# TECHNICAL NOTES

Webinar series

# Innovative Models of Primary Health Care in Colombia

10

## Tenth webinar

## Mental Health Innovations from Primary Care in Colombia

**Tuesday, February 28th of 2023**

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webinars Series

Innovative Models of Primary Health Care in Colombia

# Innovations in mental health from Primary Care in Colombia

**Tuesday, February 28, 2023**

Schedule
**4:00 p.m.** Colombia, Ecuador, Perú, Washington
**3:00 p.m.** Costa Rica, Mexico
**6:00 p.m.** Argentina, Uruguay, Chile y Brazil

Simultaneous translation
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**Skills for the diagnosis and management of mental illnesses in PHC**

**Dr. Paola Tejada**

Professor Universidad del Bosque - Faculty of Medicine
Representative for Latin America of the Global Mental Health Assessment Tool / Primary Care

**Social innovation in primary mental health care for migrants**

**Dr. Natalia Quiñones**

Co-Founder and Research director of Dunna, Creative Alternatives for Peace

**Experiences with the Decentralized Care Model: building paths for access to mental health**

**Dr. María Fernanda Rodríguez**

Mental Health and Psychosocial Care Manager - Colombia Mission at Doctors Without Borders.

**Implementation of psychosocial support models in contexts of extreme adversity: lessons from Semillas de Apego**

**Dr. Arturo Harker Roa**

Director of the IMAGINA research center, at the Universidad de los Andes, Colombia

**Panel Moderator**

**Luis Gabriel Bernal**
Specialist in Family Medicine and Master in Public Health.
World Bank Team. Professor at Rosario University

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# Content

# Introduction

The Primary Health Care Performance Initiative -PHCPI developed from 2015 to December 2022 an important work in the measurement of performance and the strengthening of Primary Health Care (PHC) in different countries of the world. In Colombia, PHCPI developed in conjunction with the Ministerio de Salud y Protección Social (Ministry of Health and Social Protection) the country's vital signs profile in PHC.

Once the alliance that arose this initiative ended, the World Bank assumed its functions and work in different countries, including Colombia. Part of our activities in the country has been the generation of a community of practice interested in strengthening and disseminating innovative actions in Primary Health Care. The series of webinars, *Innovative Models of Primary Health Care in Colombia,* which we have been promoting since April 2022, contributes to this purpose.

This document reviews the tenth webinar in the series: *"Mental Health Innovations from PHC in Colombia",* which took place on February 28th, 2023.

A special thanks to the speakers of the tenth webinar who with their experience and knowledge contributed to this dialogue that we hope will continue to enrich the reflection and work of Primary Health Care in Colombia. Similarly, thanks to the team of leaders and organizers of the webinars and the community of practice: Luis Gabriel Bernal, Oscar Bernal, Janet Bonilla, Yulieth Rodríguez, and Juan Carlos Jiménez.

**Manuela Villar Uribe**

*World Bank Senior Health Specialist*

# Key Messages
# Mental Health Innovations from PHC in Colombia

"There is a lack of knowledge about the diagnostic criteria in mental health, unlike what happens in other areas of health. There are no tests that say: this person has anxiety, this person has depression, this person has schizophrenia. The criteria and the way to arrive at the diagnoses are purely clinical and can often be complex for those who do not deal with them on a day-to-day basis." *Paola Tejada*

"There are those who consider that mental health is a matter exclusively for psychologists and psychiatrists and that it is not up to other health professionals to investigate or intervene in this area. However, most people with mental health problems have their initial contact with primary care services or non-specialized care services." *Paola Tejada*

"There are several strategies that seek to help solve the problem of mental health diagnosis. There are two that have sufficient evidence: mhGAP guide and the Global Mental Health Assessment Tool – GMHAT." *Paola Tejada*

"The mhGAP guide prioritizes a set of mental health problems: depression, psychosis, epilepsy, mental and behavioral disorders in children and adolescents, dementia, substance abuse disorders, suicide, and other important mental health problems. Based on a group of questions about the key symptoms, the guide makes it possible to identify the most probable diagnosis for the person being evaluated." *Paola Tejada*

"The Global Mental Health Assessment Tool – GMHAT is a semi-structured, computerized clinical interview which identifies and assesses mental disorders in primary care in non-specialist settings. It assesses twenty different mental health problems including anxiety, depression, suicidal risk, sleep and eating disorders, psychotic symptoms, use of alcoholic beverages and addictive substances, and post-traumatic stress." *Paola Tejada*

"The idea of the Aseyuu Project was to create a mental health route that would provide care for a particularly vulnerable population, such as migrants who have very limited access to basic health services and no access to mental health services, and to function as a funnel to reduce the number of people who

actually needed specialized mental health care, to make this universe of people manageable from a public policy point of view." *Natalia Quiñones*

"After making the previous measurements, the intervention of the Aseyuu Project consisted of the application of a module of coexistence and protection of rights based on restorative practices with joint work with the host community, with a differential approach and a mapping of the organizations in order to create a protective environment." *Natalia Quiñones*

"We were able to verify that less than ten percent of the 420 participants we had required specialized mental health care. Only eight percent of adults and nine percent of children actually required medication, psychiatric monitoring, and all these expensive investments by the state." *Natalia Quiñones*

"Significant changes were achieved in the levels of psychological and emotional well-being, social commitment and compassion, integrated into the central nervous system, and therefore the universe of those who needed specialized care and medication was reduced." *Natalia Quiñones*

"The Decentralized Care Model is a strategy designed to bring communities closer to primary health care services. It is based on the fact that it is very complex for the communities to move to where the services are and that there are barriers to care." *María Fernanda Rodríguez*

"The barriers to access are enormous and the gaps in mental health are huge, in addition to the fact that there are very few professionals specialized in mental health and psychosocial support. Finding a psychologist, even in the urban areas, is very complex, a psychiatrist is even more difficult. The professionals are not trained, nor do they know how to work, how to care, how to accompany people when they have mental health problems, whether they are mild, moderate, or severe." *María Fernanda Rodríguez*

"There are important mental health needs in the territories. What is most often found are post-traumatic stress disorders, people who come with very high stress levels, relive violent experiences, and have the images in their heads, which is called *flashback*, she adds. For this reason, it is necessary to train professionals and communities, not with theory but putting it into practice, so that they feel it, experience it, to be able to learn it and take it to their communities." *María Fernanda Rodríguez*

