A Culturally Responsive Model for Disaster Public Mental Health

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Experience combining interventions and research among adults and children in a variety of cultures HNI-TPO

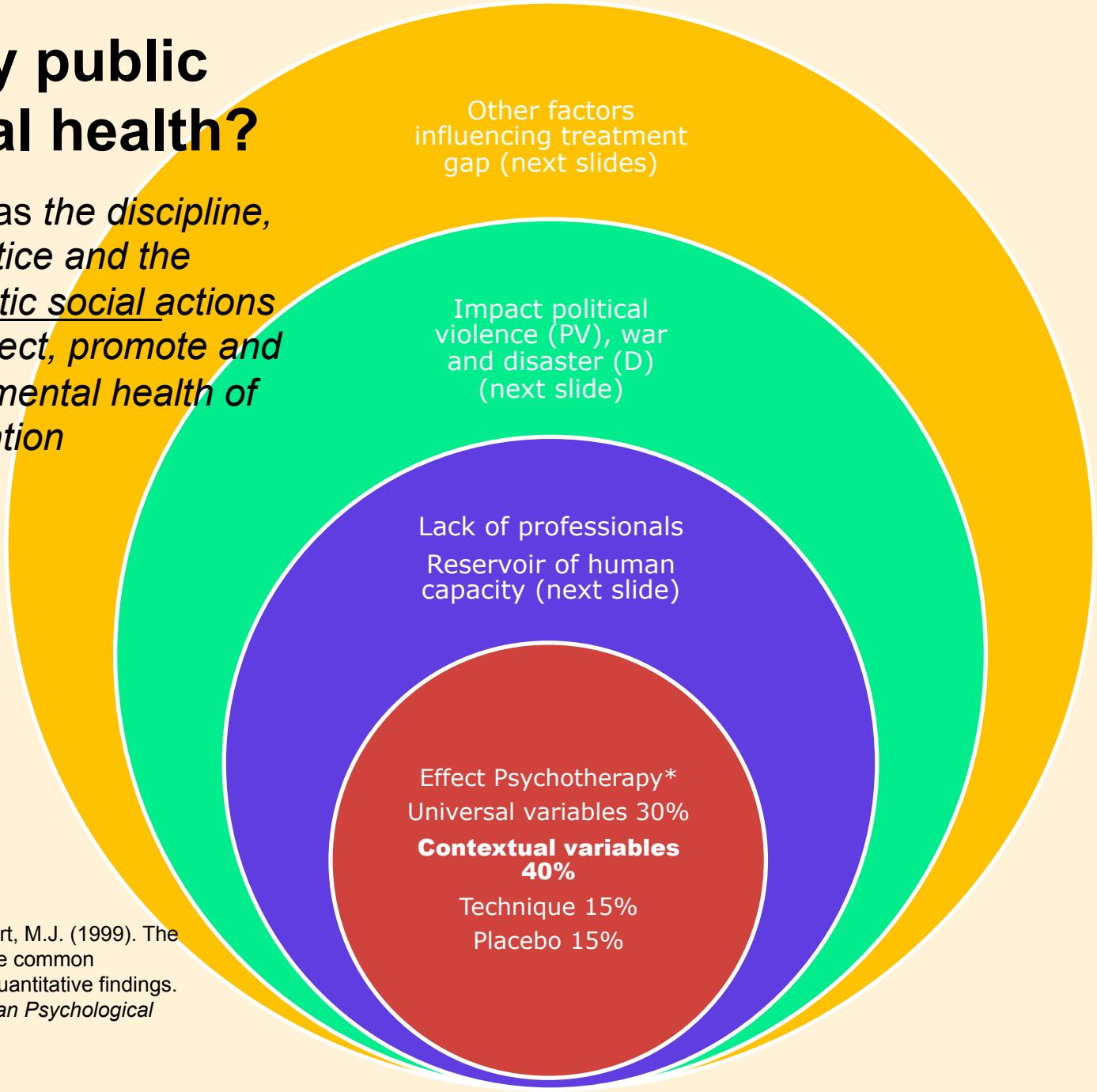
- Afghanistan
- Algeria
- Angola
- Bangladesh
- Bosnia
- Burundi
- Cambodia
- China
- Eritrea
- Ethiopia
- Gaza
- Guinea Bissau
- Haiti
- Honduras
- India
- Indonesia
- Kosova
- Mozambique
- Namibia
- Nepal
- Netherlands
- Pakistan
- Philippines
- Rwanda
- Senegal
- Sierra Leone
- Sri Lanka
- Sudan
- Surinam
- South Africa
- Swaziland
- Uganda

Outline

- **Why public mental health?**
- Public Mental Health in two steps
- A bird’s eye view on global mental health coverage
- Some challenges

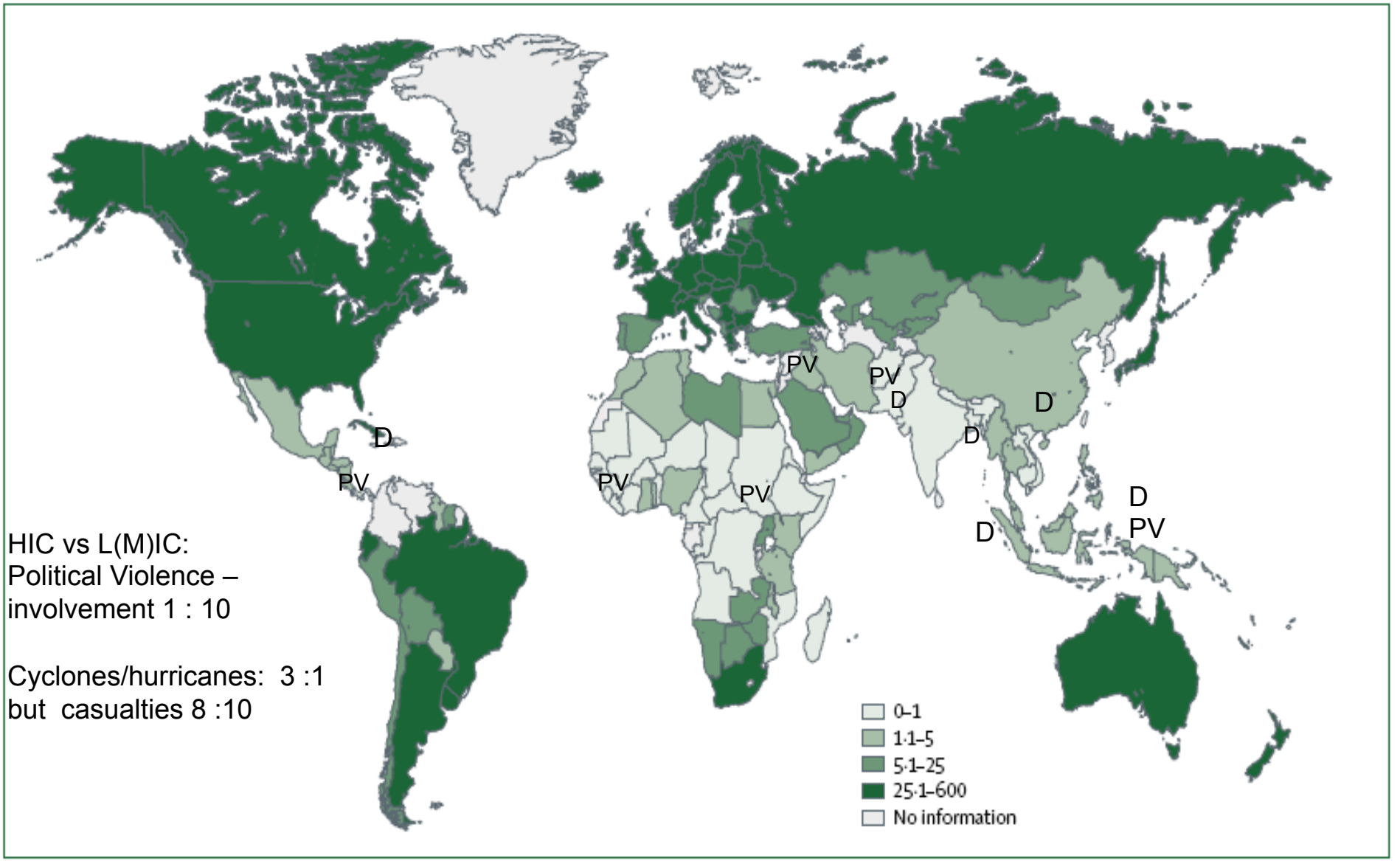
Why public mental health?

defined as *the discipline, the practice and the systematic social actions that protect, promote and restore mental health of a population*



*Asay, T.R, & Lambert, M.J. (1999). The empirical case for the common factors in therapy: Quantitative findings. *Washington: American Psychological Association.*

Human resources for mental health



HIC vs L(M)IC:
Political Violence – involvement 1 : 10

Cyclones/hurricanes: 3 :1
but casualties 8 :10

Figure 1: **Human resources for mental health (psychiatrists, psychologists, nurses, and social workers) per 100 000 population**
Redrawn from WHO Mental Health Atlas,[5] with permission of WHO.

