Joint Report on Mental Health

A Baseline Survey of Community Mental Health in Baitoa, Dominican Republic

SEPTEMBER 2022

GRACE Cares

PROJECT HEARTS
Drinking water. Living water.

Introduction

Project Hearts (PH), in collaboration with GRACE Cares (GC) designed, implemented, and analyzed the results of a mental health survey under the guidance of a mental health professional. This joint report presents the background of mental health care in the Dominican Republic (DR), the methodology governing this study, assumptions and limitations, findings, and recommendations for future Project Hearts programming to address mental health in Baitoa, DR.

Since 2014, observations made by PH staff during small community group activities, informal interviews, and regular interventions, revealed anecdotal trends in the rural area of Baitoa surrounding mental health perceptions and conditions.

The most prevalent of these was that discussion of **mental health as taboo among most residents.** Individuals and families reported knowing someone who struggled with depression or anxiety, but there were seemingly **no pathways for help** because of the widespread avoidance of such topics.

Thus, the **PH team decided that a survey of community members was imperative to deepen their and the public's understanding of mental health and formulate relevant and sensitive programming to promote talking about, addressing, and supporting positive mental health practices**.

The survey questions used are based on psychological scales and were translated to Spanish and adjusted as needed through input from community members on the PH team to ensure question clarity.

Overall, a majority of respondents did not report any significant mental health issues. There were, however, **instances of mild to moderate issues in certain cases that would likely benefit from support**.

Background

Over the last few years, the DR has taken impressive measures to improve its economy, with the World Bank reporting a 6.1% increase in GDP between 2015 and 2019. Amidst this economic growth, the DR has also taken strides in improving its healthcare structure. **However, much needs to be done to support mental health as less than 1% of the national budget for public health goes to mental health services.**

Psychologists and patients alike still lack adequate support and funds to both give and seek help. Padre Billini Psychiatric Hospital is one of the only hospitals that functions as a residential facility with inpatient facilities. Outside of that, there is only one mental hospital and one day treatment center, which are located primarily in urban areas and are not always accessible to rural communities.

There is also insufficient budget allocation, an inadequate amount of essential medications, and a lack of human resources. In fact, mental health training for physicians and nurses comprises, “only 3% of total training hours in nursing school and only 4% in medical school.” (Caplan)

In addition to the systemic and provider centered barriers to effective mental health programming, **the biggest barrier to a more comprehensive mental healthcare system remains the stigmatization of mental health.** Stigma exists not only within patients but also within doctors. Especially in tight knit communities, the opportunity to address mental health issues is not always taken due to deep rooted stigma against mental health.

To address the lack of mental health resources, the DR’s government decided to strengthen its partnership with Pan American Health Organization (PAHO) to develop the National Mental Health Plan for 2019-2022, which has a community, participatory and human-centered approach to mental health care and prioritizes prevention and recovery through a coordinated, decentralized health system.

Methodology

Expert mental health guidance on survey creation

A mental health professional was engaged to provide a technical and scientific basis for the formation of a mental health survey. In addition to collecting demographic information, such as sex and religion, the PHQ-9 depression scale, the Peritraumatic Distress Scale (PDS), and the FCV-19S to assess fear of COVID-19 were incorporated in the survey. Demographic questions were included in order to get a sense of who responded to the survey, where these respondents live, and whether they exhibit any particular characteristics. The PHQ-9 depression scale was used to assess depression, which was a focus of this study due to anecdotal evidence provided by PH staff. The PDS was used to understand the prevalence of more serious mental health disorders and the FCV-19S was used to get at how the pandemic may be impacting mental health in the rural community of Baitoa.

Local buy-in on survey questions, length, and dissemination pathways

After determining the survey questions to include, the questions and response options were translated from English to Spanish by the Executive Director (ED) of PH. Once this was completed, the ED held a meeting with all of her staff to go over the translations to ensure that the questions and terminology were understood completely. The team suggested several modifications to the language and phrasing in order to make it more culturally accessible.

Although originally three separate surveys, they were combined after being translated so that respondents would only have to respond to one survey. Once the survey questions were finalized, the method of dissemination was discussed. With COVID-19 precautions in place, it was determined that the method of dissemination would be via WhatsApp since this platform was already the primary means of electronic communication in Baitoa. To incentivize participation in the mental health survey, a raffle was held where three winners would receive a $40 voucher for a “compra” from a local mini-market, allowing them to purchase food or hygiene items for their families.