"*Semillas de Apego* was born trying to break this vicious circle that reduces the opportunities of thousands of children in Colombia, with the aim of reaching where it is necessary to in Colombia and ending this cycle that perpetuates the transmission between generations of poverty and lack of opportunities." *Arturo Harker*

"What we do at *Semillas de Apego* is to work with mothers, fathers, grandmothers, uncles, all the main caregivers, for them to have tools that allow them to process their life experiences, have a better understanding of the child

development process and how these adversities affect this process. It is sought that the main caregivers become a reliable source of emotional and physical protection for children." *Arturo Harker*

"The *Semillas de Apego* curriculum has three modules: (i) promotion of the mental health of caregivers, (ii) promotion of healthy affective bonds, and (iii) strengthening of parenting teams." *Arturo Harker*

"We have interesting impacts on the socio-emotional development of children, which is our ultimate goal. The program generated drops of 68% in the probability of presenting critical levels in socio-emotional competencies and of 79% in the probability of presenting critical levels in behavioral problems." *Arturo Harker*

"WHO Member States have committed to implement the Comprehensive Action Plan on Mental Health signed in 2013, which is aimed at improving mental health through more effective leadership and governance; the provision of comprehensive care, integrated and adapted to the needs in a community setting; the application of promotion and prevention strategies and the strengthening of information systems, scientific data, and research." *Luis Gabriel Bernal*

**"Semillas de Apego" promotes the mental health of the caregiver, healthy affective bonds and strengthens parenting teams**

There is national and international evidence that shows how traumatic experiences affect the mental health of the child, the mental health of the caregivers and, in addition, they represent a double risk because the mental health of the caregivers is what provides the emotional resources to generate a secure affective bond. This means that violence and displacement have a double impact on the development of children through the physiological mechanisms of stress.

When stress is toxic, the system that handles stress in the body, the hypothalamus-pituitary-adrenal axis, becomes overwhelmed. This affects people's behavior and when people are in development moments as important as early childhood, their brain development is affected, and this impacts their entire life course in all dimensions. This happens when millions of neural connections are developing, and prefrontal architecture in the children's brain is affected. The quantity and quality of neural connections impact areas of the brain such as the prefrontal cortex and the hippocampus, which are very important for regulating emotional and cognitive processes.

*Arturo Harker*

# Presentation
# Mental Health Innovations from PHC in Colombia

## Work with the community, creation of bonds of affection, and measurement tools, keys in innovative mental health projects in Colombia from Primary Health Care


The speakers of the *Mental Health Innovations webinar from PHC in Colombia*, presented four beautiful and successful experiences developed in different parts of the country affected by conflict and violence.

The webinar made it possible to learn about innovative and free-to-use technologies developed by the Global Mental Health Assessment Tool and MHGAP, and adapted in Colombia by a team from the Universidad El Bosque for the early diagnosis of mental health disorders. Dunna, creative alternatives for peace, presented the results of the Aseyuu Project, primary mental health care for migrants, which seeks to stabilize the central nervous system through restorative practices and mind-body strategies. The Universidad de Los Andes

shared the progress of “Semillas de Apego,” a proposal for caregivers of children from zero to five years of age in areas of violence in the country aimed at strengthening healthy affective bonds and parenting teams. The Doctors Without Borders mission in Colombia showed the results of the *Decentralized Care Model* that seeks to train health leaders in the Colombian Pacific region to identify and provide early care to mental health situations, which are very frequent in this region of Colombia.

These experiences comprise transformative strategies, tools, and models in common that seek to offer communities, particularly those in the most remote areas, the possibility of being timely diagnosed, receiving psychological first aid care, accessing prevention strategies and improvement of the well-being, being referred to local and regional health institutions for specialized care when required, and receiving support so that the care is effectively carried out.

In all cases, the proposals are based on the consideration that mental health care in the Colombian health system is deficient, does not have sufficient specialized human resources nor the time and physical infrastructure to make diagnoses by mental health professionals, nor to offer primary care derived from them.

The strategies presented show how it is possible to transfer to non-specialized health personnel and even community health workers, who often care  the emotional situations of their community members, a set of knowledge, tools and methodologies that allow a diagnosis and initial management of mental health problems and generate care routes, differentiating between those users who must be referred to specialized care due to the seriousness of their condition and those with whom their mental health problems can be managed in the context of the community, through their own efforts and of the community itself, in conjunction with the institutional offer of external projects or the health system structure , and the management of organizations and trained community health workers. Screening, carried out in this way, allows to reduce the specialized mental health care demand, thus decongesting services and reducing the costs of their provision for the health system.

*Watch video in Spanish*

*Watch video in English*

# Context Intervention
# Diagnostic Skills and Management of Mental Diseases in PHC

**Paola Tejada**

Professor at the Faculty of Medicine of the Universidad El Bosque

Psychiatrist and Master in Psychosocial Research from the Universidad de Los Andes
Doctoral studies in mental health from the University of Chester in England
Representative for Latin America of the Global Mental Health Assessment Tool / Primary Care Certified as mhGAP instructor

## The mhGAP intervention guide and the semi-structured clinical interview GMHAT are diagnostic tools in mental health that can be applied by non-specialized personnel, with training and supervision

Dr. Paola Tejada begins her intervention by presenting a graph from an international study that shows the difficulties in the diagnosis and treatment of mental diseases[1]. She states that of 100 percent of people who suffer from depression, between 60 and 70 percent see a general practitioner; between 30 and 35 percent actually receive the diagnosis of depression; only 8 percent get proper treatment and only 4 percent stay on treatment after three months.

1 Möller, HJ, Bitter, I., Bobes, J., Fountoulakis, K., Höschl, C., & Kasper, S. (2012). Position statement of the European Psychiatric Association (EPA) on the value of antidepressants in the treatment of unipolar depression. European Psychiatry, 27(2), 114-128.

These negative data show the difficulties, both diagnostic and treatment, that general practice  has, but they also shed light on what possible interventions may be, says Dr. Tejada. The first of these is the need to improve the diagnostic capacity of general practitioners and the ability to offer adequate and timely treatment both for depression and for other mental health diagnoses.