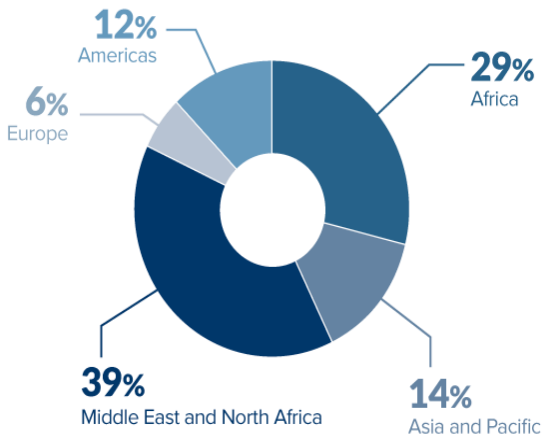
The burden of displacement and its distribution around the globe

65.3 million
forcibly displaced people worldwide

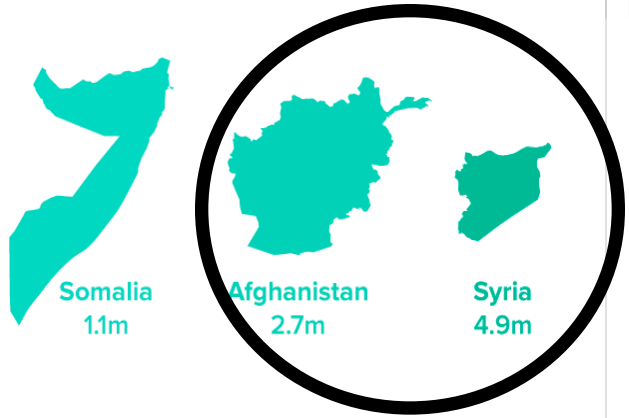
Refugees
21.3 million
16.1 million under UNHCR mandate
5.2 million Palestinian refugees registered by UNRWA

Stateless people
10 million

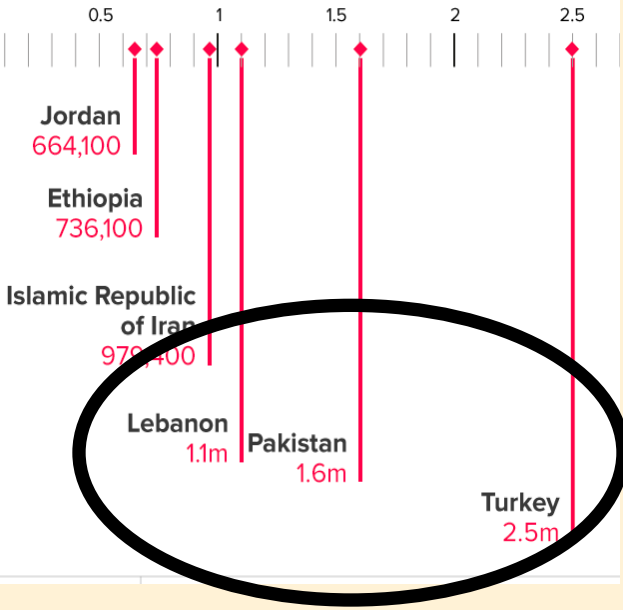
Where the world's displaced people are being hosted



54% of refugees worldwide came from three countries



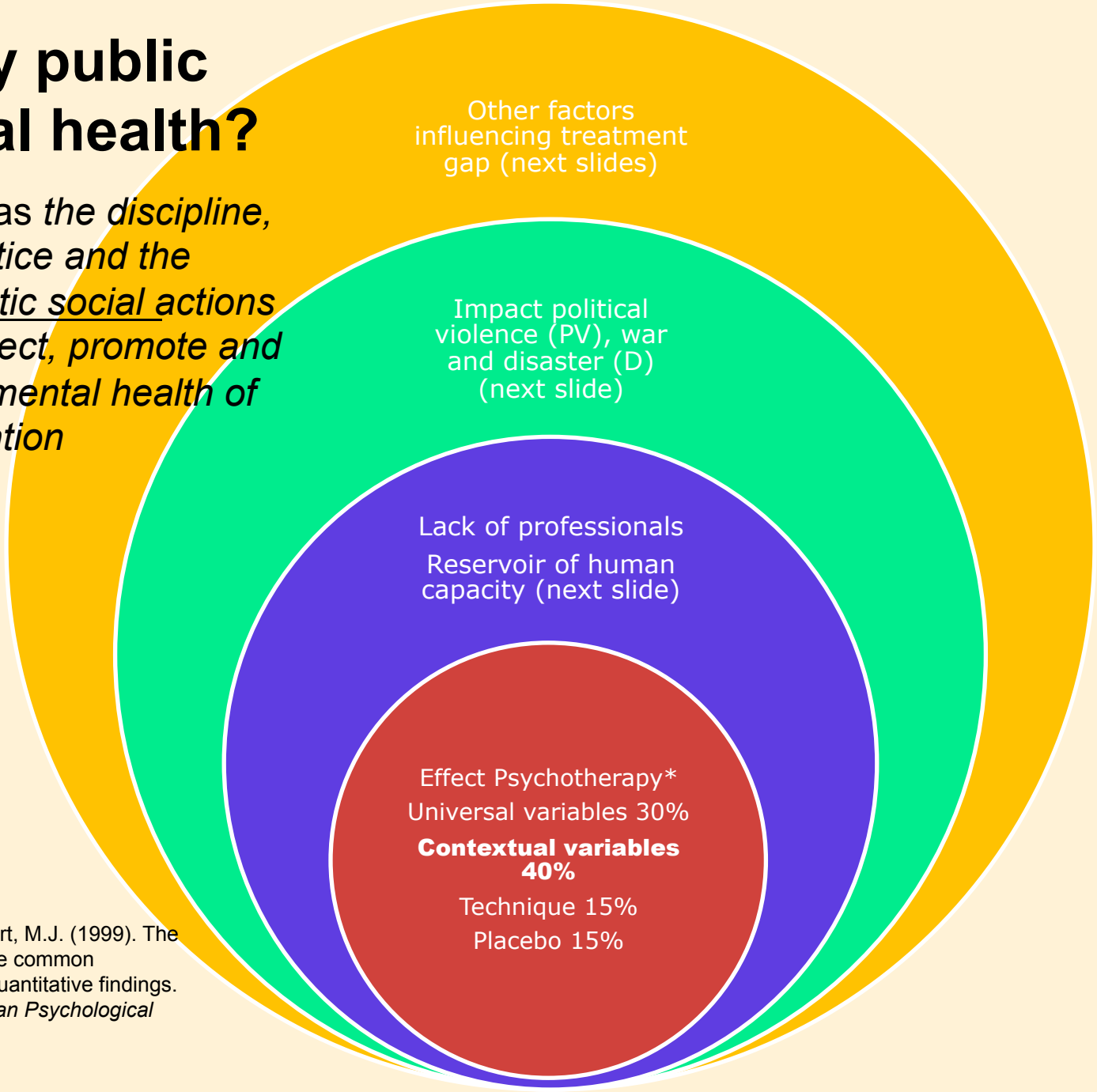
Top hosting countries



UNHCR 2016

Why public mental health?

defined as *the discipline, the practice and the systematic social actions that protect, promote and restore mental health of a population*



*Asay, T.R, & Lambert, M.J. (1999). The empirical case for the common factors in therapy: Quantitative findings. *Washington: American Psychological Association.*

Treatment gap in normal times versus disaster and war

Situation in times of peace

- Burden of Mental Disease in LMIC (11%) > contribution tb, HIV/ AIDS and malaria
- 24% of cases in developed countries and 6% in LMIC receive treatment
- Same for child and adolescent mental health

9/11

Peace & Disaster
treatment gap larger due to **Beneficiary** factors

- Expression psychopathology (depression, anxiety, ptsd, idioms of distress)
- Different EMs, illness behavior
- Suffering experienced in spiritual, religious, family, community terms
- Beneficiaries belong to different ethnic group than providers

Post-disaster/conflict:
treatment gap larger due to **Service delivery** factors

- Few resources (infrastructure, human, policies)
- Even fewer professionals: exodus, genocide
- Delivery models not prepared for mass stress, due to social or colonial history
- Professionals little training in (trauma-focused) therapy
- Survivors in rural areas, intellectuals in cities
- State sector weak: private practice at the expense of the public sector and the rural areas

Outline

- Why public mental health?
- **Public Mental Health in two steps**
  - **Some basics of the model**
- A bird’s eye view on global mental health coverage
- Some major challenges the future

Basic principles of the model

- Accommodates different age groups
- Is resilience, ecology and family-oriented
- Uses a spectrum approach towards mental health and psychosocial services (MHPSS)
- Describes universal steps used in an eclectic integrative way, going from a few interventions for many, to many for few

Basic principles of the model (cont)

- Starts bottom-up and gradually collaborates with mental health services or academia or vice versa
- Disaster Public Mental Health not totally different from day-to-day care: continuum of social, physical and psychological support →
- Model fits times of peace, disaster, conflict
- Compatible with other models (Protective or Child right approach, the CBR model, the Torture Center Model, IASC or SPHERE guidelines)

Outline

- Why public mental health?
- **Public Mental Health in two steps**
  - **A few words on prevention**
- A bird’s eye view on global mental health coverage
- Some major challenges the future

Speaking briefly about primary prevention

- On a local and a global scale, whether a disaster strikes in a HIC or LIMC, is a more important predictor than the type of disaster, both in terms of casualties, psychological distress, and the burden of refugees →
- Addressing social inequalities worldwide is the best prevention for war **and** physical/ mental disorder

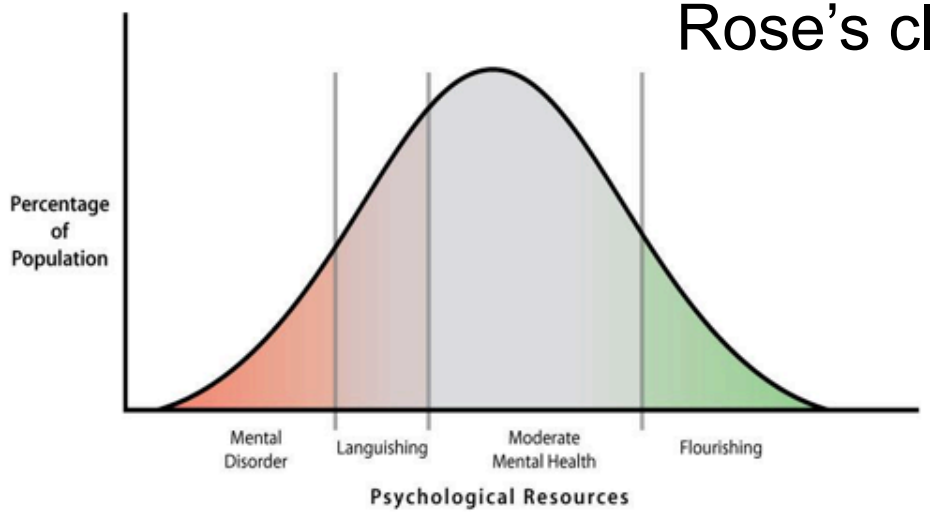
Daar et al 2007 *Nature;* Collins et al 2011 *Nature;* De Jong, 2010 *SSM*

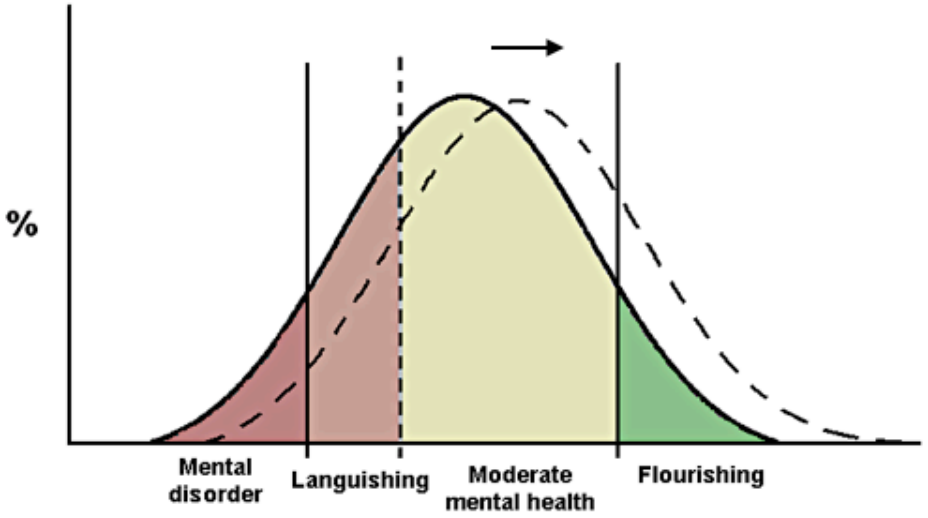
Common predictors of political violence & ill health and the possibility of prevention

