

The Global Mental Health Advocacy Working Group

Welcomes you to honor World Mental Health Day

Mental Health Needs In A Humanitarian Crisis





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Invites you to honor World Mental Health Day*

Mental Health Needs In A Humanitarian Crisis

Please join us for a panel discussion on the occasion of World Mental Health Day focused on living with chronic and severe mental illness in humanitarian emergencies and refugee settings. The speakers will examine the vulnerabilities and needs faced by individuals living with severe and chronic mental disorders and highlight opportunities and challenges to improving availability of accessible and appropriate mental health services while meeting other basic needs and to promoting social inclusion settings.

SPEAKERS

KELLY CLEMENTS, Deputy Assistant Secretary Bureau of Population, Refugees, and Migration, U.S. Department of State
DR. INKA WEISSBECKER, Global Mental Health and Psychosocial Advisor, International Medical Corps
DR. JAMES GRIFFITH, Leon M. Yochelson Professor and Chair Dept. of Psychiatry and Behavioral Sciences
George Washington University School of Medicine and Health Sciences

MODERATOR

ANNIE SOVCIK, ESQ, Director of the Washington Office, the Center for Victims of Torture

**Friday, October 10th, 2014
10:00 - 12:00 PM**

**Kaiser Family Foundation's Barbara Jordan Conference Center
1330 G Street NW, Washington, DC 20005**

Refreshments will be served.

Please RSVP to Christine Hanahan at Chanahan@InternationalMedicalCorps.org
by Wednesday, October 8th



HealthNetTM



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Mental Health Needs In A Humanitarian Crisis

KELLY CLEMENTS

**DEPUTY ASSISTANT SECRETARY, BUREAU OF POPULATION, REFUGEES, AND MIGRATION,
U.S. DEPARTMENT OF STATE**

Kelly Clements has served as Deputy Assistant Secretary since March 2010 with responsibility for humanitarian issues in Asia and the Near East, the Office of Policy and Resource Planning, and the Comptroller's Office in the Bureau of Population, Refugees, and Migration. She served from April – August 2014 as Acting Deputy Chief of Mission at U.S. Embassy Beirut, Lebanon. As Deputy and then Director, she led the Office of Policy and Resource Planning from 2002 - 2010, where she was responsible for the Bureau's strategic planning, policy development, budget, and performance activities. She currently guides the Bureau's substantial humanitarian policy portfolio and articulates to the Department and interagency community sound stewardship of financial resources of over \$2 billion provided annually to major international and non-governmental organizations to protect and assist refugees, conflict victims, and vulnerable migrants worldwide.

Clements' career with the State Department began as a Presidential Management Intern in 1990. Early in her tenure, she was detailed to the Office of the U.N. High Commissioner for Refugees (UNHCR) in Bangladesh to assist and protect over 200,000 refugees fleeing Burma in 1992. She was also a member of the State Department's Iraq Task Force on Kurdish Refugees and Displaced Persons in 1991, which coordinated the U.S. Government's emergency response to the flight of 1.8 million Kurdish refugees to Turkey and Iran.

From 1993-1996, Clements served at the U.S. Mission to the United Nations in Geneva, Switzerland on a foreign service appointment. Shortly thereafter, she became Special Assistant to the Under Secretary of State for Global Affairs where she was responsible for communicating humanitarian policy issues to Department leadership. She was then the Bureau's Congressional and Non-Governmental Organization Liaison. Clements was deployed to Albania in 1999 to respond to the outflow of one million refugees from Kosovo and in early 2000, she was appointed Senior Emergency Officer for Europe, the NIS, and the Americas and later served as Balkans Assistance Coordinator.

Ms. Clements has a B.A. in International Studies (1988) and an M.A. in Urban Affairs (1990) from Virginia Tech. Clements is a career member of the Senior Executive Service.

Clements is married with two children.

DR. INKA WEISSBECKER

GLOBAL MENTAL HEALTH AND PSYCHOSOCIAL ADVISOR, INTERNATIONAL MEDICAL CORPS

Dr. Weissbecker is the Global Mental Health and Psychosocial Advisor for the International Medical Corps (IMC). In this role, she provides remote and on-site technical oversight and support to IMC project countries in the areas of assessment, program design, project implementation, and evaluation of mental health and psychosocial programs, which include integrated health and nutrition projects. She has completed field assignments in South Sudan, Ethiopia, Sierra Leone, Libya, Jordan, Lebanon, Gaza, Turkey, Syria, Afghanistan, Pakistan, and Japan. Dr. Weissbecker has been a contributor to several and global IASC and WHO guidelines and working groups. She has also served as an NGO representative of the International Union of Psychological Science to the United Nations (ECOSOC and DPI).

Her academic credentials include a PhD in Clinical Psychology specializing in health and public sector psychology from the University of Louisville and University of South Florida as well as an MPH in Global Health and Population Studies from the Harvard School of Public Health.

DR. JAMES GRIFFITH

**LEON M. YOCHELSON PROFESSOR AND CHAIR DEPT. OF PSYCHIATRY AND BEHAVIORAL SCIENCES
GEORGE WASHINGTON UNIVERSITY SCHOOL OF MEDICINE AND HEALTH SCIENCES**

Dr. Griffith is Professor and Chairman in the Department of Psychiatry and Behavioral Sciences at the George Washington University School of Medicine and Health Sciences. As a psychiatric educator, Dr. Griffith developed a psychiatry residency program at George Washington University that has been distinguished for its curriculum in cross-cultural psychiatry, global mental health, mental health policy, and psychosocial care for medically-ill patients. In his clinical research, Dr. Griffith has published extensively on family-centered treatment of psychosomatic disorders and chronic medical illnesses, including several books.

Currently, Dr. Griffith provides psychiatric treatment for immigrants, refugees, and survivors of political torture at Northern Virginia Family Services in Falls Church, VA. He has received the Human Rights Community Award from the United Nations Association of the National Capital Area and the Margaret B. and Cyril A. Schulman Distinguished Service Award from the George Washington University Medical Center, both for the training of mental health professionals and development of mental health services for survivors of political torture in the Washington metropolitan area. As an educator, he has received the Distinguished Teacher Award from the George Washington University School of Medicine and Health Sciences. He has been selected by the Washington Psychiatric Society as its 2003 Psychiatrist of the Year and for its 2014 Distinguished Service Award. Most recently, he was selected by Washingtonian Magazine as a 2014 “Top Doctor in Washington.”

ANNIE SOVCIK, ESQ

DIRECTOR OF THE WASHINGTON DC OFFICE, THE CENTER FOR VICTIMS OF TORTURE

Ms. Sovcik has spent almost ten years working on refugee, asylum and immigration policies. Prior to joining The Center for Victims of Torture, Ms. Sovcik was the Advocacy Counsel for the Refugee Protection Program at Human Rights First where she focused on laws and policies impacting refugees seeking asylum in the United States. Ms. Sovcik was also a Staff Attorney with the Access to Justice and Children’s Services units at Lutheran Immigration and Refugee Service. As a law student, she interned at the United Nations High Commissioner for Refugees office in Washington, DC and the Pro Bono Asylum Representation Program in Harlingen, TX. Prior to law school, Ms. Sovcik taught English in Shanghai, China.

She is a graduate of the University of New Mexico School of Law and received her B.A. in International Studies from the University of Denver. Ms. Sovcik is admitted to practice law in the State of Maryland and presently serves at the Vice-Chair of Refugee Council USA.