## *It is urgent to improve the diagnosis of mental health*

Dr. Tejada states that there is a lack of knowledge about the diagnostic criteria in mental health, unlike what occurs in other areas of health. There are no tests that say: this person has anxiety, this person has depression, this person has schizophrenia. The criteria and the way to come at the diagnoses are purely clinical and can often be complex for those who do not deal with them on a day-to-day basis, explains Dr. Paola. In general, she says, there is little familiarity with the correct questions to assess the mental state. The professional knows that a person with depression must be questioned about suicidal risk, but they are not used to asking whether the person wants to die or not, nor are they used to addressing the person who has hallucinatory ideas, nor to adequately ask about eating disorders.

Other reasons why diagnosis and treatment often fail are time constraints, clinical settings with many patients and very little time to make evaluations, explains Dr. Tejada. She has the idea that in mental health it is necessary to sit down with the patient for an hour to do a complete interview and in an environment with patients every fifteen minutes, that cannot be done.

Also, indicates Dr. Paola, there are many actors in health, but it is thought that it is not up to them to carry out mental health evaluations. There are those who consider that mental health is exclusively a matter for psychologists and psychiatrists and that it is not up to other health professionals to investigate or intervene in this area. However, most people with mental health problems have their initial contact with primary care services or non-specialized care services. That is the reality, says Dr. Tejada. That is why it is very important to have strategies that help professionals who are at these levels of care to identify those who have mental health problems, initiate appropriate management, and know if they can be managed at the first level of care or need the intervention of a specialist.

## *The Mental Health Gap Global Action Program Intervention Guide - mhGAP*

Dr. Tejada affirms that there are several strategies that seek to help solve the problem of diagnosis in mental health and emphasizes two that have sufficient evidence. The first one is the mhGAP guide and the second one, the Global Mental Health Assessment Tool – GMHAT.

The mhGAP guide originates from a study to evaluate the gaps in mental health in different countries of the world, understood as the number of people with mental health problems, the number of those who actually receive care, and the number of those who are left out.

Countries with very good health systems, says Dr. Tejada, had gaps of 20 percent, that is, out of every 100 people who had mental health problems, 20 did not receive adequate care. Countries in Africa, however, had gaps of 90 to 95 percent, she says. For this reason, the WHO created the Global Action Program to Overcome the Gaps in Mental Health (mhGAP). Within this program, the mhGAP Intervention Guide was designed for mental, neurological, and substance use disorders, aimed at the level of non-specialized health care. The guide already has a second version. The mhGAP guide is a downloadable PDF that can be freely accessed by anyone, says Dr. Tejada. It can also be accessed as an app for cell phones and tablets.

The mhGAP guide prioritizes a set of mental health problems: depression, psychosis, epilepsy, mental and behavioral disorders in children and adolescents, dementia, substance use disorders, suicide, and other important mental health problems. Based on a group of questions about the key symptoms, the guide makes it possible to locate the most probable diagnosis for the person being evaluated.

The guide, says Dr. Tejada, includes a management chapter with diagnostic protocols, clearly differentiated with psychosocial or pharmacological interventions, as necessary, and offers specific elements for special populations, for example, children and adolescents or women in pregnancy and lactation.

The mhGAP guide has been published in more than 20 languages, has been applied in more than ninety countries and works as part of a strategy that involves two phases: training and supervision, says Dr. Tejada. The training must be offered by professionals who are trainers in mhGAP. The second phase is the supervision of the implementation to verify that the guide is being used in the field and that doubts that arise along the way can be resolved. Training and supervision can be requested in the territories from the Ministry of Health and are offered by some of the Health Secretariats, especially in capital cities.

## *The semi-structured clinical interview - GMHAT*

The second tool, explains Dr. Paola, is the Global Mental Health Assessment Tool – GMHAT, a computerized semi-structured clinical interview to assess and identify mental disorders in primary care in non-specialist settings.

This instrument evaluates twenty different mental health problems, including anxiety, depression, suicidal risk, sleep and eating disorders, psychotic symptoms, use of alcoholic beverages and addictive substances, and post-traumatic stress.

The GMHAT application takes 15 minutes, says Dr. Tejada. It includes a series of questions whose answers allow rating the presence or absence of a certain symptom and its severity. The algorithm with which the tool works guides the interviewer towards certain topics, which even go beyond mental health, according to the answers obtained.

At the end of the interview, the program creates a printable file containing the information collected from the patient, the symptoms evaluated, the severity of each one, and the diagnosis reached based on the responses. It also gives the possibility for the interviewer to make a clinical judgment of what he considers to be happening.

The GMHAT was created in the United Kingdom, in English, but it is available in many other languages, including Spanish, and it is validated for Colombia, says Dr. Tejada. It is a free-to-use tool that can be downloaded to a computer or cell phone. It is recommended to assume it as part of a broader strategy and to be applied by professionals who have received the respective training.

Dr. Tejada clarifies that there are many other diagnostic tools in mental health, but the idea, she says, is not to compete with each other, nor to decide that one is better than the other. Based on her experience, she finds that these two instruments complement each other quite well. The GMHAT, explains Dr. Tejada, has more diagnoses and is a little easier to use because the program includes the diagnostic flowchart. The mhGAP has a large module on children and adolescents that is very important and has the topics of intervention and management.

Dr. Tejada ends her intervention by saying that there is an urgent need for professionals or non-specialized health personnel, or those who are not necessarily health professionals, to have the skills to detect, manage and, in some cases, follow the people with mental health problems. Dr. Tejada assures that the evidence shows that it is possible to carry out training in relatively short times, with an impact on the knowledge and abilities of people who are in contact with a possible mental health problem.

See *presentation*, *watch video in Spanish*

Watch video in English

# Core Interventions

# Aseyuu Project: Social Innovation in Primary Care in Mental Health for Migrants

**Natalia Quiñones**

Co-Founder and Research Director of Corporación Dunna Alternativas Creativas para la Paz

Philosopher from the Universidad de Los Andes
Lawyer from the Universidad del Rosario
Master of Laws from New York University

## Mental health care for the Venezuelan migrant population based on the stabilization of the central nervous system, viability of interpersonal relationships, community integration, restorative protection, and self-protection

Dr. Natalia Quiñones Cruz begins her presentation by explaining that the Corporación Dunna, of which she is a co-founder, and the Program "Conectando Caminos por los Derechos" (Connecting Paths for Rights Program, funded by USAID and executed by the Alliance between PACT, ABA-Roli, Freedom House and Internews) thought it was very important to create innovative ways to provide mental health care to the Venezuelan migrant population, who is especially vulnerable due to their socioeconomic conditions and their very limited access to basic health care services and no access to mental health services.