Survey ethics

All survey results were anonymized to protect the identity of respondents. Furthermore, individual results were kept confidential and only shared with the survey project team (ED of PH, GC Program Manager, and a mental health professional). The aggregated results of this study are shared in this report. No individual respondent data will be shared with internal or external stakeholders other than the project team. The one exception to this is survey participants who indicated that they wished to receive their personal results were sent them via the contact information provided.

Assumptions & Limitations

Assumptions

Several assumptions were made prior to the creation and implementation of this survey:

Firstly, it was assumed that the community tended to not talk about mental health and ignore those who present with symptoms of a mental disorder.

Secondly, it was thought that there were undiagnosed mental health conditions in need of treatment.

Lastly, it was presumed that the community would benefit from the breaking down of mental health taboos, mental health education, and access to mental health services/informational programming.

These initial assumptions were based on anecdotal and informal observation.

After the review and translation of the survey questions by the PH team, it was assumed that community members would understand and respond to them honestly.

During the data cleaning and analysis stage, blank responses were omitted from the analysis as it was assumed that, for optional questions, if someone did not respond, that they were opting out of sharing.

Limitations

As with all **self-reported data**, it is important to be wary of possible survey anxiety and dishonesty that can occur when answering questions. Response bias occurs when respondents attempt to input the "right" or expected answer. By having a sample size of 100 respondents, this assumption is mitigated when analyzing the results as an aggregate. It is also possible that, since community members are rarely surveyed on their mental health, they may not have known what the "correct" answer may be. Unfamiliarity, however, can lead to omitted responses.

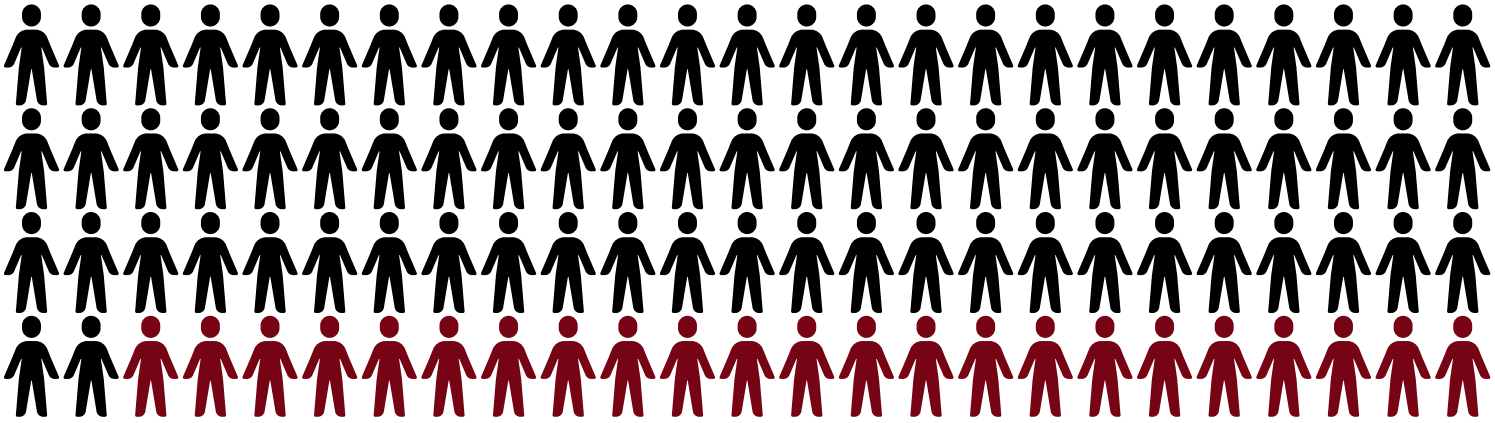
Efforts were made to reduce the possible biases of non-Baitoan team members involved in this analysis. By deferring to Baitoans when it came to the translation, phrasing, and roll-out of the survey, this bias was reduced.

There were also operational limitations for this survey. There was **no specific funding** allocated to this endeavor, meaning that the survey process was conducted on a very low budget. As a result, the work on this survey was gradual and the staff and volunteers working on it were unable to dedicate extensive time to its creation and implementation. From survey design to the analysis of results, a full calendar year was needed.