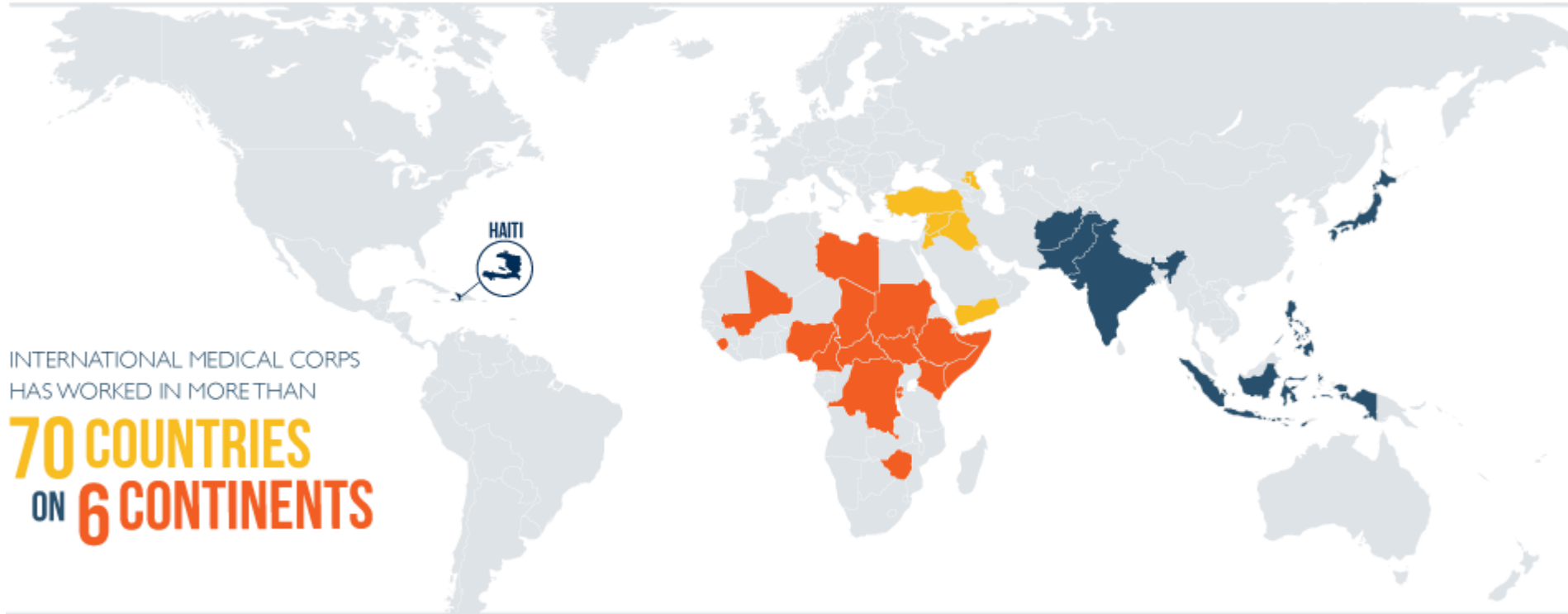
From Relief to Self-Reliance



Addressing Chronic and Severe Mental Health Problems During Humanitarian Crises: Why and How?

IMC Technical Unit
Dr. Inka Weissbecker, PhD, MPH
Global Mental Health and Psychosocial Advisor

Where do we Work?



INTERNATIONAL MEDICAL CORPS
HAS WORKED IN MORE THAN

70 COUNTRIES
ON 6 CONTINENTS

WE ARE CURRENTLY ACTIVE IN:

Addressing Chronic and Severe Mental Health Problems During Humanitarian Crises

- **Why?** 7 Reasons
- **How?** Basic principles and practical examples

7 REASONS FOR ADDRESSING CHRONIC AND SEVERE MENTAL ILLNESS DURING HUMANITARIAN CRISES

#1: PREVALENCE

Prevalence of MH Problems After Emergencies

	BEFORE EMERGENCY: 12-month prevalence (median across countries and across level of exposure to adversity) ^b	AFTER EXPOSURE TO EMERGENCY & DISPLACEMENT 12-month prevalence (median across countries and across level of exposure to adversity)
Severe mental disorder (e.g., psychosis, severe depression, severely disabling form of anxiety disorder)	2-3%	3-4% ^c
Mild or moderate mental disorder (e.g., mild and moderate forms of depression and anxiety disorders, including mild and moderate PTSD)	10%	15-20% ^d
"normal" distress / other psychological reactions (no disorder)	No estimate	Large percentage

MH diagnoses in five humanitarian settings

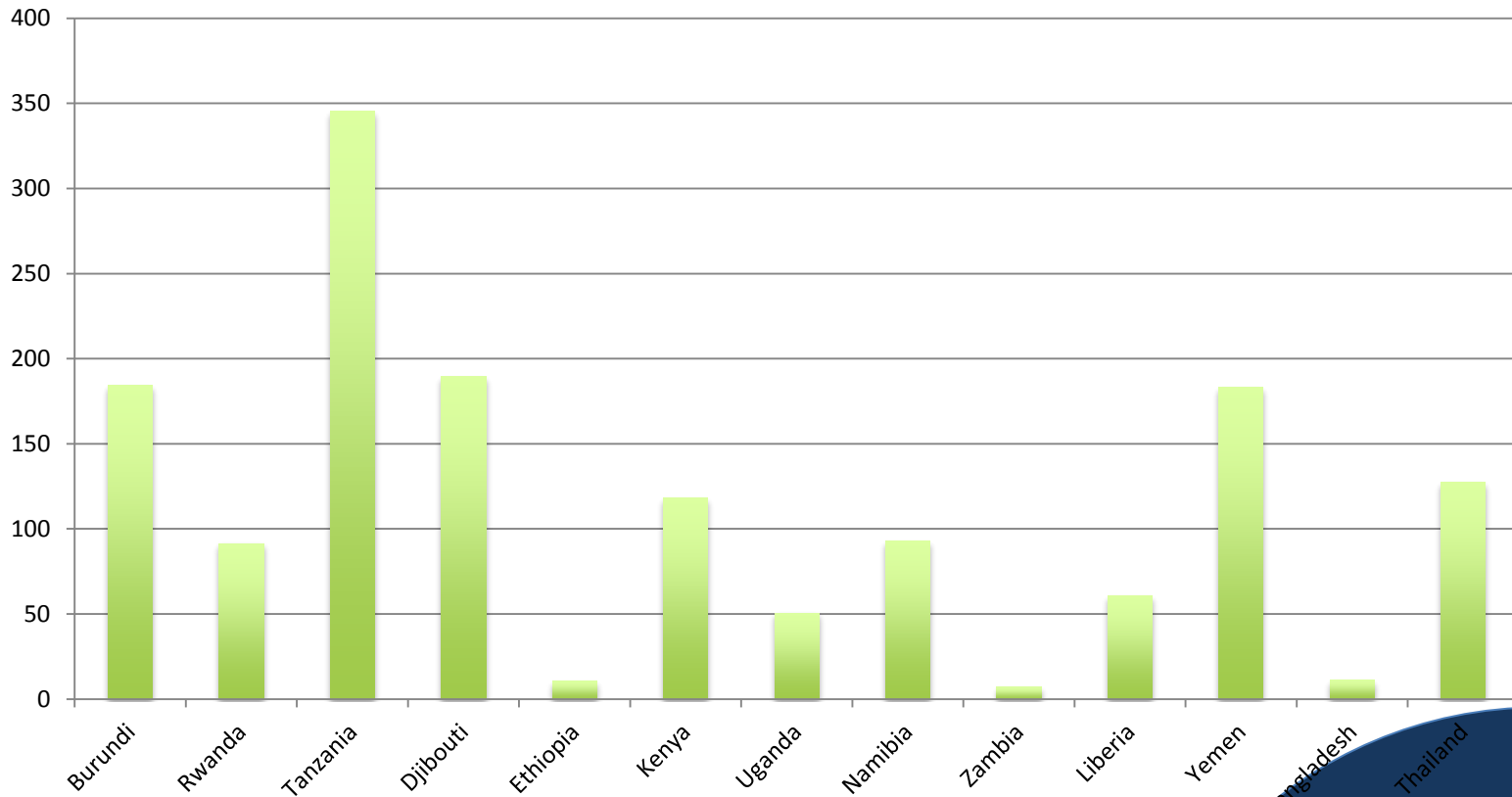
	ICD-10 code	Sierra Leone, November, 2004– March, 2005	Chad, July, 2005– March, 2006	Aceh, March, 2005– December, 2005	NWFP, December, 2005–May, 2006	Somali region, January, 2008– April, 2008
Dementia	F-00-F03†	2	9 (3%)	5 (1%)	1	1 (2%)
Organic brain syndrome	F 06†	0	0	2	5 (2%)	0
Substance dependence	F 12.2†	0	0	2	0	0
Substance-induced psychosis	F 12,5†	5 (3%)	1	5 (1%)	1	0
Schizophrenia, schizotypal, and delusional disorders	F 20–23†	10 (5%)	12 (4%)	85 (18%)	14 (6%)	20 (31%)
Other non-organic psychotic disorders	F 28†	35 (17%)	0	0	2 (1%)	0
Bipolar disorder, manic episode, psychotic depression	F 30–31,32.2†	8 (4%)	7 (2%)	11 (2%)	10 (4%)	4 (6%)
Depression‡	F 32	5 (3%)	47 (13%)	120 (25%)	92 (38%)	12 (18%)
Neurotic and somatoform disorders	F41–42;F44–49.3	1	35 (10%)	41 (9%)	5 (2%)	3 (5%)
Reaction to severe stress and adjustment disorders	F43.1–43.2	0	39 (11%)	92 (19%)	6 (3%)	4 (6%)
Mental retardation	F70–F79†	4 (2%)	38 (10%)	9 (2%)	13 (5%)	6 (9%)
Developmental disorders including PDD	F80–85†	0	3 (1%)	3 (1%)	3 (1%)	1 (2%)
Epilepsy	–†	122 (60%)	97 (27%)	14 (3%)	46 (19%)	4 (6%)
Others	–	1	42 (12%)	2	6 (3%)	1 (2%)
No psychiatric diagnosis	–	0	26 (7%)	49 (10%)	27 (11%)	8 (13%)
Information unavailable	–	11 (6%)	0	43 (9%)	12 (5%)	0
Severe neuropsychiatric disorders	–†	186 (91%)	167 (47%)	136 (28%)	95 (38%)	37 (55%)
Total	–	204 (100%)	356 (100%)	483 (100%)	243 (100%)	64 (100%)