The idea of this project, says Dr. Quiñones, was to create a mental health route that would allow primary care for this population, reducing the number of people who really needed specialized care in order to have a manageable universe of users from the point of view of the public policy, considering the limited budget for financing this type of program.

## *Stabilize the central nervous system and provide pathways for interpersonal relationships and community integration*

At the beginning, a pilot program was designed in four municipalities with a very high migratory flow: Bogotá, Cucuta, Medellín, and Riohacha. Later, explains Dr. Quiñones, in the replica of this route, the program was taken to Bucaramanga, Cali, and Barranquilla, measuring the impact that this route could have on the mental health of migrants.

The program, explains Dr. Natalia, had a very innovative objective related to the stabilization of the central nervous system and also sought to provide migrants with ways for interpersonal relationships and community integration. Thus, the two central problems that generate mental health conditions or problems were attacked, which are the deregulation of the central nervous system and the difficulty in interpersonal relationships.

A characterization of the population was performed, and a hypothesis was formulated according to which about 10 percent of the population needs specialized care, while the remaining 90 percent can take care of their own well-being in mental health issues as long as they receive tools for self-management.

In the development of this strategy, explains Dr. Quiñones, there was a differential focus for adults and children, and an ethnic focus for the Way**ú**u community in Riohacha. In total, she says, we piloted 420 direct beneficiaries.

## *Phase 1. Methodological transfer and pre-test measurement*

**a.** *Self-reporting diagnostic tools.* Dr. Quiñones reports that the care strategy was implemented by training communities in the use of diagnostic tools such as (i) the Self-reporting Symptom Questionnaire SQR[2], created by the WHO and used to screen for mental health problems, (ii) the RQC Questionnaire, which seeks to identify symptoms and signs of mental health concern in children, (iii) the Mental Health Continuum (MHC-SF), which is a multidimensional instrument that assesses emotional, psychological

2 SQR Symptom Self-Report Questionnaire created by the WHO and adapted for the Colombian population. It is used to screen for mental health problems.

and social well-being, and (iv) the tools mentioned by Dr. Paola Tejada in her presentation.

The idea was to have installed capacities in the territory and to be able to diagnose the migrant population. Through social organizations, a call was made to people between the ages of seven and ninety, including pendular migrants, returnees, and even the host community, which is also a key community to receive this type of care.

**b.** *Biometric measurements to see changes in the central nervous system.* Another innovation of the program in the first phase of methodology transfer and pre-test measurements, says Dr. Natalia, was to apply biometric measurements that had never been used in social programs in Latin America, in addition to the self-reporting diagnostic tools. We wanted to find out if in addition to achieving the benefits that we were reporting in the program with self-reporting measures, we were also achieving a fundamental change in the central nervous system of the people.

For this, says Dr. Natalia, we took two physiological measures, cardiac variability and facial micro-expressions that have to do with the response that people have to everyday depressants, with the difficulties that a migrant may have when arriving in Colombia.

**c.** *Assessment of neuroception*[3] . This is a new measure that refers to the process by which neural circuits differentiate whether a situation or person is dangerous or threatening to us or whether, on the contrary, we can feel safe with it without the need to implement defensive strategies. This measure is also integrated into the management of the central nervous system.

## *Phase 2. Intervention strategy*

After carrying out the measurements, says Dr. Quiñones, the intervention itself was performed, consisting of applying some modules of coexistence and protection of rights, based on restorative practices with a differential approach for children and adolescents and through joint work with the host community, after mapping the organizations.

In this way, they sought to create a protective environment that was very different in each of the territories, in some with a great offer of reference organizations and in others with much less.

The intervention included, in addition, Dr. Natalia reports, a well-being self-protection module based on body-mind practices, which is the central axis for

3 Stephen W. Porges (2007) has coined the term neuroception\.

physiological changes and which seeks to regulate the central nervous system. This module includes activities such as yoga and dance. The beneficiaries were offered guidance capsules for common situations: what do I do when I feel sad or depressed, what can I do if I have anxiety, what do I do if I can't sleep. Thus, it was expected that they could self-manage their mental health well-being. After delivering the modules, some post-test measures were applied, identifying the cases that needed referral.

## *Phase 3: Follow-up and report*

The third phase, monitoring and reporting, included sharing the findings of each individual case with social organizations to optimize care and referral of relevant cases to specialized services in health organizations along the territories.

## *Results*

Dr. Natalia shows the results in comparative graphs between the group of migrants who participated in the project and the group that received the usual interventions provided to the population affected by the migration phenomenon in the country.

**a.** *The universe of those who needed specialized care and medication was reduced.* Dr. Quiñones explains that the results of this pathway confirm the project's hypothesis that less than ten percent of the 420 participants required specialized mental health care and only eight percent of the adults and nine percent of the children required medication, psychiatric follow-up, and other costly investments for the State.

Reducing the universe from 100 percent to eight or nine percent is very useful, she said, especially because this is a low-cost route and easy to implement in territories that do not have many human resources in psychiatry, psychology, and professionals trained in mental health.

The results showed that most of the risk is concentrated in Cucuta and Bogotá with a high prevalence of depressive disorders and anxiety disorders in adults. In the case of migrant children and adolescents, the need to address learning disorders was detected.

**b.** *Increased flexibility in biometric measurements.* The biometric evaluations were carried out with the support of independent universities, in this case Ohio State University and the Universidad Externado de Colombia, says Dr. Natalia. The doctors went to the territories to make different measurements of cardiac variability and measurements with a very innovative software of facial response.

We still do not have final data, but the preliminary data, says Dr. Quiñones, show that relevant changes can be achieved with a short, simple, and low-cost intervention such as this one. Measures of heart rate and cardiac variability indicate how flexible a person is in responding to stress. What we saw, she says, is that in the intervention group, people's flexibility to respond to stress increases, while in the control group it remains the same or decreases slightly as time passes and they begin to integrate into Colombian society.

**c.** *Significantly improved levels of psychological and emotional well-being.* The results of the SRQ self-report showed a very noticeable difference in terms of decreased levels of depression and distress, comparing the group that benefited from these interventions, versus people who were not on the route and followed the normal care that migrants receive when they arrive to Colombia.