Predictor	Human rights violation	Lack of social justice
Faulty governance/ Lack of democracy •Inequality/inequity •Marginalization of groups •Lack of intersectoral collaboration •Health and nutritional indicators per se	•Criminalization of the state •Faulty leadership/ Corruption •Widening socio-economic inequalities/ struggle over access resources (oil, water) •Political power exercised differentially applied according to ethnic or religious identity •Poor interaction international agencies, governments and ngo's; poor engagement in preventive, rehabilitative, and reconstructive interventions that may fuel cycles of violence	• Low priority of health • Low government spending • Lack of health policy • Impaired access to sanitation, health, education • Differential access to services and differential outcomes for minorities, urban/ rural residents/IDPs • Lack of interconnection (sub)national policies, inability to address crucial social determinants mostly located outside the health sector

- Daar ea 2007 Nature
- Collins ea 2011 Nature
- Collier 2008
- WHO 2011 Determinants of public health
- De Jong 2010 SSM

Rose's classical curve





Shifting the mean of the mental health spectrum

Outline

- Why public mental health?

- **Public Mental Health in two steps**
- **Step 1. Pre-assessment**
- **Step 2. Selection criteria to define priorities**

- A bird’s eye view on global mental health coverage

- Some major challenges the future

What do you assess?

Core characteristics of the emergency (politicians, policy-makers, the UN/NGOs/CBOs; representatives district, local community, family): (Inter)agency plans & people's experiences and responses & threats

Resources and needs (Map HR & training resources, Current and previous social support mechanisms, Coping skills, Stigma, taboos and shame (e.g. GBV) Involve community leaders and traditional healers: causes emergency, mourning, reconciliation or cleansing rituals & timing)

Communities (ownership, participatory mapping and context analysis, risk analysis, community response plan incl early warning system, protection issues, past and present perpetrators; family separation, unaccompanied children, the elderly and the disabled, institutions and hospitals; ask about current safety and security concerns, facilitate reconciliation)

Cf. IASC 2007

Mostly with qualitative techniques

10 criteria to define priorities

1. Community concern
2. Prevalence & incidence

Complementarity of Criteria One and Two: Community Concern Prevalence

Qualitative research: social science

Assesses perceived needs/concerns, idioms of distress, CCD

Assesses suffering, psychological pain

Cyclical (once/1-2 years)

Assessment & reporting 2–8 weeks

Emic

Quantitative research: epidemiology

Assesses disorder and its distribution: depression, alcohol, PTSD

Assesses morbidity, mortality, disabil, qol

Cross-sectional, rarely longitudinal

Survey plus reporting 1-3 years

Etic/emic

10 criteria: complementary

1. Community concern
2. Prevalence
3. Severity (DALY, PARP, QOL, Stigma)
4. Treatability or feasibility
5. Sustainability

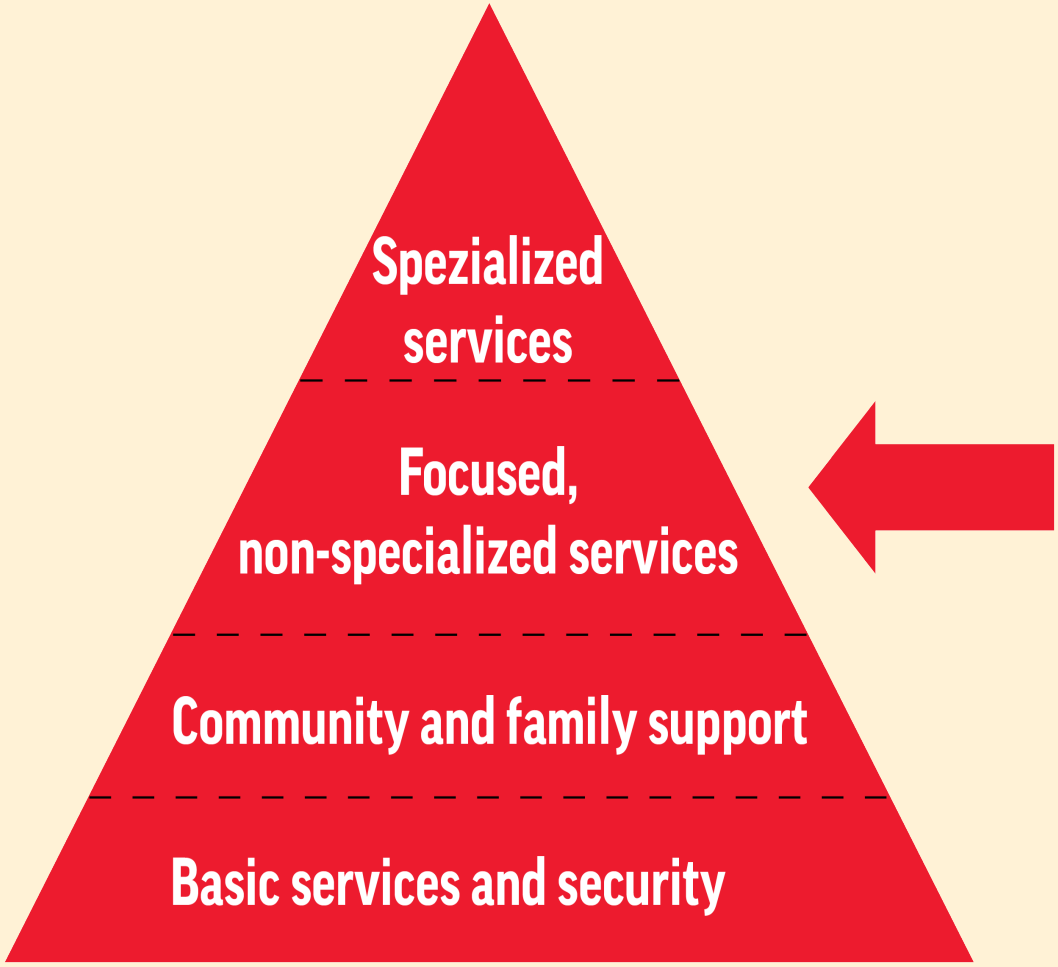
10 criteria: complementary

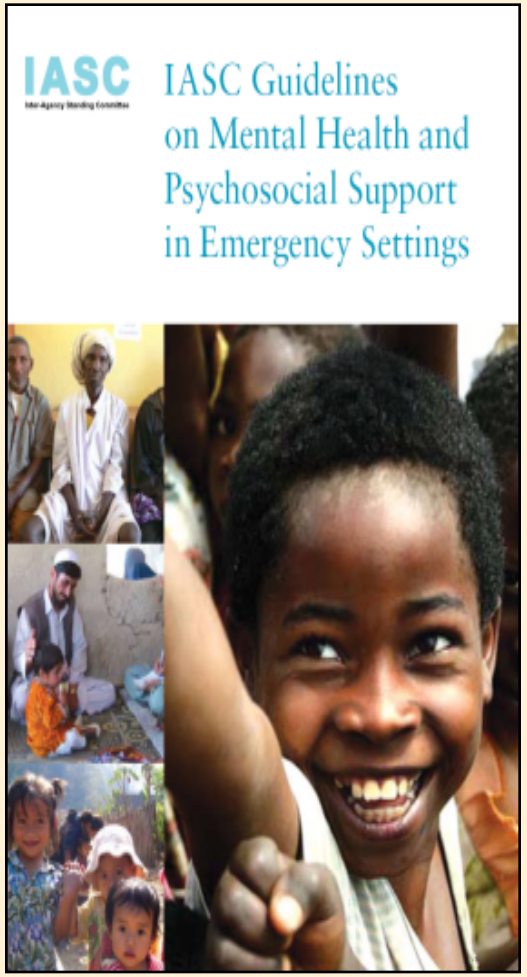
6. Knowledge, skills, availability of (mental) health care professionals
7. Political acceptability
8. Ethical acceptability
9. Cultural sensitivity
10. (Cost-)effectiveness, individual/societal

Outline

- Why public mental health?
- Public Mental Health in two steps
- **Step 2. Interventions**
- A bird’s eye view on global mental health coverage
- Some major challenges the future

International Guidelines: public health triangles and mansions





Interagency Standing Committee (IASC) 2007.
Guidelines of Mental Health & Psychosocial Support in Complex Emergencies

Step 2. Interventions: A multi-modal, multi-sectoral, multi-level Public Mental Health mansion