Data are numbers (%). ICD-10=International Classification of Diseases, 10th revision. NWFP=North-West Frontier Province. PDD=pervasive developmental disorder. * Percentage figures have been rounded up.
 †These rows indicate severe mental disorders. ‡Depression indicates mild, moderate, or severe non-psychotic depression.

Table: ICD-10 diagnoses of cases at community-based emergency mental health clinics in five humanitarian settings*

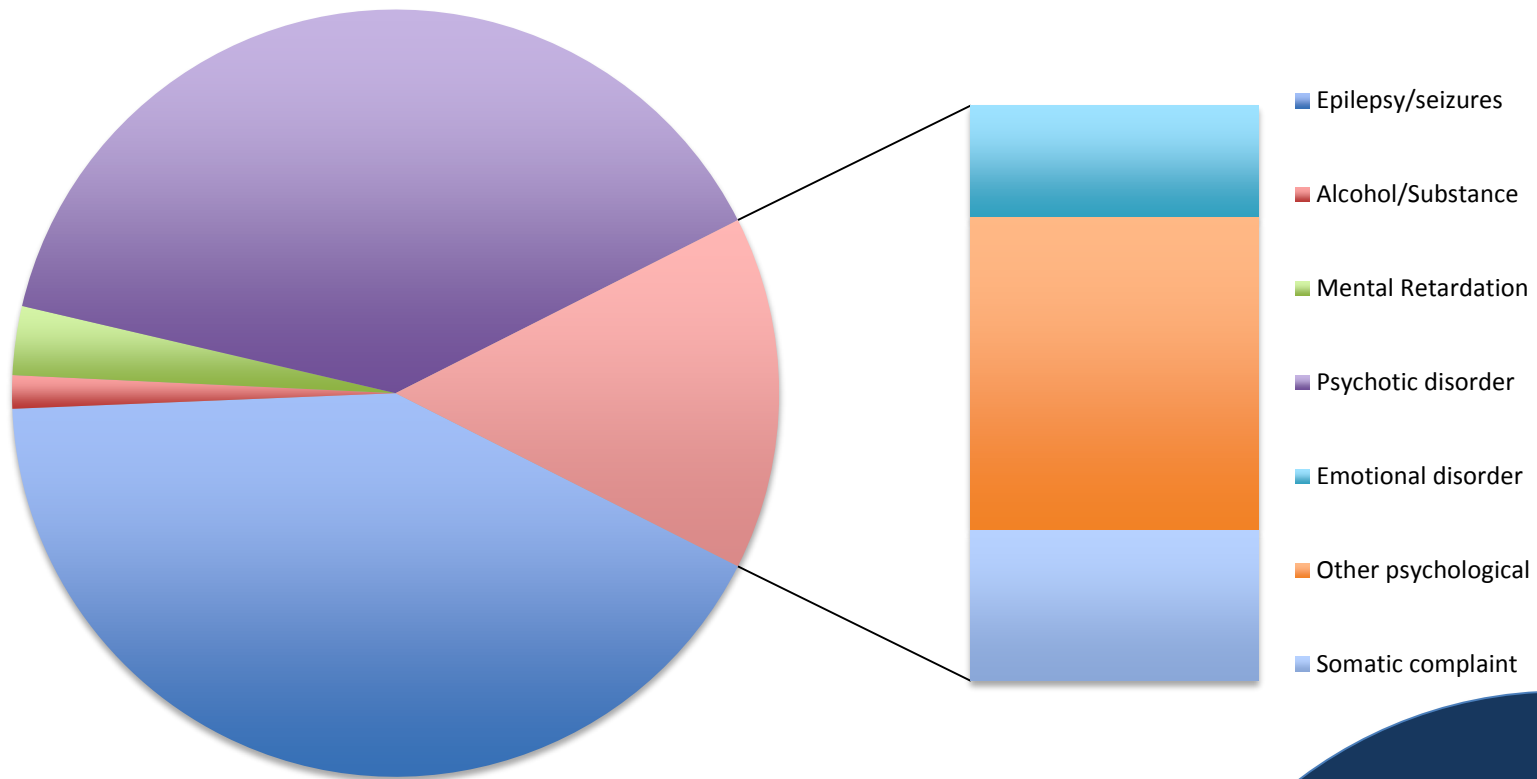
Source: Jones et al. (2009). Severe mental disorders in complex emergencies. Lancet.