**d.** *The improvement in neuroception is statistically significant.* We used, says Dr. Natalia, a new scale developed by Stephen W. Porges, a theorist of the polyvagal theory from the United States, which shows how people integrate the level of psychological well-being and the level of emotional well-being in the central nervous system. We found very good changes in both areas attributable to the intervention.

**e.** *A relevant increase in the level of social commitment and in the level of compassion was achieved*. The project results also show, Dr. Natalia points out, a very noticeable increase in the level of social commitment and in the level of compassion in the group of migrants who participated in the project versus those who did not use the route. These levels were also measured in relation to the central nervous system, says Dr. Natalia. A new scale that is being validated worldwide was used for this purpose.

Dr. Quiñones concluded by assuring that something as simple as these interventions can be very innovative and very useful when integrated into public policies for the mental health care of any population.

*See presentation, watch video in Spanish*

*Further project information*

*Watch video in English*

# Doctors Without Borders
# Decentralized Care Model: Building Roads for Access to Mental Health

**María Fernanda Rodríguez**
Gestora de Salud Mental y Atención Psicosocial
Misión en Colombia de la ONG Médicos Sin Fronteras

Psicóloga Universidad Santo Tomás
Magister en Terapia Familiar Universidad Nacional Autónoma de México

Based on the construction of trust, the training of community health workers and respect for ancestral knowledge, MSF implemented in Nariño and Chocó a model of basic mental health care, with an ethnic focus.

Dr. María Fernanda Rodríguez began her speech by recognizing her teammates Lina María Quintero and Laura Ximena Garzón, mental health managers in Doctors Without Borders (MSF) projects. Doctors Without Borders, she says, is an independent, neutral, and impartial humanitarian healthcare organization that operates in nearly seventy countries, primarily caring for victims of armed conflicts, epidemics, natural catastrophes, neglected diseases, and natural disasters.

MSF has four projects in Colombia, explains Dr. Rodríguez, one of which is an emergency team that is in charge of monitoring the entire territory and carries out mental health activities in emergency situations.

In the department of Nariño, reports Dr. Rodríguez, Doctors Without Borders operates in the municipalities of Roberto Payán, Magüí Payán and Barbacoas, which make up the Telembí Triangle, inhabited by populations living in poverty and trapped in the territorial confrontation between illegal armed groups. The project is based in Barbacoas. In Chocó, the organization works in Alto Baudó and the project is based in Istmina.

In these territories, explains Dr. Rodríguez, Doctors Without Borders has implemented the Decentralized Care Model (DCM), for which a process of approaching and consulting key actors in the communities was carried out on how they see the mental health, how is their community on an emotional level, and to know if the activities of the DCM are prioritized and if there are some mental health needs that can be worked on and that justify the training of community health workers.

To illustrate the nature of this consultation, Dr. Rodríguez evoked a quote from a resident of the community of Patía Viejo, in Nariño:

> *"Here the main disease we suffer from, even though we do not recognize it, is the trauma caused by the war, living thinking about displacement, not leading a normal life, living thinking about what time they are going to kill you, not being able to sleep when you hear sounds, that even hunger will go away when they are present on the sidewalk, that the memories get into your head and that no matter how hard you try you cannot take them away."*

The quote summarizes the recurring responses of the communities, which make it possible to identify many people with very high levels of anxiety, post-traumatic stress, depression, or psychotic symptoms, among others.

## *The Decentralized Care Model seeks to bring communities closer to PHC services*

The Decentralized Care Model, explains Dr. Rodríguez, is a strategy designed to bring communities closer to primary health care services. She is aware that it is very complex for the communities to go to where the services are and that there are barriers to care.

There are important geographical barriers, says Dr. Rodríguez, these are communities that are very far from the municipal capitals and can only be accessed by rivers. There are barriers associated with the armed conflict, which still presents complex situations because the reality of the territory is that, despite the signing of the Peace Agreement with the FARC guerrillas, the conflict is still alive there. There are economic barriers, it is very expensive to leave the

communities, sometimes it is more expensive to move from a community to a capital city than to leave the country, says Dr. Rodríguez.

In this context, the gaps in mental health are huge, explains Dr. Rodríguez. There are very few professionals specialized in mental health or psychosocial support. Finding a psychologist, even in the urban zones, is very complex, and a psychiatrist, even more difficult. The professionals present are not trained, nor do they know how to work, how to care, how to accompany people when they have mental health problems, be they mild, moderate, or severe.

That is why it is so important that the mhGAP guide reaches the territories that are most isolated. There, moreover, says Dr. Rodríguez, there is very little intercultural focus. In these places, where there are different ethnic groups and cultures, it is very difficult to find mental health care that understands the different worldviews, the different cultures and that can offer support at a professional level.

## *There are great needs and a lot of ignorance about how to manage mental health*

According to Dr. Rodríguez, there is a lack of knowledge about mental health. Communities sometimes say they don't know what it is, but in reality, they do have their own conceptions of mental health and know what the effects are. Although they name them differently, they understand what mental health is.

Many people do not understand very well what it is like to identify their own emotions or the emotions of others, and practices of discrimination occur with those who have mental health problems, or practices that can be torturing or undignified, because they do not know how to act. In addition, the medical professionals, nurses, and promoters who are at the head offices or health posts are also not very clear about what mental health is and how they can accompany it.

There are important mental health needs in the territories. What is found most, says Dr. Rodríguez, are post-traumatic stress disorders, people who come with very high stress levels, relive violent experiences, and have the images in their heads, which are called *flashbacks*, she adds. For this reason, it is necessary to train professionals and communities, not with theory, because it has already been established that this is not how it works, but by putting it into practice, so that they feel it, experience it, in order to learn it and take it to their communities.

## *Building trust and training community health workers*

The Decentralized Care Model, says Dr. Rodríguez, has several synchronous components: selection of community health workers , involvement and development of trust with the communities, territorial incidence, referencing,

training, reinforcement and supervision of community health workers, prioritization of issues, and interaction with health structures.

The success of the project depends on involvement and trust. For this reason, an evaluation stage is carried out in which the Médecins Sans Frontières – MSF (Doctors Without Borders) team approaches the communities and later, MSF professionals work on building trust and involvement with the communities. It is a very social process.