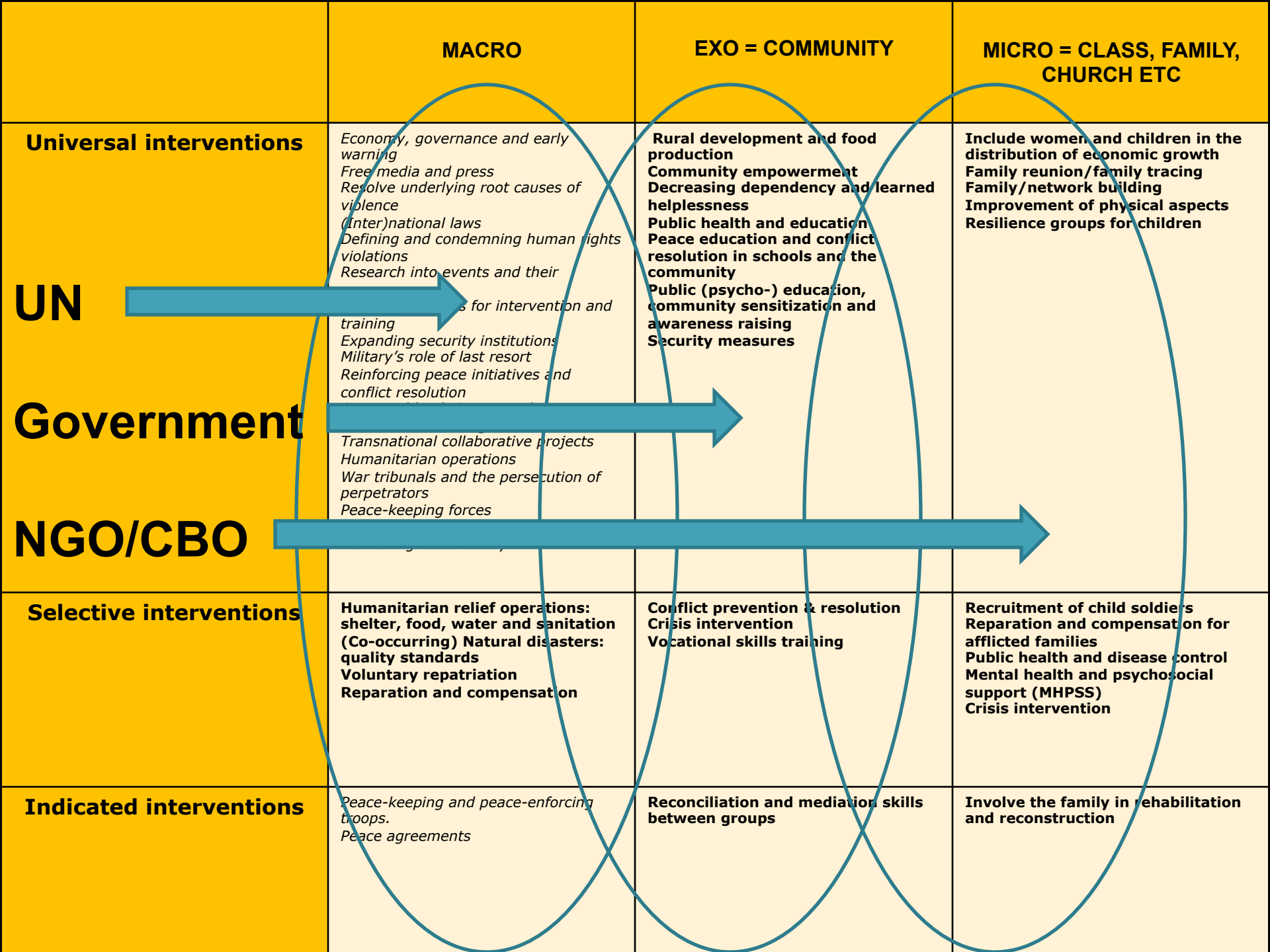
Step 2. Interventions

- The scaffolding of the PMH ‘mansion’

- Matrix showing the relation between Universal, Selective, and Indicated Preventive Interventions

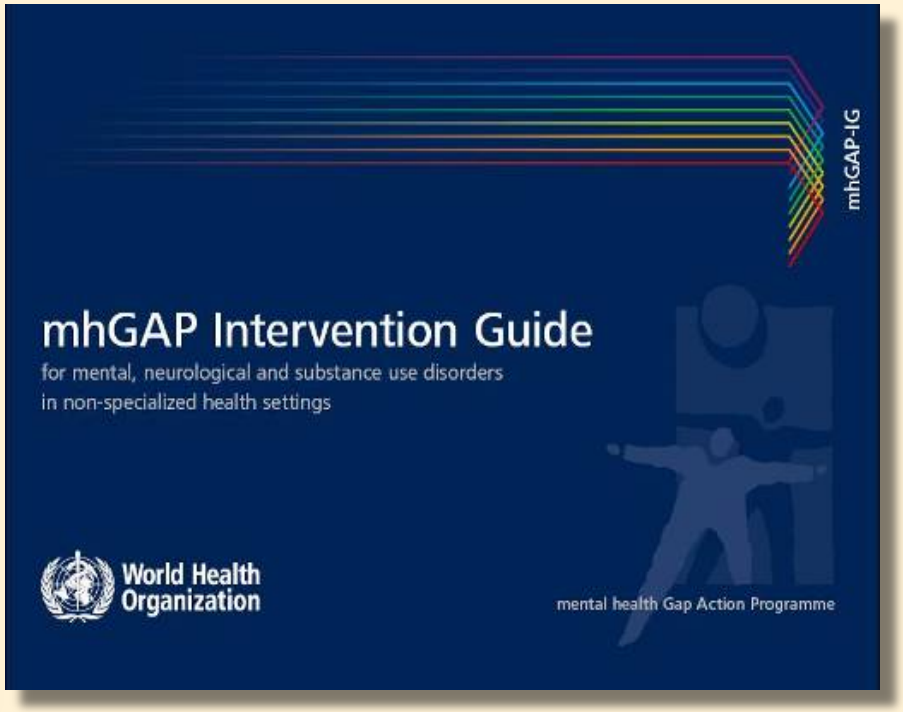
	MACRO	EXO = COMMUNITY	MICRO = CLASS, FAMILY, CHURCH ETC
Universal interventions			
Selective interventions			
Indicated interventions			

- Universal interventions are targeted at the general public or a whole population group that has not been identified on the basis of individual risk
- Selective preventive interventions are targeted at subgroups or individuals whose risk of developing a problem (e.g. a psychosocial problem or a mental disorder) is significantly higher than aver-age. The risk may be imminent or lifetime risk: think of accumulation of risk factors during emergencies
- Indicated preventive interventions are targeted at high-risk individuals who are identified as having minimal but detectable signs or symptoms foreshadowing a problem or a disorder.


MACRO
EXO = COMMUNITY
MICRO = CLASS, FAMILY, CHURCH ETC
Universal interventions
Economy, governance and early warning
Free media and press
Resolve underlying root causes of violence
(Inter)national laws
Defining and condemning human rights violations
Research into events and their
s for intervention and training
Expanding security institutions
Military's role of last resort
Reinforcing peace initiatives and conflict resolution
Transnational collaborative projects
Humanitarian operations
War tribunals and the persecution of perpetrators
Peace-keeping forces
Rural development and food production
Community empowerment
Decreasing dependency and learned helplessness
Public health and education
Peace education and conflict resolution in schools and the community
Public (psycho-) education, community sensitization and awareness raising
Security measures
Include women and children in the distribution of economic growth
Family reunion/family tracing
Family/network building
Improvement of physical aspects
Resilience groups for children
UN
Government
NGO/CBO
Selective interventions
Humanitarian relief operations: shelter, food, water and sanitation
(Co-occurring) Natural disasters: quality standards
Voluntary repatriation
Reparation and compensation
Conflict prevention & resolution
Crisis intervention
Vocational skills training
Recruitment of child soldiers
Reparation and compensation for afflicted families
Public health and disease control
Mental health and psychosocial support (MHPSS)
Crisis intervention
Indicated interventions
Peace-keeping and peace-enforcing troops.
Peace agreements
Reconciliation and mediation skills between groups
Involve the family in rehabilitation and reconstruction

	MACRO	EXO = COMMUNITY	MICRO = CLASS, FAMILY, CHURCH ETC
Universal preventive interventions	*Economy, democracy* *Free media and press* *Respect human rights* *Child rights advocacy* *Research* *Setting standards for intervention and training* *Peace education* *Conflict resolution*	*Poverty reduction (Rural development, food production)* *Community empowerment* *Conflict resolution in schools and the community* ***Public (psycho-) education, community sensitization and awareness raising (radio, TV, theater)***	***Non-violent upbringing*** ***Non-violent education***
Selective preventive interventions	*Development: water and sanitation, shelter, food*	*Vocational skills training*	***Public health & disease control*** ***Mental health and psychosocial support (MHPSS) next slide*** ***Crisis intervention***
Indicated preventive interventions	**De Jong (2010) Prevention consequences of war. SSM**		***Involve the family in rehabilitation***

2010: WHO launches the mhGAP Intervention Guide



Caveat:

Needs cultural adaptation and long-term implementation

In the meantime: explore other resources, religious, community, healing..

Treatment

- Treat those with medium high levels of distress

- These are the evidence based treatments for some major stress-related problems:

WHO Guidelines for Management of Acute Stress, PTSD & Bereavement

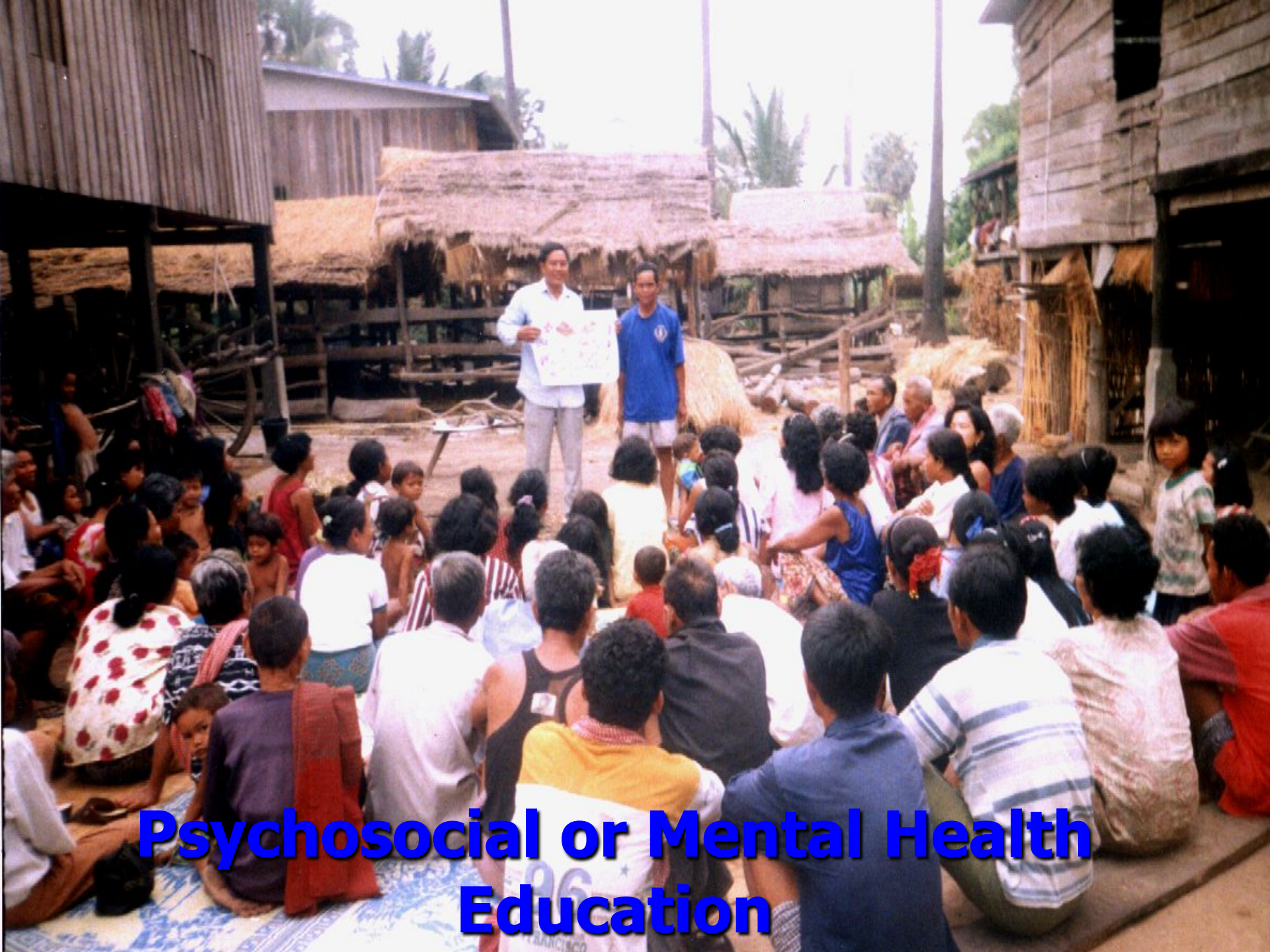
Tol et al. 2014 PLOS Med

Mental health condition	Recommendation
Acute traumatic stress	CBT with a trauma focus (CBT-T) should be considered in adults Benzodiazepines or antidepressants should not be offered to adults and children
Insomnia	Relaxation techniques, no benzodiazepines
Secondary nonorganic enuresis	No punitive responses, simple behavioral interventions
Hyperventilation	Paper bag should not be offered to children
PTSD	CBT-T, EMDR, stress management for adults & youth
	SSRIs and TCAs not first line treatment for adults & youth
Bereavement (without a mental disorder)	No structured psychological interventions, no benzodiazepines

