVE wrote *ventilation* on the 4 Ws map, I am unclear what is meant by this.

MSF Spain is working in the proposed International Medical Corps AOR in Southern Leyte and have agreed that International Medical Corps will take over health capacity building from them when they withdraw in January. Their clinical psychologist explained their programme:
5 counsellors had been trained in 'emotional debriefing', and psycho-education. In addition they had done trainings for hospital staff to sensitise them to psychosocial problems and know when to refer. MSF Holland local language leaflets are delivered with food distribution.

The MSF psychologist was '*trying to phase out debriefing'* and put more emphasis on psycho-education as to what people might feel and experience post disaster and the possibilities of later problems. She was doing stress reduction and more training and supervision for national Staff. *Staff also need more support themselves*.

In addition many local NGOs and some international ones are providing direct services to the affected community without coordination through the Cluster system. For example on one mobile clinic day we coincided with a large team from a neighbouring archdiocese who were providing: direct relief, a medical mission and had brought a team of psychosocial processors (see description of activity above).

Apart from IOM and CBM, I have not encountered any other NGOs addressing the needs of those with more severe mental disorders. Informal discussions with Dr. Nick Rose (assessing for CBM) and IOM have led to an agreement that we will cooperate and try to ensure equitable geographical coverage.

IS THE CLUSTER SYSTEM WORKING?

Better than in previous emergencies. However MHPSS is not visible anywhere as a sub-cluster in the Cluster list on the home page of the Philippines Humanitarian response. Nor is it listed as a cross cutting issue. You have to go to individual hub timetables to find it, if you are lucky. At the most recent child protection meeting in Leyte, 17/12 there was concern that they knew nothing about the MHPSS sub-cluster which had met that morning. There was some duplication.

CONCLUSIONS

In summary this assessment has revealed that as in previous emergencies the primary sources of psychosocial distress are material hardship and that some basic needs, particularly for shelter and information, have not been met. There are likely to be growing concerns around food security when direct distribution stops. Aid Distribution is patchy with the less visible non-urban, noncoastal settings receiving less attention

The needs of the severely mentally ill are largely invisible outside urban areas as they were prior to the disaster. Case finding revealed that there are at least 2-3 people in each Barangay in need of assistance but the majority have not accessed continuing care because they lack resources.

The government of the Philippines produced a National Mental Health Act in 2009 that stated:

What is ideal is to assimilate mental health into primary health care, provide mental health care in general hospitals and develop community-based mental health services. Services for mental health should be obtainable within the public health and the hospital system in the country.

The purpose of this bill is the comprehensive addition of Mental Health in the national system. It is to render available, accessible, affordable ·and equitable quality mental health care and services to the Filipinos especially the poor, the underserved and high risk populations.

The government has already begun on the process PHC integration through the training RHU staff. The tragic events of Yolanda may provide an opportunity to assist and take that process forward.

INTERNATIONAL MEDICAL CORPS PROPOSED PLAN

In line with Government policy, International Medical Corps is beginning a three month mental health capacity building pilot training programme for RHU doctors and public health nurses from 7 municipalities in Southern Leyte in January. This will allow health workers to integrate mental health into primary health care and provide more accessible less stigmatizing care for the mentally ill.

The programme will use the mhGAP humanitarian curriculum. Training will also allow for the introduction of basic psychological skills to assist patients. They will also train Barangay health workers in de-stigmatisation and case finding.

ANNEX 1

Case Vignette DA

DA was a normal child with no birth or developmental difficulties. She had friends and did well in School but left without graduating because she wanted to move to Manila. Once there she got a job as a home help and also married and had 3 children. Apparently her husband was physically abusive and alcoholic. He had no work. When DA became sick he brought her and the youngest two children back to her mother's house. This was three years ago, when she had already been unwell for one year. She has remained unwell since then. Her mother describes her as sitting staring blankly most of the time, refusing to eat much and rarely talking although sometimes she talks to herself. She also cries a lot. Sometimes she stands without moving in the same position for many hours. Sometimes she lies down and won't move. Sometimes she is incontinent of urine. Sometimes she dribbles and then plays with her saliva. She is in a world of her own. She can dress and take care of herself. Her children are now 6 and 8. She does not recognize them but she sometimes takes nits out of their hair. She has not menstruated for three years. During the Typhoon she was terrified, hugging herself and shaking and crying. She was also incontinent of faeces and urine.