+ Number of annual MNS consultations per 1000 refugees (UNHCR, 2009-2012)

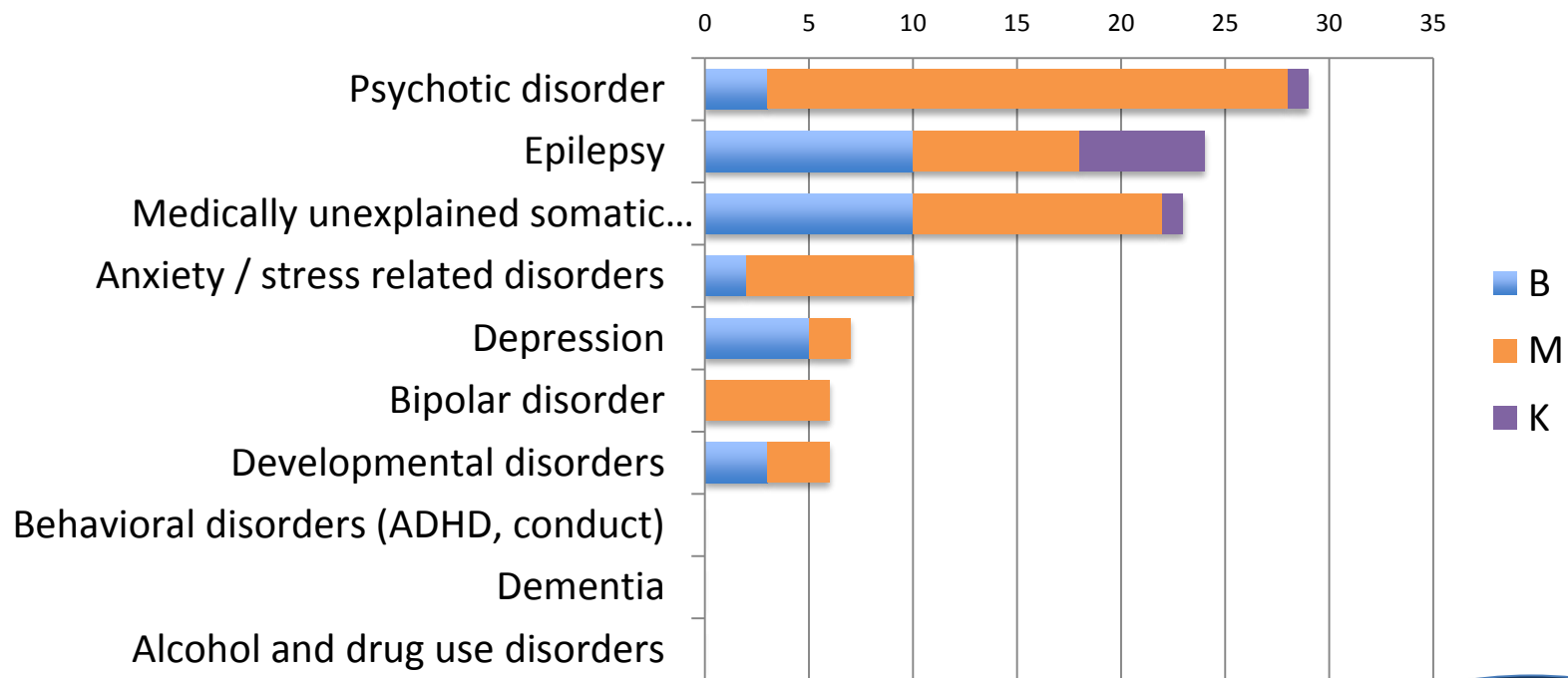




Breakdown of MNS categories (world, UNHCR, 2009-2012)

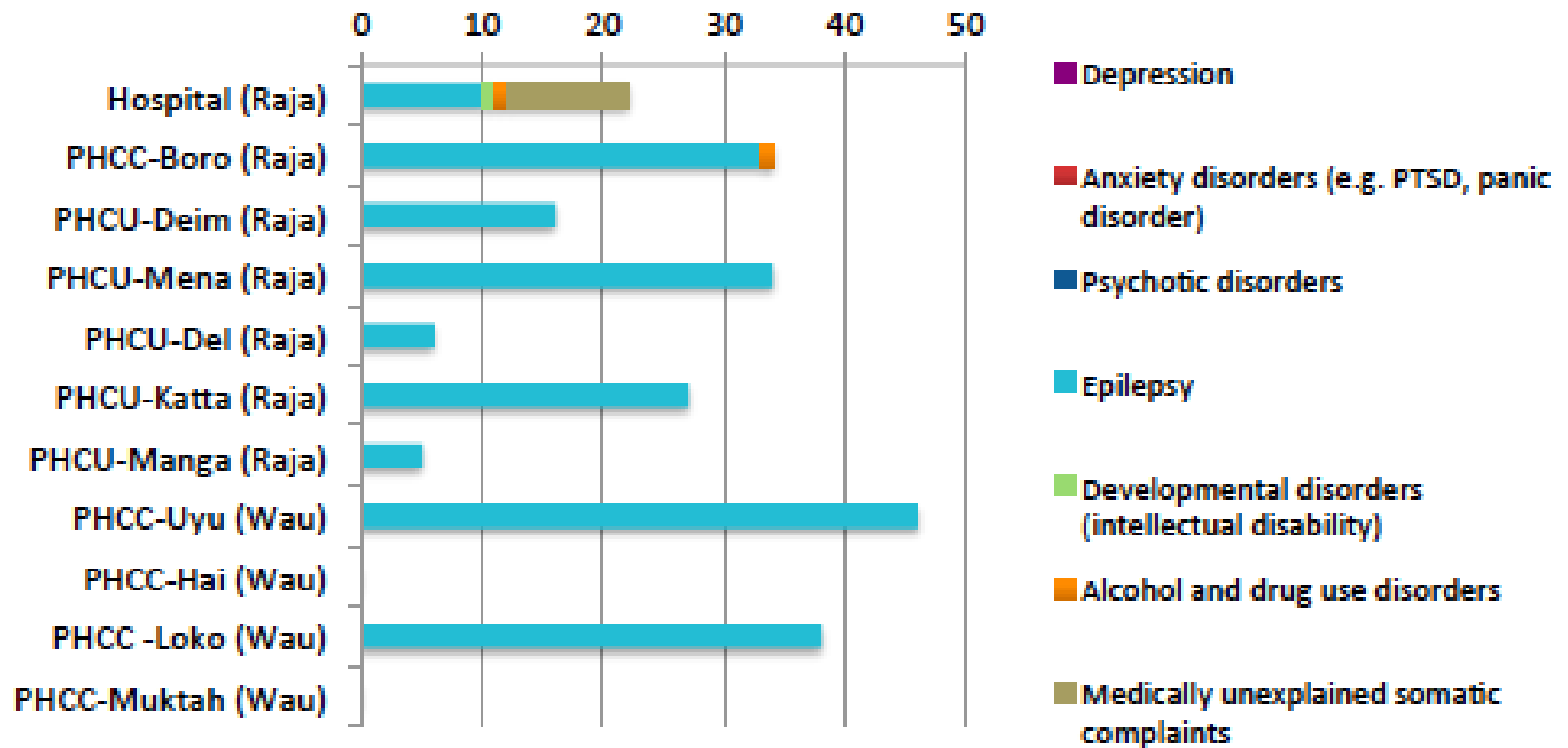


Ethiopia: Number of MNS cases recorded per month at Somali refugee camp health facilities (Dollo Ado)