Barriers to the delivery and uptake of mental health interventions

What is problematic with the existing evidence?

- Most evidence exists for PTSD by specialized professionals
- But often CMD, problems with daily tasks for survival & recovery
- For scalability, interventions should be of **short duration, simple**, to be carried out **in PC** or in **the community**
- Brief interventions may prevent more serious disorders (assumption)
- CBT, NET, EMDR good candidates, but need cultural adaptation and cultural competence
- Lack of family interventions
- Interventions should address **a range of outcomes**
- PM+ future candidate: 5-sessions, reduces *symptoms of depression, anxiety, PTSD, and related conditions*, *trained non-specialized workers or lay people*, individual and group formats (children and adults)
- PM+ uses EBT of (a) problem solving, (b) stress management, (c) behavioural activation, and (d) accessing social support



Psychosocial or Mental Health Education

បញ្ហាចិត្តសង្គម
Psychosocial problems

Self-help groups

Outline

- Why public mental health?
- Public Mental Health in two steps
- **A bird's eye view on global mental health coverage:**
  - **1 slide →**
- Some major challenges the future

The appalling state of affairs in global mental health (mh)

%	Burden	Mental health budget	Treatment Fys/Men	Budget residential	Aftercare
LIC	7,9	0,5	48 6	73	7
LMIC					
HMIC					
HIC	21,4	5,1	65 24	54	45

Development Assistance for Health 1990-2007: 5,6 bilion to 21,8 billion $ but not to MHPSS (IHME, 2010)

So? Develop a locally adapted public mental health plan

Outline

- Why public mental health?
- Public Mental Health in two steps
- A bird’s eye view on global mental health coverage
- **Some challenges**

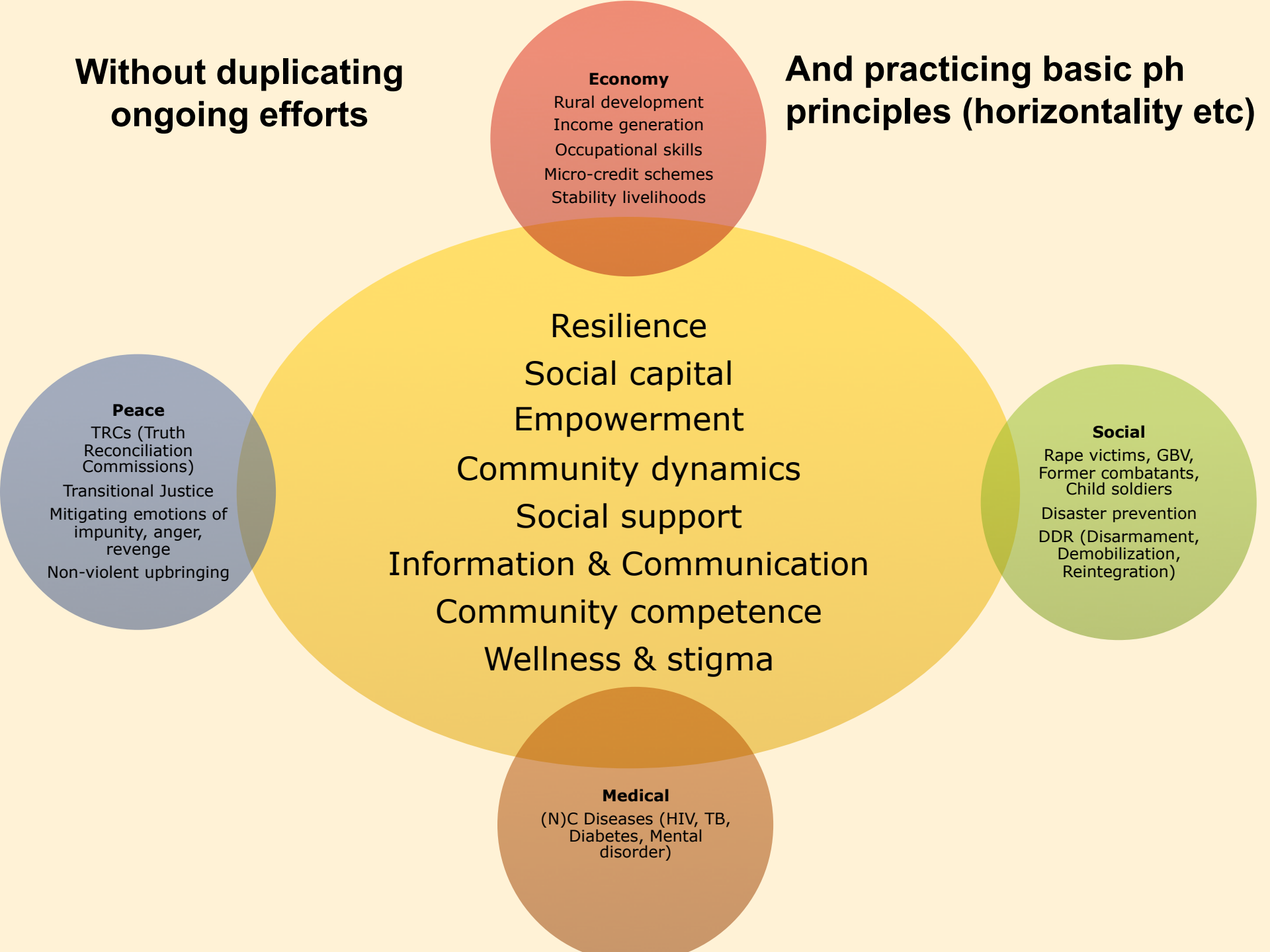
Challenge 1

- Practice ‘Alma Ata’

- Pool and share resources →

Without duplicating ongoing efforts

And practicing basic ph principles (horizontality etc)



Challenge 2

- Get culturally sensitive and competent

- Follow the debate on culture and psychopathology, eg the
  "PTSD & Culture" debate →


کل یوم عاشورا کل ارض کربلا

Culture and PTSD debate: Three major issues

- Ecological utility
- Validity/historicity
- (Politisation/medicalisation)

Ecological utility: PTSD not the most significant expression

Validity/historicity

- PTSD found around the globe
- Despite diagnostic validity trauma reactions not identical
- Culture influences
  - Local phenomenologies of post-trauma experiences
  - Local illness vocabularies, IODs
  - Mental and bodily experience (local ethnopsychology and ethnophysiology)
  - Attention to particular symptoms (eg somatic due to arousal, catastrophic cognitions)
  - Healing and ritual practices aimed at reducing symptoms
- Historicity: symptoms PTS change, a historical era expresses itself in an idiosyncratic way in the presentation of individual suffering

Challenge 3: Collaborating in addressing the mental health gap

- GMH realistic?
- Lacks innovation
- Unvalidated assumptions
- Faulty governments
- Collaborate with lay practitioners, local practitioners, community organisations

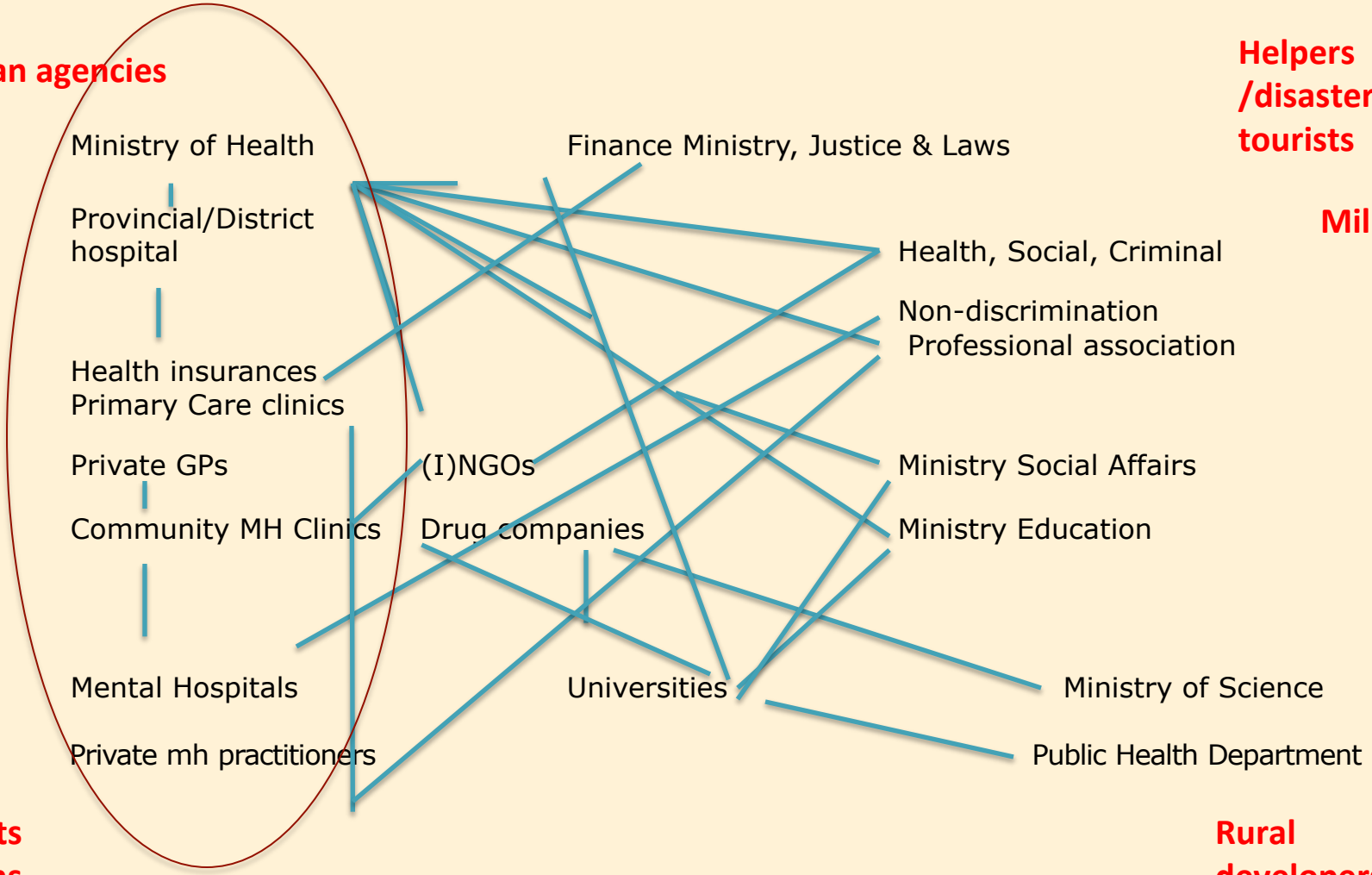
Add community, lay and healers' resources