I observed her in the Clinic. She was very thin, clean and well cared for. She was very reluctant to climb the stairs to the interview room, appearing frightened but then did so with much cajoling, resisting the pressure from her mother and moving very slowly. She then sat in the chair and remained mute for the entire interview. Sometimes when I spoke directly to her she made eye contact but mostly not. She was often distracted, looking elsewhere around the room; sometimes she would smile slightly to herself. She occasionally whispered very quietly to herself. When the interview was over she was very reluctant to get out of the chair, but responded passively to being gently pulled to her feet and then allowed herself to be slowly guided downstairs. Her mother had taken her to an Albulario for treatment but they said she had lost her mind and needed a doctor. She went to the general hospital to see a physician, who told her to see a psychiatrist but she had no money for this and therefore has never been.

Diagnosis and management: Although the presentation appeared to be catatonia secondary to an underlying psychotic depression or schizophrenia, I was also concerned to exclude any underlying organic problems. She was referred to the psychiatrist with funds to pay for investigations and access to free psychotropic medication provided by the agency

Case Vignette CB

The 25 year old girl became ill in 2009 when according to her mother she became depressed over the many problems in the family. In particular there was conflict between her sister and brother in law which upset her. *She became hysterical- shouting and crying, trying to hurt people, hearing voices. We had to tie her. When she calmed down we loosened the bonds.* Her developmental history was normal apart from milk digestion problems at 6 months there were no other hospitalisations. However when small she preferred own company and did not play with others, was not interested in dolls, never dressed up or engaged in imaginative play. She was able to speak but preferred not to do so. More recently she would get angry if forced to speak. She left school at 16 because too shy to go. Since then she has worked at home. She enjoys housework very much and likes the house to be clean. She does not like to stop cleaning. She is fussy about food and won't eat if she does not like it. There is no history of mental illness in the family. She was seen by private psychiatrist in 2009 and put on daily Haloperidol. However financial constraints meant that the family stopped taking medication. They wait until their daughter becomes violent or unwell, then physically restrain her and give medication- about once a month.

When I talked to M. She was sitting in collapsed house on Cane platform above flood water looking remarkably well given circumstances. She made eye contact. Said she felt well but explained she got mad sometimes but could not give the reason. She acknowledged hearing voices. *I hear someone singing to me*. *Or talking and telling me to get mad. They tell me that people here are tired of me. It makes me upset so I destroy tings and I get restless. I try to control it.* There was no association with menstrual cycle. There were no problems during the Typhoon. The most recent problems had been a few days ago. She showed me burn marks on her wrists and ankles where family had tied her. There was also bruise on face where mother had slapped her to calm her. Medication helps her feel calmer.

Impression: Violence may be part of psychotic illness or is possibly a behavioural response to frustrations and misunderstandings arising from ASD, or most likely a combination of both. She would benefit from further observation and behavioural analysis and time spent with family explaining Autism. The case was discussed with and referred back to private psychiatrist. Free medications were provided to the psychiatrist for her care.