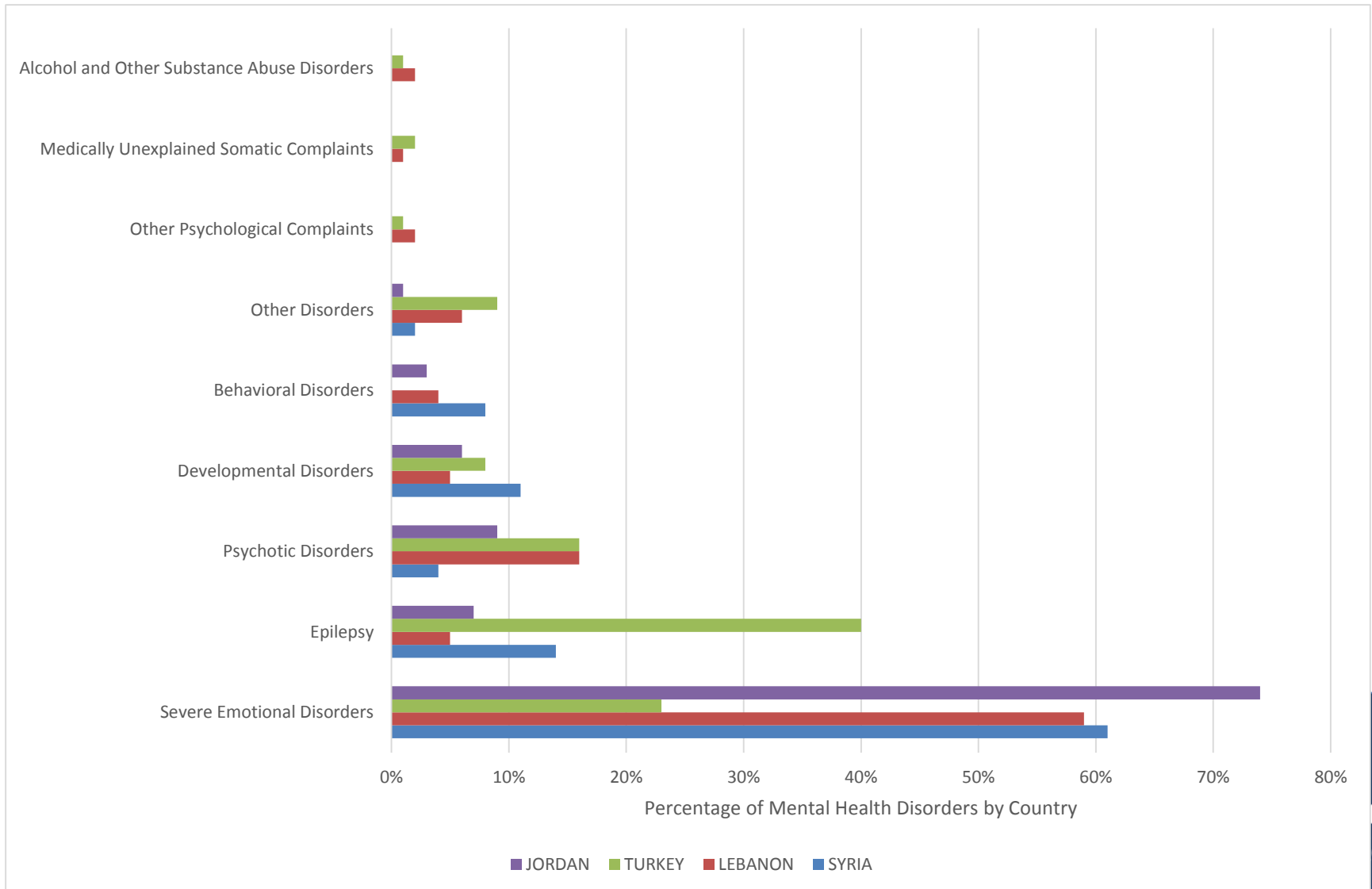


South Sudan : Number of MNS cases recorded per month at health facilities (Raja and Wau States)

Figure 1. Reported estimated number of mental health and neurological and substance use disorder cases over the past month.

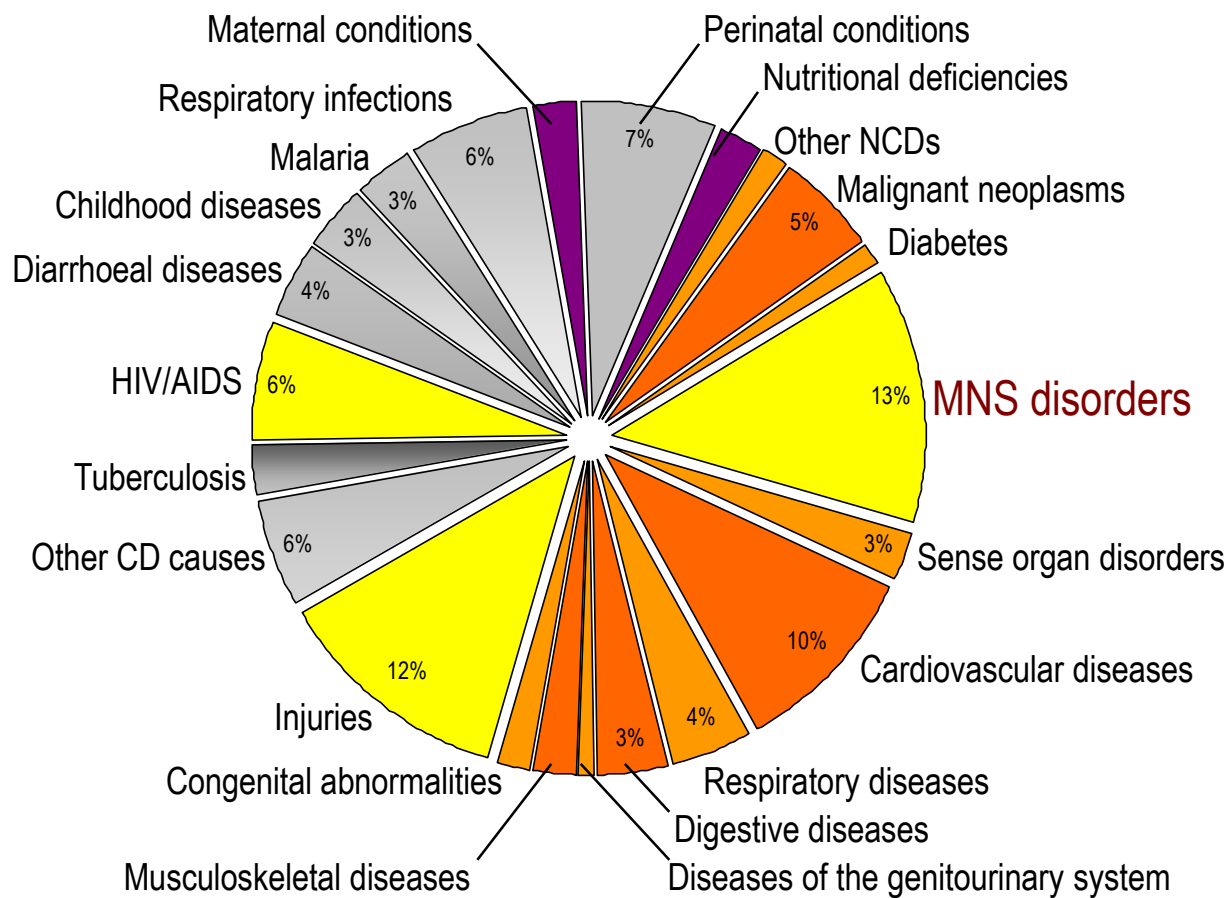


Middle East: % of MNS cases among Syrian Refugees receiving services at health facilities



#2: BURDEN AND IMPACT

Disease Burden (DALYs)



Impact of severe mental illness

- Impairment in day to day function
- Family impact
- Poor prognosis
 - Severe mental disorders associated with 2 to 3 fold increase in mortality, independent of suicide
 - In a 20-year study in South India of people with schizophrenia, the average age at death was 34.2 years compared to average life span of 60.5 years

#3: VULNERABILITY

People with severe mental health problems are especially vulnerable

- Stigma and Discrimination
- Violence and Abuse
- Human Rights Violations

“A person with a mental health problem is termed ‘Wawali’ meaning mad or crazy in Somali language. Once recognized as mad there is a belief that says ‘mad is mad’, so there will be job restriction, restriction from community activities, and someone with mental illness may even not be considered as being alive among some” ~ Camp counselor