- Evidence for lay practitioners
- Healers 'ideal' primary care workers
- Geographically, culturally and financially accessible
- Share the world view and villagers' meaning-making systems
- Wide variety of (systemic) psychological interventions
- LIC: 50-80%. HIC: 50% patients use CAM
- Modesty & research instead of depreciation?

Challenge 3: learn to think in health systems

- Few (N)GO policy planners use models to calculate the capacity of their mental health system on a national, regional or district level
- Try to distribute limited resources in proportion to demographics, socio-economics, national or social insurance, number of hospital beds, duration of hospitalization, incidence, suicide rates, or stigma

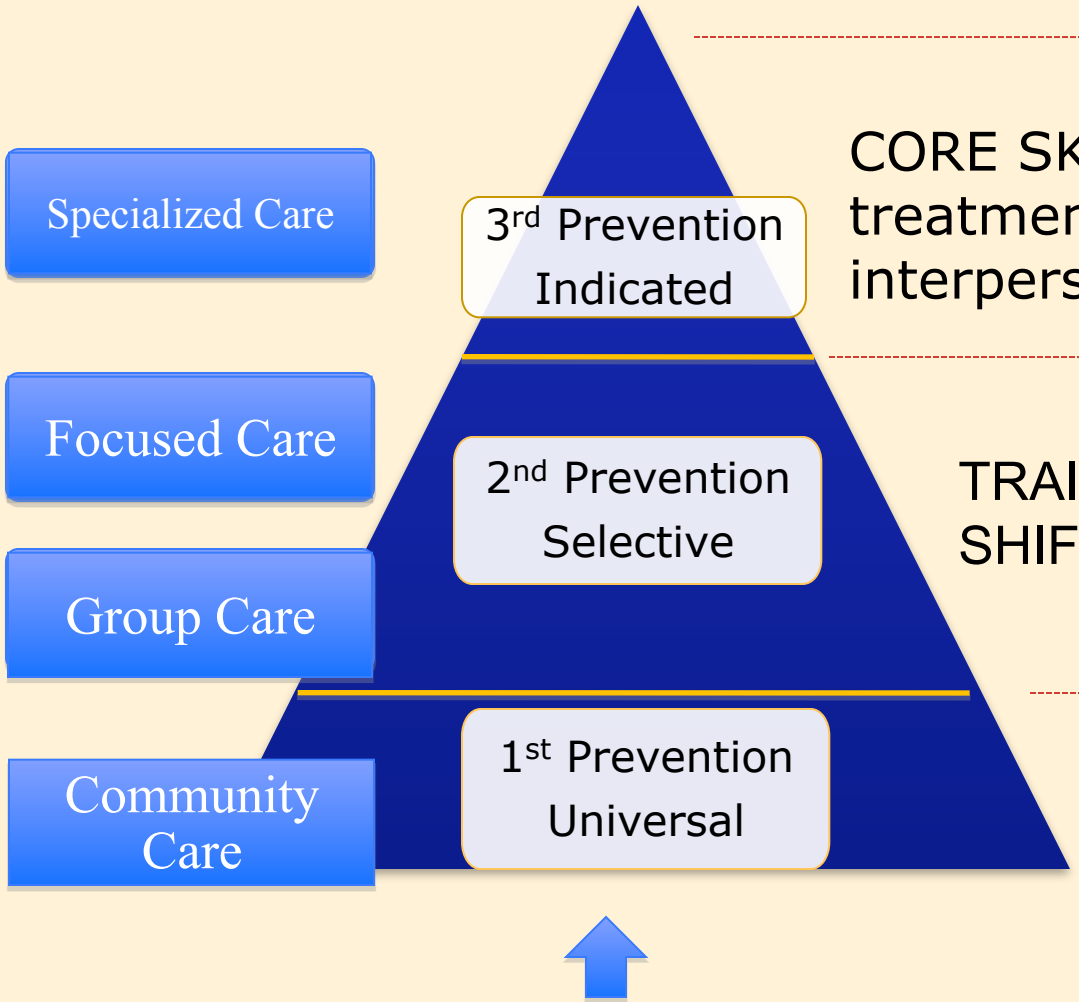
Complex systems



In other words

- Health systems in post-disaster rapidly become increasingly complex →
- We need additional competencies i.e. mental health professionals as core team players

Competencies Trauma Providers within a Public Mental Health Framework



CORE SKILLS
treatment referral consultation interpersonal

TRAINING TASK SHARING & SHIFTING

COLLABORATION
Healers? Churches? CAM

Poverty Reduction | Peace & Security | Education | Health

Cf Jordans et al 2010 JChildPsychPsychiat; 2012 PLOS. Tol et al 2008 JAMA; 2010 JCCP

Challenge 4: reflect on some aspects of psychology

- Eg resilience as an ecological concept

Resilience: From individual to ecological

Ind

- *people's ability to withstand the most negative consequences of stressful challenges*

Ind

- *those who when faced with major life challenge either develop few or no symptoms of pathology, or who perhaps after experiencing moderate symptoms, recover quickly* (Bonanno, 2004)

Ind

- *the extent people remain vigorous, committed, and absorbed in important life tasks, even amidst significant challenge* (Hobfoll & De Jong, 2014)

Ecol

- *those assets and processes existent on all social-ecological levels that have shown to have a relationship with positive outcomes after exposure to situations of mass distress* (Tol et al 2009; Ungar 2012)

.

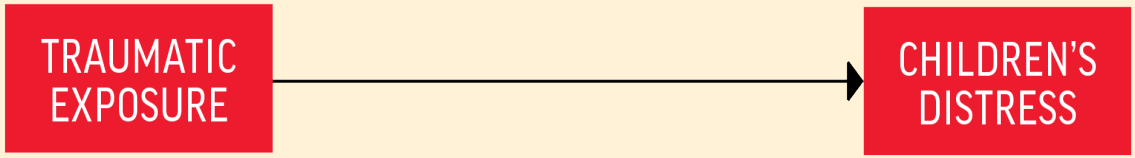
- Eg Liberia: village-level traumatic and individual experiences as well as wealth inequality important determinants of posttraumatic stress (Rockers et al.2010). Katrina: not being insured, degree of home destruction, and human loss strongest predictors (Lee et al 2009)

Challenge 4: rethink some aspects of psychology (cont)

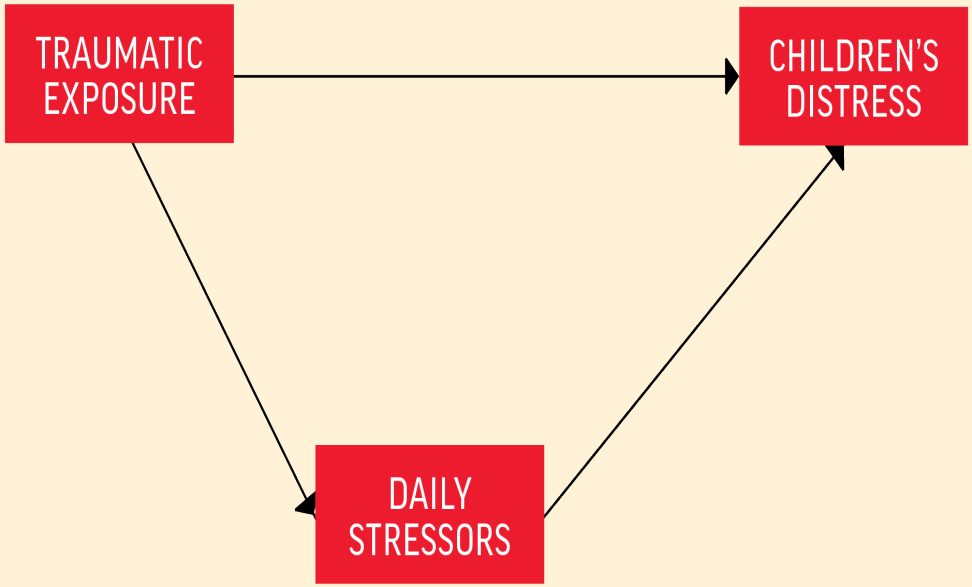
- Eg resilience as an ecological concept, which is related to the stress models we use:

DISASTER/WAR EXPOSURE MODEL. Example children

- Psychiatric epidemiology typically focused on a trauma-exposure model: association between ‘traumatic events and current mental health status’
- Primary focus was on measuring and treating war-related PTSD