At the beginning of the DCM project in Nariño, the selection of community health workers was addressed. They had to know how to read and write and be of a certain age. Later, the MSF team realized that other roles were needed, people who had a position on health in the community, regardless of whether they knew how to read and write.

On the other hand, says Dr. Rodríguez, the DCM does not work, even if the community health workers are trained and informed, if the health structure does not work, if it does not receive referrals or does not understand the impact on mental health. That is where the process ends. Then an approach is also made to all health entities, and it is about accompanying them and seeing what they need and how to support them to facilitate access to health.

## *Prioritization and interaction with health entities*

For the development of the DCM, explains Dr. Rodríguez, Médecins Sans Frontières prioritizes warning signals, signs, and symptoms, how to identify mental health effects, how to perform psychological first aid, how to screen and how to refer, among others.

Based on this prioritization, the community health workers are trained and then the topics that need reinforcement are evaluated. On-site supervision is carried out with the managers and the teams of psychologists that accompany them. The cases that the community health workers face are reviewed with them, it is evaluated if they are correctly classified, if they are emergencies, the management that was given to them. Full accompaniment is done so that the person receives care.

Finally, there is an incidence component, which has to do with what MSF does with health entities, warnings about the need for trained mental health professionals, a psychologist and ensuring that mental health follow-ups are carried out.

## *We must respect and integrate the knowledge of the communities*

Dr. María Fernanda Rodríguez pointed out some of the challenges and lessons learned from the DCM experience. On the one hand, she said, it is key that the construction be done jointly with the communities. We have understood that it is not possible to be vertical in the training processes and arrive with "our medical knowledge and our knowledge in mental health" to teach the community how to manage it, because they already have some knowledge and do some health management. However, they open the door for external teams to work in mental health. She narrated that, for example, the Embera Dóbida indigenous community of Chocó has ancestral health practices and in the communities of Nariño there are healers for each area. So, she says, it is weaved with this knowledge to see what the DCM project can contribute to improve general health and mental health care.

Another of the complex issues, explained Dr. Rodríguez, is gender-based violence. This must be prioritized and paid attention to. In many cases, handling has been difficult due to the routes and the difficulties of access. The effects on mental health are quite strong, even with risks of suicide due to this violence.

Dr. Rodríguez indicated that the DCM project is not only mental health but needs to be articulated with the components of community involvement and physical health. And she adds that it has been a challenge to implement the training in the mhGAP guide. It has been very difficult to bring this guide to the territories and all the related guidelines that the Ministry of Health has. Those territories so far away, so complex, is where you get the least and where it costs more for the strategy to work.

Dr. Rodríguez concluded by saying that it is very important to understand that this process is circular, it is a spiral, and you need to constantly retrace it. It is not so easy to understand, and it has been very challenging for the projects and for certain positions within the projects to understand the complexity and the way in which mental health processes need to be monitored.

*See presentation, watch video in Spanish*

*Watch video in English*

# Models of Psychosocial Support in Contexts of Extreme Adversity: Lessons from the Program "Seeds of Attachment" from the Universidad de Los Andes

**Arturo Harker**

Director of the Imagina Research Center
Universidad de Los Andes

PhD in Economics from the University of California, Los Angeles
Associate Professor, School of Government
Universidad de Los Andes

## "Semillas de Apego" (Seeds of Attachment): Psychosocial attention to caregivers to promote healthy affective bonds and strengthen the parenting teams of children affected by the conflict

The Cofounder of the *Semilla de Apego* program, Dr. Arturo Harker, says that this program was born from a motivation that was originated in the adversities and traumas generated by violence. If you add the Venezuelan migration crisis and the crisis of decades of forced internal migration in Colombia, you have more than eleven million people forced to migrate, he says. Of these, more than a

million are children between the ages of zero and five, exposed to the Colombian armed conflict, and more than 300,000 are children from Venezuela.

It is well documented, explains Dr. Harker, that these adverse experiences directly affect the health of all family members. But in the first years of life these potentially traumatic experiences have a very important impact that affects brain development, health, and the developmental process that determines the skills that allow us to achieve our full potential.

*Semillas de Apego* was born, says Dr. Harker, trying to break this vicious circle that reduces the opportunities of thousands of children in Colombia, with the aim of reaching where it is necessary, and ending this cycle that perpetuates the transmission of poverty and lack of opportunities between generations. In the end, what is wanted is to promote mental health in families affected by conflict, forced migration, and other adverse environments, knowing that it is essential to ensure that all children reach their full potential and the well-being they deserve.

## *Psychosocial care to promote the mental health of children affected by violence*

Dr. Harker states that *Semillas de Apego* is a group psychosocial care program that seeks to promote mental health and early childhood development in contexts of violence and forced migration. Unlike other programs, it works with caregivers as an innovative element.

*Semillas* takes care of children from 0 to 5 years old, explains Dr. Arturo, integrating services and primary care. He works so that mothers, fathers, grandmothers, uncles, and the main caregivers have tools that allow them to process their life experiences, have a better understanding of the child development process and how these adversities affect this process. It is sought that the main caregivers become a reliable source of emotional and physical protection for children.

## *Healthy and safe affective bonds are a protective shield in early childhood*

This approach, explains Dr. Harker, comes from the theory and clinical evidence of healthy and safe affective bonds, which can work as a mechanism to create a protective shield that promotes early childhood development, including in settings of extreme adversity. He points out that there is national and international evidence that shows how potentially traumatic experiences directly affect the mental health of the child, the mental health of the caregivers, and also represent a double risk because the mental health of caregivers is what provides the emotional resources to generate a safe affective bond. This means

that violence and displacement have a double impact on the development of children through the physiological mechanisms of stress.

Stress is a survival mechanism that has helped us succeed and proliferate as a species, Harker says; but when it's too frequent and spikes too high, it's toxic and causes the system that handles it in the body, the hypothalamus-pituitary-adrenal axis, to go into overdrive. This affects people's behavior, and when these people are in developmental moments as important as early childhood, brain development and brain configuration are affected. This impacts the entire life course , increases the probability of health risks, communicable and non-communicable diseases, their chances of success as students, workers, and members of society.