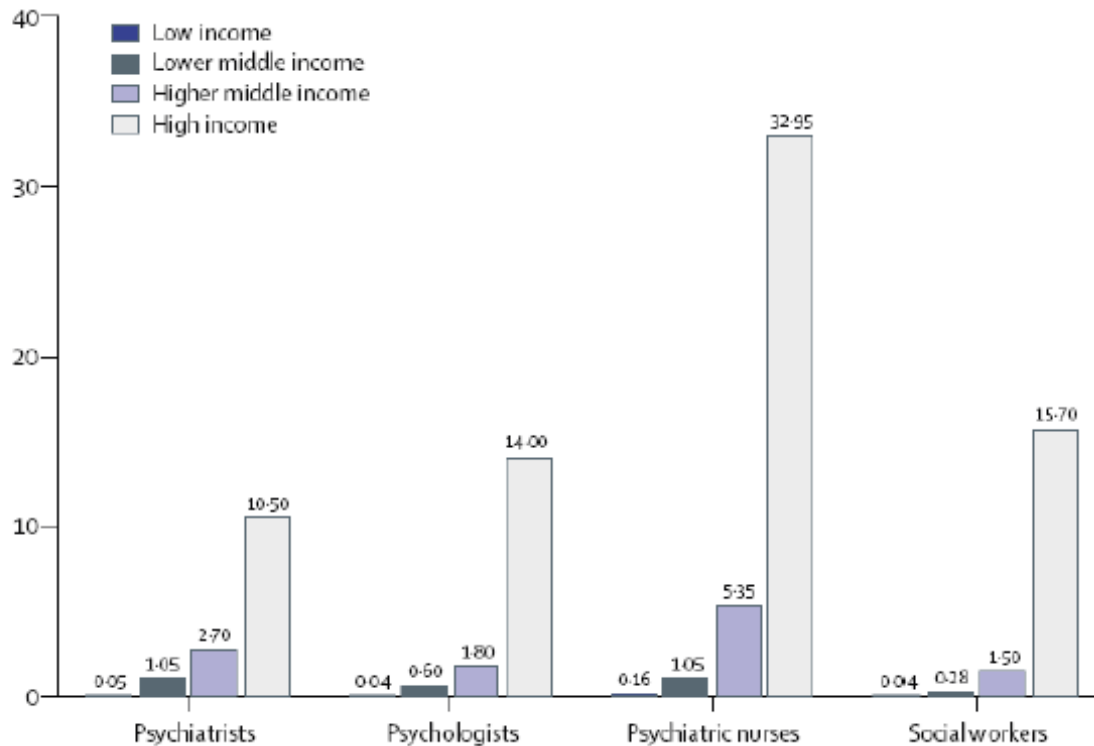
Dr. Lynne Jones

#4: TREATMENT GAP

Human Resource Gap for Mental Health

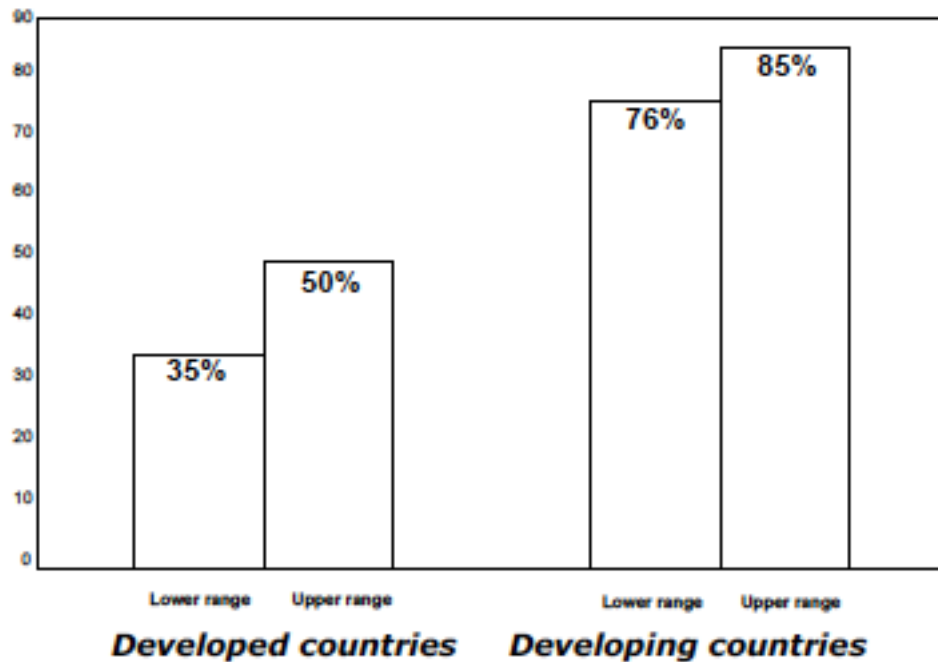
Inequities in resources

MH human resources /100.000 persons
(WHO Mental Health Atlas)



Treatment Gap

- Percentage of cases receiving no treatment for past 12 months



(WHO World Mental Health Consortium, JAMA, 2004)

- Poor access to MH care for severe and Chronic mental illness
 - Community practices
 - Institutionalization



#6: RIGHTS AND OPPORTUNITIES FOR PEOPLE WITH SEVERE MENTAL ILLNESS

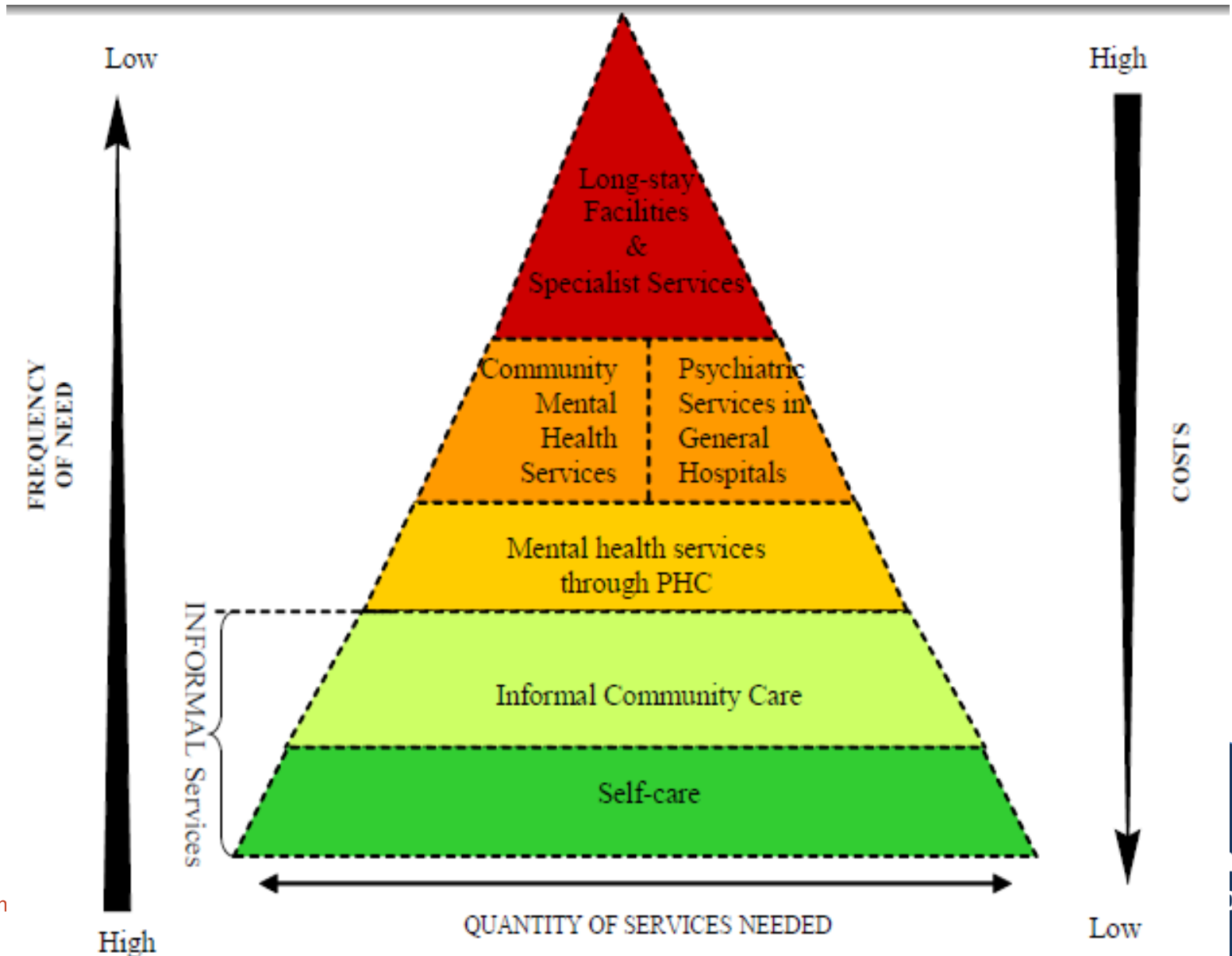
Rights and Opportunities

- Convention on the Rights of People With Disabilities
 - **Article 11: Situations of risk and humanitarian emergencies**
 - *States Parties shall take, in accordance with their obligations under international law, including international humanitarian law and international human rights law, all necessary measures to ensure the protection and safety of persons with disabilities in situations of risk, including situations of armed conflict, humanitarian emergencies and the occurrence of natural disasters.*
- Limited access to basic needs and opportunities