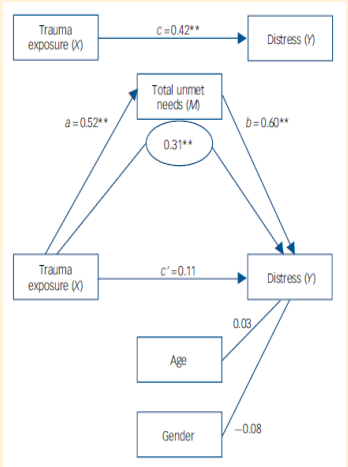


MODEL WITH DAILY STRESSORS



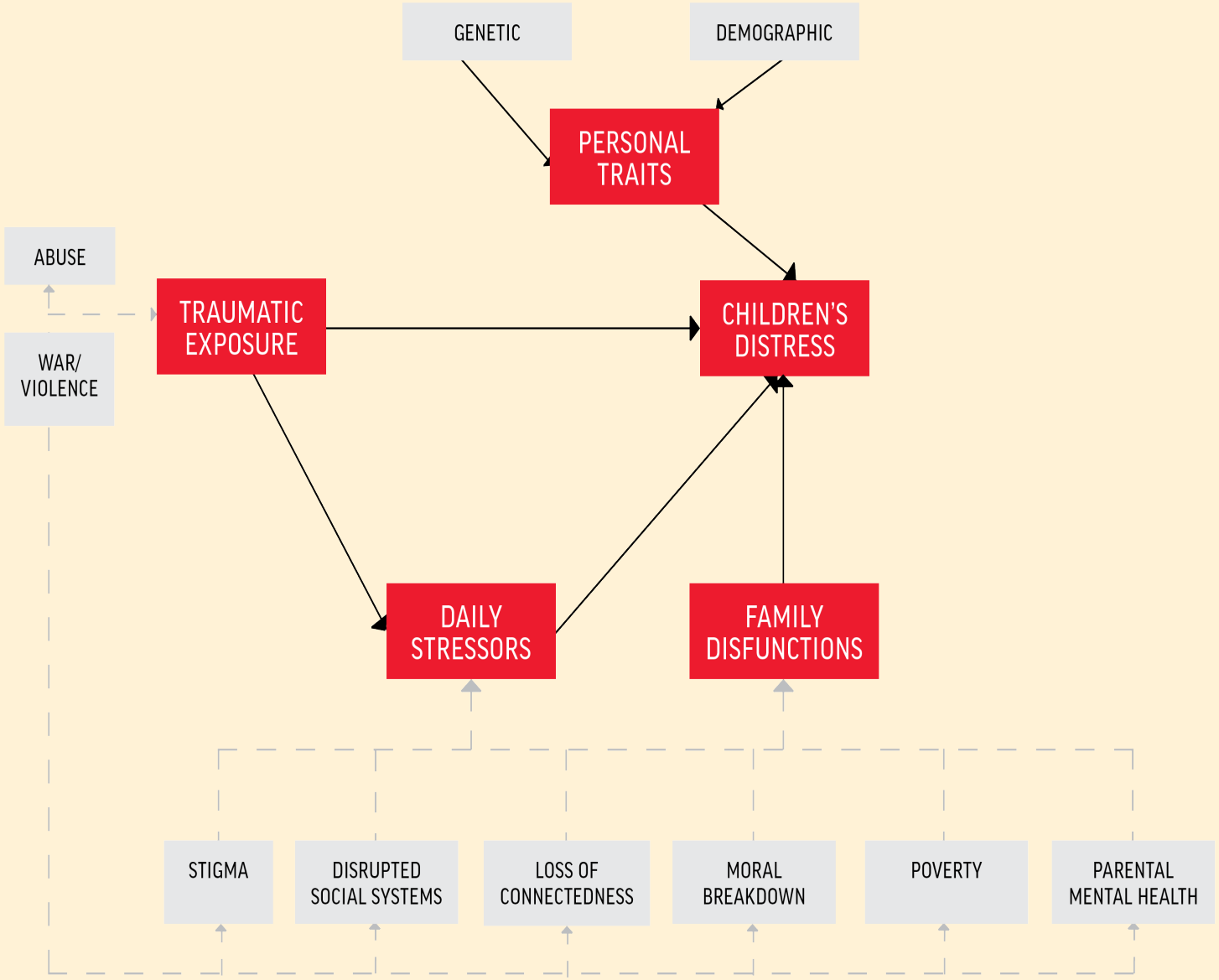
What about non-traumatic stressors?

- Social isolation
- Poverty, lack of access to basic resources
- Discrimination
- Family violence
- Chronic uncertainty (eg among asylum-seekers)
- Insecurity



Current stressors were found to mediate the association between past traumatic exposure and distress

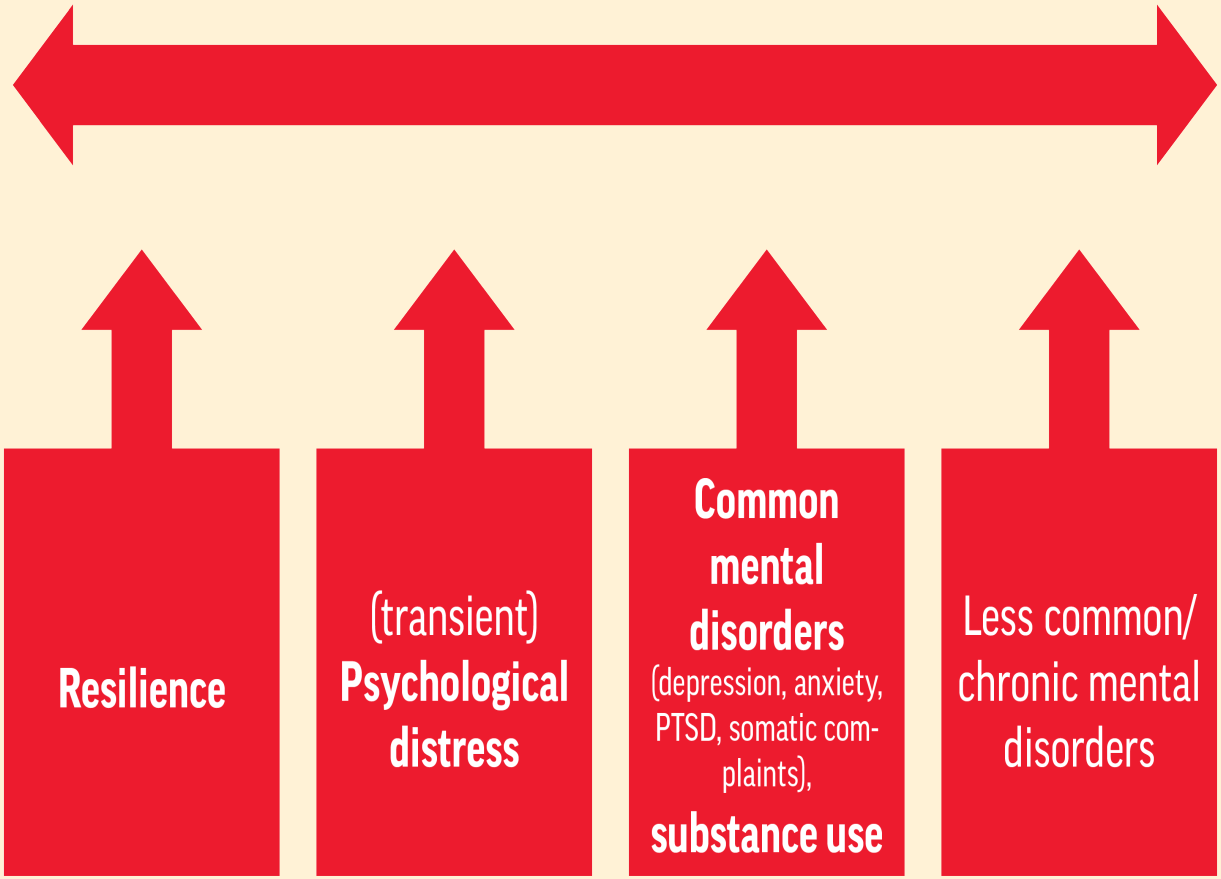
ACTUAL STORY IS EVEN MORE COMPEX



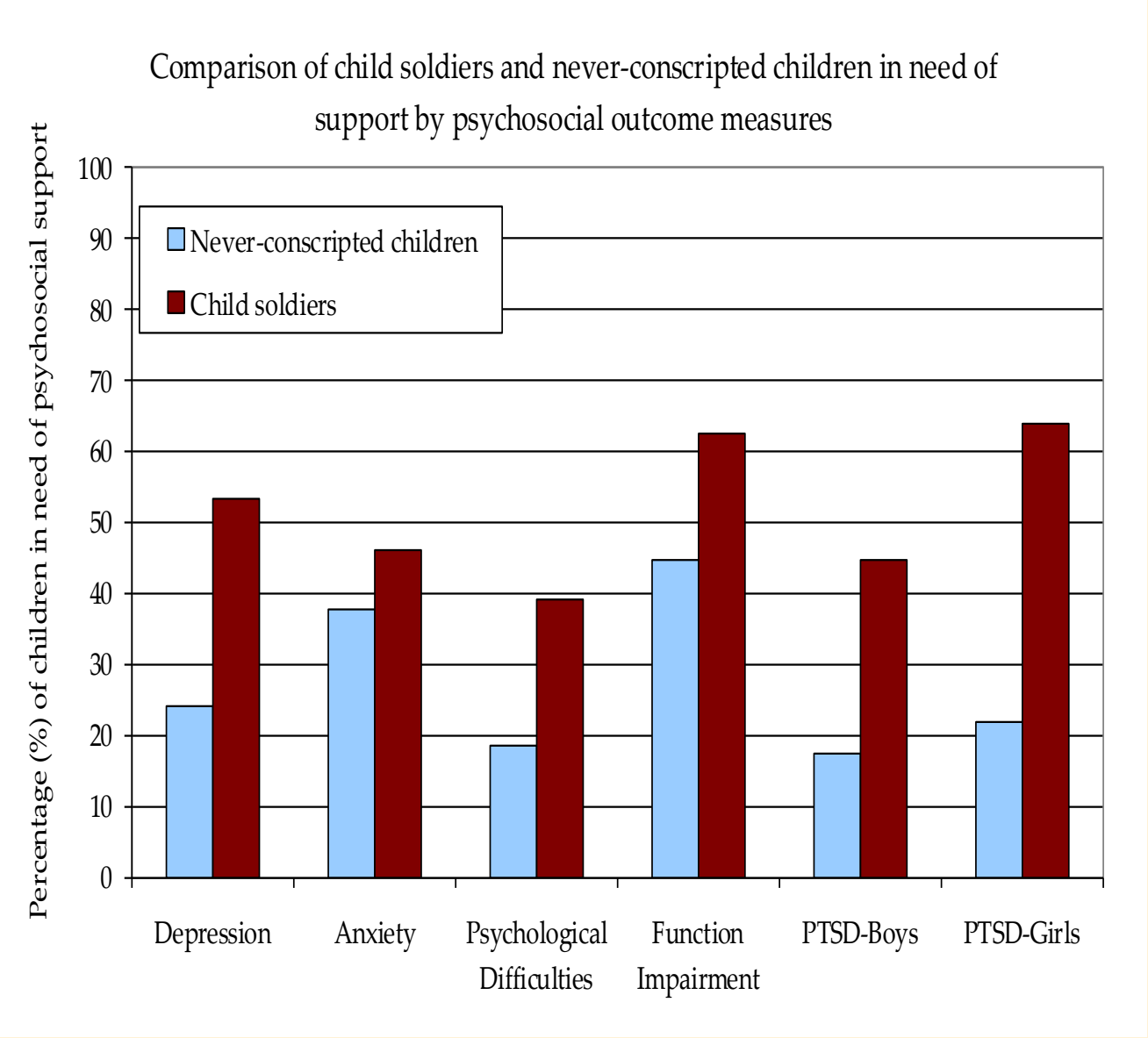
PROBLEM MANIFESTATIONS

- Meta-analysis of 17 studies (n=7,920)
    - PTSD: range 4.5 – 89.3% (47%)
    - Depression (43%)
    - Anxiety (27%)
- But also:
    - Drop out from schools
    - Sleep problems
    - Concentration problems
    - Anger, aggression, acting out
    - Isolation
    - Grief, sadness, emotional problems
    - Moral problems: disobedience, early sexual behaviors, gang-like behaviors
    - Substance abuse