Case Vignette MW

MW was well before the Typhoon with no problems. During the Typhoon she was calm and helped with the grandchildren while the family sheltered in their stone house. A week after the Typhoon she received news that a niece had died. She became extremely distressed and began to act in an unusual way. She was withdrawn and would stare blankly, she wandered. She kept repeating how sorry she was because of niece's death. She could not sleep and did not eat much. She became very weak and developed a severe headache, the family had her admitted to one of the regional hospitals. Blood investigations were normal apart from some pus in her urine. She was treated with ciprofloxacin. However she did not want to remain in the hospital so she was also heavily sedated. (No information was available as to what sedative was used.) Her husband became alarmed at her sedation and discharged her and brought her home after 4 days without any medication. Since then she remained on her bed. She was doubly incontinent and had to be fed. When she was awake she recognized her family and could on occasion be made to walk with assistance. The family called the Albulario who did a treatment. When I saw her one week after discharge she was unrousable, although moving her legs a little and able to roll over in the bed. Her skin was hot to touch and her BP was 150/90 with a pulse of 92. We recommended that she was taken back to the District hospital for further investigation of underlying organic pathology. We thought it likely that she had been suffering from a severe grief reaction, but that this was unlikely to be the cause of the incontinence, high BP, fever and unrousable state. The Family agreed to this plan.

ANNEX 2

PSYCHIATRIC SERVICES CEBU CITY:

Human Resources

- 30 psychiatrists in Cebu city.
- 6 consultants at hospital
- 5 residents plus many of 30 are visiting consultants.
- 4 psychologists
- Psychiatric nurses
- 30-40 medical students do one month internship in OPD and IP in fourth year
- 1 US trained child psychiatrist
- Many like Dr. Obra have 6 months training in child psychiatry

Facilities

'Centre for Behavioural Sciences' (*We changed name to avoid Stigma*) at Vincente Soto Memorial Medical Centre: One of three public inpatient facilities in Philippines. (Other private ones). Point of referral for all disaster affected communities in Visayas except Western Visayas which go to Ilo Ilo.

OPD

>11000 Outpatient Consultations Jan-Sept 2013 of whom 344 were from outside Cebu City. I.e. most rural patients don't come here.

Diagnoses:

- Psychosis
- Mood Disorder
- Substance induced problems

No data post-Earthquake and Yolanda

Dr. Obra, Director reports OP consultations increased. Currently 50-100 a day

Increase in:

- acute stress and PTSD
- manic Cases,
- relapsed Schizophrenia because of poor compliance
- substance abuse, alcohol and methamphetamine

Cost 30 pesos but no charge if cannot pay.

Inpatient Wards

60 beds, occupancy rate 283%. Average number of patients at any one time 170, not changed in last few months. Youngest age for admission is 14. Currently one of 16 years old with bipolar disorder. Most patients brought by families and involuntary

Diagnoses:

- Psychotic disorders
- Mood disorders
- Substance induced
- Other (e.g. Currently 2 epilepsy, 2 mental retardation and 2 cerebral palsy on Male ward because nowhere else to go

Average Length of stay:

May spend 2-3 days in Acute Admission ward and then discharged after rapid tranquilisation. Or admitted on average for 2 weeks, but 5 patients been there 20 years because nowhere else to go. Do accept homeless and indigent mentally ill. *There is a nun in City who goes out finding them and bringing them in*

Inpatient unit housed in 1936 old TB hospital in Vicente Campus. Not fit for purpose. Half building unsafe because of October earthquake. Admissions unit moved into reception area where 25 patient sleep and lounge in front of open doorway.

Both male and female wards large open rooms where patient lie squat sleep in +++ overcrowded conditions. Share one bed to three, many sleep on floor or plastic tables and chairs.

Each ward has three cages for violent patients- room to stand and take 3 paces. Latrine hole in floor. None in use on this visit.

Rooms very clean but walls graffiti covered. No activities for patients. No access to outside wards locked. Patients cleanly dressed floor and beds and toilet area clean. Nurses benign and friendly- do music and dance therapy when time. 1 nurse to 60-70 patients. Female staff nurse tries to talk with every patient for one hour a week

Treatment in OPD and Inpatient:

- Use ECT with anesthesia for non- responsive chronic schizophrenia, depression and Mania. ECT machine broken and need they one.

- Drug therapy. Have full range of new generation anti psychotics and SSRIs. Drug treatment available and given free if patient can't pay. Drugs are mostly available at the hospital and can be bought in city. Different situation outside the City.