#7: GLOBAL RECOMMENDATIONS AND NATIONAL PLANS

WHO Recommendations for Optimal Mix of MH Services



National Health Policies and Plans

- MH as part of general health care including care for severe mental disorders (e.g. Middle East, Ethiopia, SS)

Table 2. BPHS mental health activities outlined in the SS MoH Strategy, 2010

Services and Activities	Village	Boma PHCU	Payam PHC Center	C Hospitals
Mental health education and awareness	✓	✓	✓	✓
Case detection	✓	✓	✓	✓
Anxiety disorders (e.g. post-traumatic stress-; panic disorder)	refer	follow up	✓	✓
Depression: identification and bio-psychosocial management	refer	follow up	✓	✓
Epilepsy: identification and treatment	refer	follow up	✓	✓
Psychotic and psychiatric cases: bio-psychosocial management	refer	follow up	✓	✓
Mental retardation: identification, education to parents	✓	✓	✓	✓
Community based care and rehabilitation incl. support groups	✓	✓	✓	
Inpatient treatment			refer	✓ + refer
Reporting	✓	✓	✓	✓
Monitoring and supervision		✓	✓	✓

WAYS TO ADDRESS CHRONIC AND SEVERE MENTAL ILLNESS DURING HUMANITARIAN CRISES

Social considerations for people with mental illness

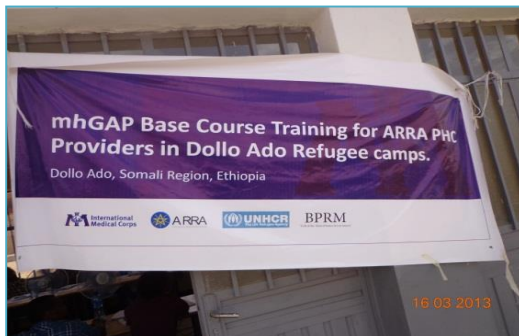
- Ensure and monitor safe, dignified and equitable access to basic services (e.g. distribution of food, NFIs)
- Include people with severe mental disorders as ‘people with specific needs’ in programs that provide support for these groups



Source: IASC Action sheet 6.1 Social considerations

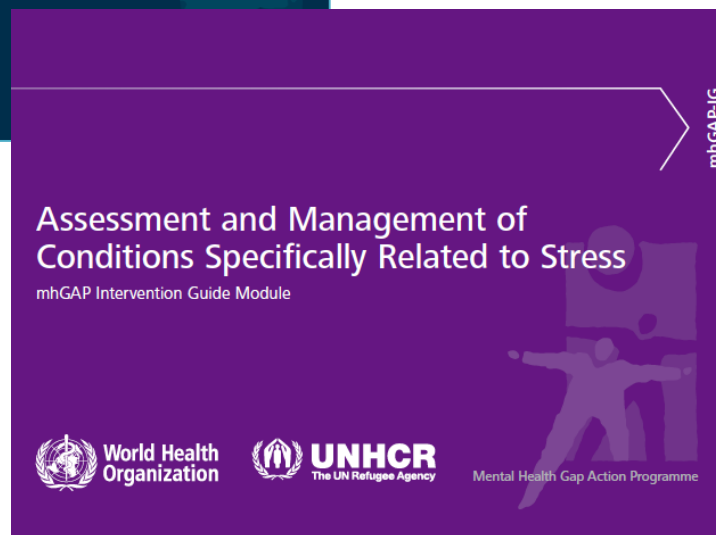
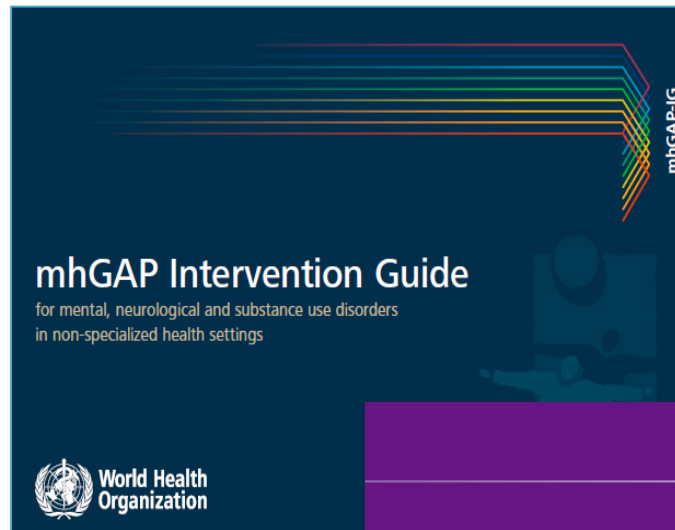
Integration of mental health services into general health care

- Training and supervision for general health care providers and supportive staff (e.g. CHWs, refugee volunteers)
- Medication Supply
- HIS systems