## *Toxic stress affects prefrontal architecture and the quantity and quality of neural connections that are important for regulating emotional and cognitive processes*

Toxic stress, explains Dr. Harker, affects the trajectory of boys and girls in all dimensions, as evidenced by measurements of brain connections, comparing children who have an environment of adversity versus children who do not have an environment of adversity. This happens when millions of neural connections are developing in the brain of children, so the prefrontal architecture is affected. The quantity and quality of neural connections impact areas of the brain such as the prefrontal cortex and the hippocampus, which are very important for regulating emotional and cognitive processes. So, what *Semillas de Apego* does, says Dr. Harker, is promote caregiver's mental health, promote healthy bonding, and strengthen parenting teams. It's the way the program flows.

## *Community monitors are mothers or caregivers who go through a process of experiential training*

Professor Harker explains that *Semillas de Apego* is a model based on community capabilities. The psychosocial monitors are local mothers, and the professionals of the team undergo  a deep adaptation and contextualization process, which has very clear and non-modifiable principles, but adapted for an appropriate and relevant intervention as validated in the 2018-2019 impact evaluation.

The community monitors who work on the model are mothers or caregivers who go through an intensive, experiential training process to implement it in groups, which makes the model viable in any community, says Dr. Harker.

Another fundamental aspect in these interventions, says Dr. Arturo, is that there is a reflective supervision system whose focus is to protect the

emotional well-being and promote coherence in the relationships of the program facilitators themselves. This supervision aims to oversee that everything is being done as it should be done, but also to monitor their own processes, to avoid the typical occupational risks to which community health workers in mental health and psychosocial care issues are often exposed, such as vicarious trauma,[4] and other types of risk.

## *The Semillas de Apego curriculum has three modules*

In general, says Dr. Harker, the *Semillas de Apego* curriculum has three modules: (i) promotion the mental health of caregivers; (ii) promotion of healthy affective ties and, (iii) strengthening of parenting teams. It is a program that has fifteen sessions, one per week, between two and three hours, of a group nature, with an average of fifteen participants and led by two community monitors.

- *The first module, promotion of the mental health of caregivers,* seeks to promote emotional regulation in caregivers, the ability to reflect on the impact of the experiences they are living, identify, and enhance their resilience capacities and their personal strengths, that positive and optimistic vision of what their assets are.
- *The second module, promotion of healthy affective bonds,* seeks to promote affective bonds and focuses on strengthening curiosity about the internal process of boys and girls; identify what they need during early childhood and how they are affected by adversity; strengthen the capacity for reflection on how to generate protection and security for boys and girls; identify assertive and affectionate ways to relate to them; strengthen the repertoire of parenting strategies. It seeks to contribute to the caregivers themselves remembering and turning to their emotional resources. Dr. Harker affirms that it is not about good or bad caregivers, but that, in certain situations, in contexts of adversity, emotional resources are not available to be able to provide what a child, especially in early childhood, needs to have. That's why it all starts by recognizing how the context affects the caregiver and how it affects such bond.
- *The third module, strengthening parenting teams*, seeks to consolidate a parenting team so that there is graduation, empowerment, confidence to involve family members and the community to advance on a path that will always remain complicated, and create a support network.

4 Known as the psychological or emotional exhaustion that people who care for others and are in permanent contact with the emotions of other people who are having a hard time can suffer.

## *A seed that germinates*

*Semillas de Apego* began in 2014 designing the curriculum. In 2023 a first scaling step has been already finished and we are starting a new one that goes until 2026, says Dr. Harker.

In 2014 *Semillas* began working with a team from the "Child Trauma Research Program" at the University of California, in San Francisco, led by Alicia Lieberman, one of the eminences and developer of the attachment theory. Lieberman and Patricia Van Horn designed the Child's Parents Psychotherapy program, widespread in the United States, but difficult to scale and take to territories, for which they created a group version, called *Construyendo Puentes*, which was scaled to Colombia through a long process of appropriation and joint investigation by the two teams.

Initially, a pilot test was carried out with displaced women with the support of the Ministry of Health, the Bogotá Mayor's Office, and the Victims Unit, considering *Semillas de Apego* as a psychosocial care program for victims. We worked with the Secretariat for Integration with 65 displaced women, with children between 0 and 5 years of age. There, information was collected that showed that it was relevant, viable, and very satisfactory for the participants.

From this experience, it was taken to territories, where the need was total and the complexity was much greater. It was first taken to Tumaco. Six mothers were trained as monitors of the program implemented between 2018 and 2020 with 1,300 mothers. This phase was conditioned to carry out an impact evaluation where the standards and a proof of concept were met.

Professor Harker explains that the experience was wonderful and eight months after finishing the program a positive impact was evaluated in the five dimensions of interest: the mental health of the caregiver, the quality of the affective bond, the type and frequency of interactions between the mother and child, child mental health and child development.

In the mental health of the caring mothers, there were drops of 46% in the probability of presenting typical symptoms of anxiety, of 26% in typical symptoms of depression, of 59% in critical sensitivity symptoms, and of 38% in the probability of presenting critical symptoms of parental stress.

In child mental health, there was a 36% decrease in the probability of presenting critical symptoms of anxiety, a 43% decrease in the probability of presenting critical symptoms of depression, and a 36% decrease in the probability of presenting critical symptoms of post-traumatic stress. Interesting impacts were achieved on the socio-emotional development of the children, which is the ultimate goal. The program generated falls of 68% in the probability of presenting critical levels of socio-emotional competencies and 79% in the probability of presenting critical levels of behavior problems.

## *A new phase that seeks to benefit 15,000 caregivers and 22,000 early childhood boys and girls*

The team is finishing the Tumaco phase, says Dr. Harker, which is a first scaling step, where a focus point has been on understanding what is needed to scale the program to new municipalities, to new communities. The process in Tumaco, he says, has made it clear that starting in a new territory is complicated due to adaptation and trust in the community. Today, *Semillas de Apego* is a benchmark in Tumaco and it is easy to open doors, fathers and mothers want to participate, everything flows, but it was not like that in the first cohort of the four that were carried out.

The new stage, which develops in partnership with Heartland Alliance International and Hilton Foundation, is an escalation where work is being done in thirteen municipalities and it will reach up to 26. The idea is to benefit 15,000 caregivers and 22,000 early childhood boys and girls.

The quality of the implementation will be evaluated, more than the effectiveness, to guide all the resources in reaching more territories, trying to understand what can be measured, always thinking about the continuous cycle of quality: we have to measure to adjust to redo and release a new version.