As this survey project was carried out in the year 2020-2021, the **COVID-19 pandemic** also restricted a quick implementation of the survey. It was important to be mindful and follow public health guidelines throughout the process and often put this particular project on hold when more immediate projects required attention, such as hand washing and mask-wearing initiatives. COVID-19 also eliminated the opportunity to conduct interviews in addition to the written questionnaire. Interviews would have been helpful in reaching populations who are less technically inclined and those with low reading levels.

Findings - Demographics

77 of the **100** respondents were **female**.



The **average age** of respondents was **32**, with the youngest respondent being 17 and the oldest 60 years old.

92% of respondents follow a **religion** and **80%** are somewhat involved, involved, or very involved in **church activities**.

86% of respondents have completed at least **high school** and **39% work full time** (17% work part time).

Of the **59 respondents** who indicated their salary range, **53%** have a **monthly household income of $206 USD or less**, which equates to about **$7 per day** (based on 30 days in a month).[1]

Findings - Scale Results

PHQ-9 Scale (depression)

Overall, the results to the PHQ-9 scale questions were **positive**.

61%
reported they had **no** or **minimal** instances of being bothered by symptoms of depression.

26%
reported they had **mild** instances of being bothered by symptoms of depression.

11%
reported they had **moderate** instances of being bothered by symptoms of depression.

100%
of those whose reported **moderate** or **moderately severe** depression were **women**.

Correlations were found between those who **expressed thoughts of suicide** and those with **moderate** or **moderately severe** depression.

PDS (trauma)

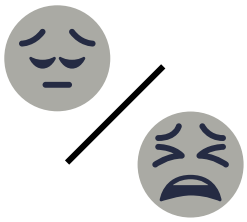
98%
of respondents reported having only **mildly** been bothered by symptoms related to PDS.

Fear of COVID-19

80%
reported, overall, they had a **mild** fear of COVID-19.

20%
reported, overall, they had a **moderate** fear of COVID-19.

Findings - Other



PHQ-9 Scale and PDS correlations

5 of the 6

participants with **moderate** levels of trauma-related anxiety (PDS) also had scores indicating **moderate** or **moderately severe depression** (PHQ-9).

1 respondent

had **mild** depression despite expressing thoughts of suicide and having **moderate** levels of trauma-related anxiety.

Community interest in mental health

91%

of respondents said they **would like to receive their results** from the survey and **want to be referred to professional psychological support** if the results indicated a need.

Recommendations

Based on the results of this survey, **we believe it would be of great value to the communities of Baitoa if Project Hearts were to expand mental health programming**. This is especially encouraged by the overwhelming interest of survey participants in receiving their results and being open to further communication.

Short-term recommendations *(use existing resources and programming)*

1: Use the existing network of Community Health Leaders (CHLs) to increase awareness and open dialogue about mental health conditions and treatments.

Within the existing PH CHL training curriculum, expand the mental health-related module and invite the PH staff psychologist to teach lessons on mental health to deepen CHLs' understanding. Then, as CHLs are already active and trusted in their communities, they can speak with members about mental health and share information to increase awareness and spark dialogue. Additionally, when conducting future mental health surveys, CHLs can visit their neighborhoods to encourage survey participation, answer questions respondents may have, and explained the importance of the survey. Although most residents use WhatsApp for communication, it is important to have in-person visits because not everyone has access to or knows how to use this technology.

Mid-term recommendations *(requires minor programming expansions using existing resources plus some additional monetary and human captial)*

2: Create community support groups that foster trust and an understanding of mental health.

With the support of CHLs, PH staff can organize weekly community meet-ups for six months to talk about mental health. Ideally, attendance would be incentivized with a free meal. Support sessions would run for one hour in a public, but private space so as to uphold confidentiality. Using Appreciative Inquiry methods, facilitators would ask attendees questions and engage in trust-building activities. The aim of these group sessions is to further understand how community members perceive and cope with mental health challenges. Additionally, participants would have a chance to learn coping strategies, how to discuss mental health concepts with others, and about their related causes and effects.

3: Continue surveying the community on mental health.

Based on baseline results, redesign the survey to target the areas of mental health that are most relevant for this particular population. This survey would ask only 5-10 questions to encourage more participants to complete it. Additionally, consideration should be made to how images/pictures can be used on surveys to uncover the feelings and experiences of illiterate community members and (possibly) children.

Long-term recommendations *(requires additional resources and advanced planning)*

4: Establish a counseling center in Baitoa.

Locate a safe and private space for the PH staff psychologist to see community members in need of counseling. This service would be provided at no cost to patients, thus it requires additional funding.

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