SPECTRUM

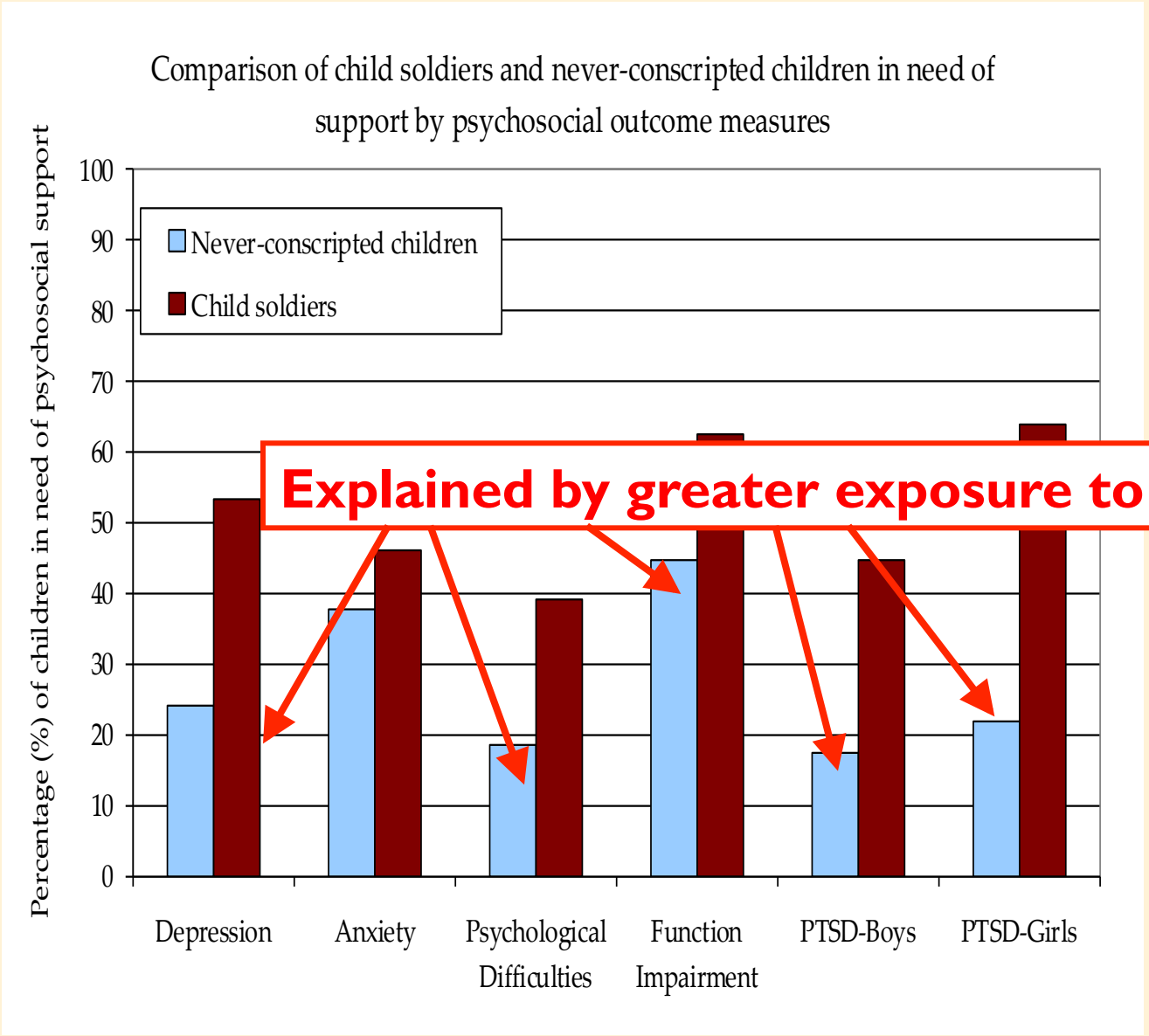

Resilience
(transient)
Psychological distress
Common mental disorders
(depression, anxiety, PTSD, somatic com-plaints),
substance use
Less common/ chronic mental disorders

EXAMPLE: FORMER CHILD SOLDIERS NEPAL



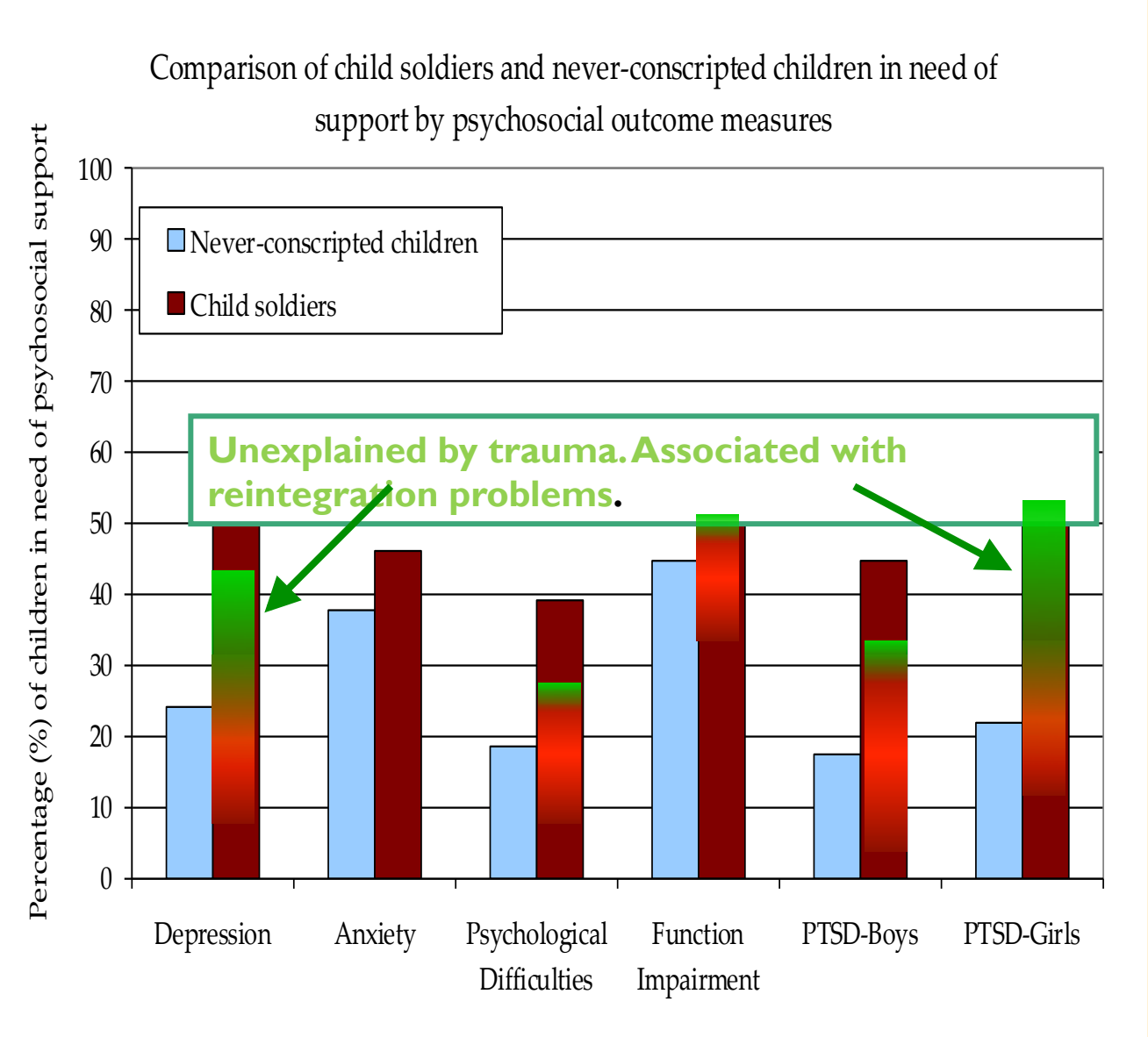
Kohrt BA, Jordans MJD, Tol WA, Perera E, Karki R, Koirala S, et al. Social ecology of child soldiers: child, family, and community determinants of mental health, psychosocial well-being, and reintegration in Nepal.Transcult Psychiatry 2010; 47: 727–53.

EXAMPLE: FORMER CHILD SOLDIERS



Kohrt, B. A., Jordans, M. J. D., Tol, W. A., et al (2008) Comparison of mental health between former child soldiers and children never conscripted by armed groups in Nepal. JAMA, 300, 691–702.

EXAMPLE: FORMER CHILD SOLDIERS



Conclusion

- The PMH model accommodates a variety of preventive and curative interventions
- Multi-sectoral, multi-modal and multi-level preventive principles that can be applied in an integrative and eclectic way
- Prevention to be molded to the requirements of the specific socio-cultural contexts
- The model helps to clarify the complementary relationship between the UN and (Non)Governmental actors
- It shows how the sectors of health, education, social affairs, human rights, gender and rural development can collaborate
- The model may help to identify gaps in our knowledge and to guide the future elaboration of a preventive approach

Conclusion (cont)

- We need to pool resources, to understand the PTSD and Culture debate, learn to address health systems, and reflect on our resilience and stress models

- Thank you for your attention

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Wake up on the ‘mhGAP’

- Downsides medical discourse WHO’s mhGAP policy in LMIC:
- Inward looking hospital vs public health
- Psychiatric facility absorbs majority of financial resources, leaving limited-to-no funds, nor the desire to deinstitutionalize or decentralize
- Private practice at the expense of the public sector and the rural areas
- Basic coverage will take decades. Caveat HIC