This program, says Arturo Harker, is the result of a broad collaboration of people who are working in different sectors. The program was born from the collaboration between the University of California in San Francisco and the Universidad de Los Andes[5] in Bogotá, but also has an alliance with United Way Colombia and with Heartland Alliance International. Funding support for implementation and evaluation has been extensive. The Fundación Éxito and Saving Brain, which is the Canadian cooperation, have participated. And today, we are working on an innovation to incorporate Sesame Workshop materials, with which there is a scaling up project. Finally, the IDB has always supported the process.

*See presentation, watch video in Spanish*

*Watch video in English*

5 Program leader team: Andrés Moya, Professor at the Faculty of Economics of the Universidad de los Andes, co-founder and general director of Semillas de Apego. Blasina Niño Sáenz, technical director of the program. María Alejandra Palacio, executive director. Arturo Harker, co-founder, researcher and member of the steering committee of Semillas de Apego.

# Discussion Panel
# Mental Health Innovations from PHC in Colombia

**Paola Tejada**

Professor at the Faculty of Medicine of the Universidad El Bosque

**Natalia Quiñones**

Co-Founder and Research Director of Dunna Corporation, Creative Alternatives for Peace

**María Fernanda Rodríguez**

Mental Health and Psychosocial Care Manager
Mission in Colombia of the NGO Doctors Without Borders

**Arturo Harker**

Director of the Imagina Research Center
Universidad de Los Andes

**Moderator: Luis Gabriel Bernal**

Specialist in family medicine and master's degree in public health. Member of the PHCPI facilitator team and Professor at the School of Medicine and Health Sciences of the Universidad del Rosario

The panel featured the participation of the four webinar speakers and the moderation of Dr. Luis Gabriel Bernal. Dr. Bernal explained that WHO Member States have committed to applying the Comprehensive Mental Health Action Plan signed in 2013, which is aimed at improving mental health through more effective leadership and governance; the provision of a complete type of care, comprehensive and adapted to the needs in a community setting; the application of promotion and prevention strategies; and the strengthening of information systems, scientific data, and research. The Comprehensive Action Plan, explains Dr. Bernal, proposes three ways of transformation for countries to substantially improve the mental health of their inhabitants:

1. Increase the commitment, value, and investment that people, communities, different sectors, and governments give to mental health.
2. Act on the physical and socioeconomic characteristics of the family, school, work, and community environments in general, in order to protect and promote mental health and prevent disorders associated with it.
3. Strengthen access, affordability, and quality of mental health care through a community network and support services.

## *Mental health in community dynamics*

When asked about how emotional regulation and the development of socio-emotional skills translate into transformations of community dynamics, Dr. Natalia Quiñones specified that there is a strategy that starts from all the routes that were developed in the Dunna Corporation, which is to train people from the community, from social organizations, who want to work on this. This training is short and it is cost-efficient to be able to scale it to a national level. She also referred to the incorporation of innovations in the management of mental health in the community. She said that the Dunna Corporation has developed capsules that are designed for specific situations: what to do when the person cannot sleep, when the person expresses being depressed or sad, when people mention having fears or anxiety.

## *Standardization in the use of tools*

Dr. Bernal expressed concern about the differences that may exist in the application of the Intervention guide mhGAP by health assistants or community health workers in comparison to the application by health professionals, due to the difference in profiles and competencies, and asked how to achieve standardization in this application.

Dr. Paola Tejada, representative of the Global Mental Health Assessment Tool, recognizes that, in principle, the tool being designed for primary health care is intended to be applied by physicians, nurses, social workers, psychologists, occupational therapists. However, she says, in reality it has been seen that in addition to this group, other people can receive training to apply it, from people who hold managerial and administrative positions to people who are not from the health field, but who are the referents of local health: the community leader, the teachers, people who, from the spiritual point of view, are recipients of many problematic situations in mental health. So, the application of this Guide has been broader than initially designed.

Nevertheless, according to Dr. Tejada, the advantage of these strategies is that from their conception, they allow them to be adaptable. And in the case of mhGAP, it is recommended that a diagnosis of the context, needs, and what

is useful as a guide and what is not, is made before the application. And it is proposed that the groups that apply it be homogeneous and receive training, so as not to generate gaps in the application.

Another important aspect that Dr. Tejada highlights is that, taking into account the changes in meaning that the questions can have and their effect on the answers of the interviewee, in the training it is indicated that people who do not have enough expertise in the application of the Guide adhere to the script and the recommendations given by the guide, to reduce variability.

## *Early childhood care services are fundamental, so more must be demanded of the health system in this regard*

Dr. Luis Gabriel Bernal raised the issue of how health services could learn and articulate their actions with community-based psychosocial support models in areas affected by the armed conflict in Colombia. Dr. Arturo Harker, director of the *Semillas de Apego* project, pointed out that in large urban centers, where the service network is extensive and strong, there is better articulation between the education and health sectors with routing to mental health services. But in other parts, there is a deficit of these services which is sometimes only covered by projects like the one run by Doctors Without Borders in Tumaco.

Dr. Harker points out that it is necessary for health care programs in the territories to go beyond the care offered to the immediate crisis and referral. The important thing is that there is accompaniment. He added that early childhood care services are essential in these processes, so more should be demanded of the health system in this regard. And he stated that a good example of identification of needs in health and routing of users is the *Programa Ampliado de Inmunizaciones*, PAI (Expanded Program of Immunizations). Therefore, it should be analyzed what incentives or regulations made the scaling up so successful in order to replicate it in mental health and psychosocial care.

On the issue of articulation, Dr. María Fernanda Rodríguez acknowledges that it is a very complex challenge that the DCM projects have faced, both in Chocó and Nariño, because they are hard-hit territories, where there is very little state presence and where it is very difficult to build a relationship, a rapprochement with the deficient health structure. Despite this, a lot of work has been done to build a link between the community, the projects, and the health agents.

In addition, says Dr. Rodríguez, in Chocó, for example, there is a very marked discrimination against indigenous communities, which sometimes have their own health services, but when they approach certain health entities, they are denied the service. They are much more distant communities, farther from health services and that do not speak Spanish, so it is necessary to rely on an intercultural mediator to validate the instruments, translate, and accompany the training and sessions on mental health.

Dr. Bernal ends by calling attention to the fact that projects or entities external to the health system and to the local and national governments are the ones that take the initiative to interconnect when it should be a State initiative.

*Watch video in Spanish*

*Watch video in English*