IMC MH specialist and case manager assessing child with possible epilepsy

WHO mhGAP Intervention Guidelines



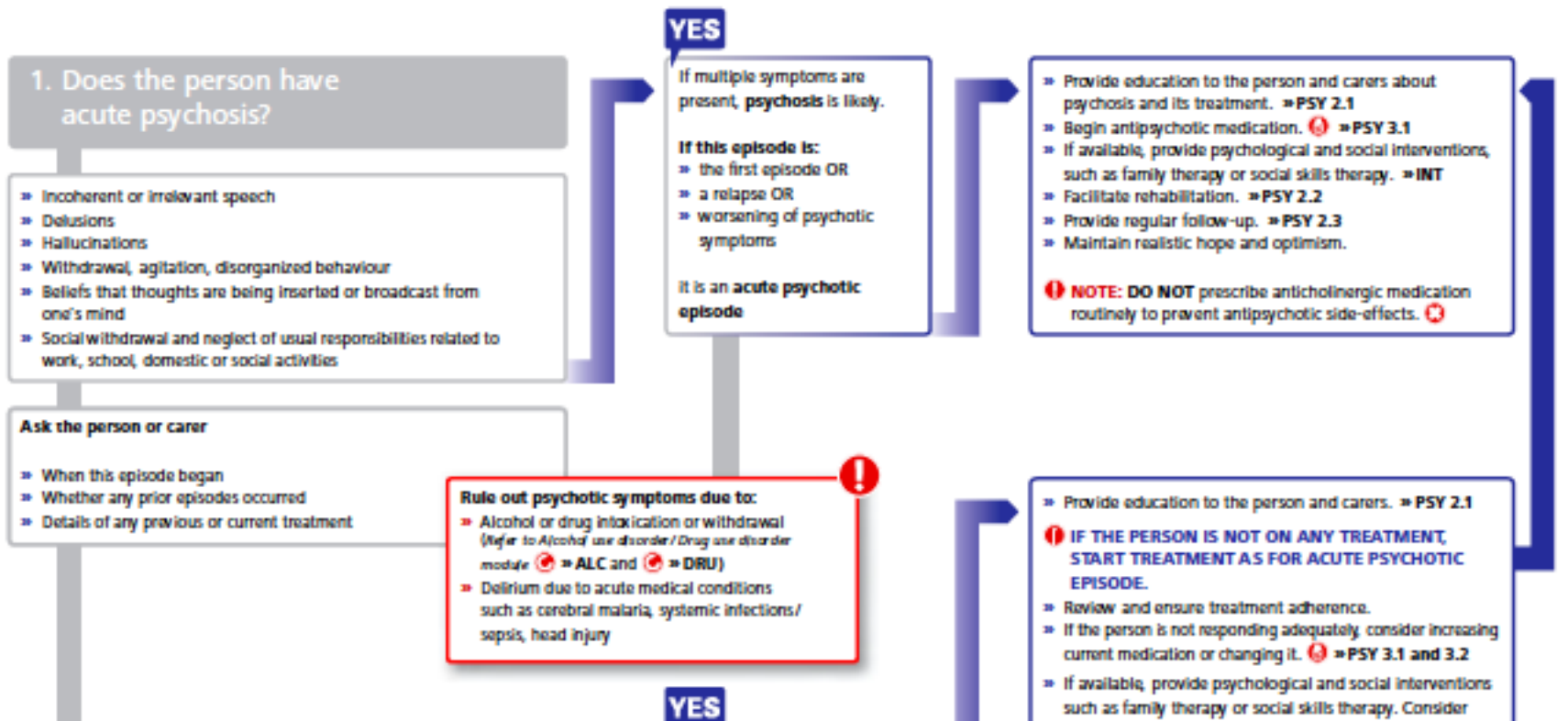
IV Modules

1. Moderate-Severe Depression	10
2. Psychosis	18
3. Bipolar Disorder	24
4. Epilepsy/ Seizures	32
5. Developmental Disorders	40
6. Behavioural Disorders	44
7. Dementia	50
8. Alcohol Use and Alcohol Use Disorders	58
9. Drug Use and Drug Use Disorders	66
10. Self-harm/ Suicide	74
11. Other Significant Emotional or Medically Unexplained Complaints	80

Psychosis

PSY1

Assessment and Management Guide



Integration of mental health services into general health care

- Additional elements:
 - Training in mental health case management (e.g. social workers)
 - Referral pathways
 - Psychosocial activities
 - Mental health advocacy
 - Peer to peer support



Example: Middle East

- Urban and camp based refugee populations from Iraq and Syria (Jordan, Lebanon, Turkey, Syria)
- Integrated MH services with IMC and gov. general health care
 - MH training for select general health staff (camp and community) using mhGAP and e-learning
 - MH case management
 - MH Training Videos in collaboration with WHO
- MH community links and referrals
 - Strong links with IMC supported refugee community centers and child/youth programs
 - Referral pathways



IMC mhGAP training video (behavioral disorders)



Example: Ethiopia

- Somali and SS refugee camps
- Comprehensive clinical and community mental health care
 - MH training for select general health staff (camp and community) using mhGAP
 - MH case management
 - Basic MHPSS training and capacity building for refugee community volunteers
- Community outreach and referral
 - Community ‘tea talks’ for MH promotion
 - Referral pathways



CONCLUSIONS

Take Home Points

- There are many reasons for addressing severe and chronic mental illness in humanitarian emergencies
- There is a critical gap of available mental health professionals and services globally
- Guidance, tools and practical examples for scaling up the availability of integrated quality and culturally acceptable MH services in humanitarian contexts exist

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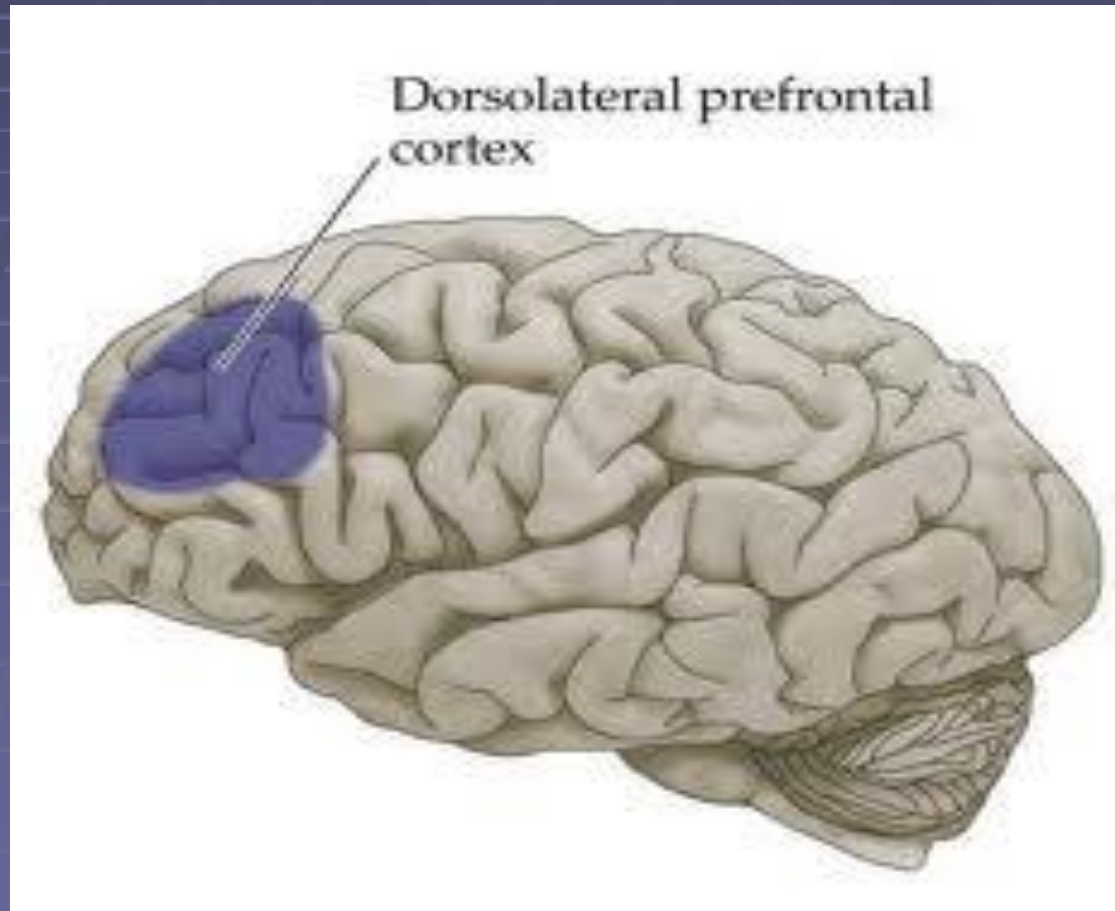


Severely Mentally-Ill Persons in Conflict-Affected Areas— Strengthening Families to Protect the Vulnerable

James L. Griffith, M.D.

Leon M. Yochelson Professor
of Psychiatry and Chair
Dept. of Psychiatry and Behavioral Sciences
The George Washington University

Dorsolateral Prefrontal Cortex— Home of Executive Functions and Source of Vulnerability in Schizophrenia



Schizophrenia and Other Psychoses Rapidly Decompensate Under Stressors of Post-Conflict Settings

Neurobiological Vulnerabilities:

- Flooding by intense emotions— fear, anger, humiliation, uncertainty
- Excessive cognitive load from managing chaos and disrupted routines
- Social isolation & demoralization from stigmatization

Antipsychotic Medications Are Not Enough

One-Year Relapse Rate for Schizophrenia in
United States—

70% with No Treatment

50% with Antipsychotic Medications Alone

25% with Medications + Family Therapy

0% with Medications + Family Therapy +
Social Skills Training

Families and villages provide natural buffering from stresses that exacerbate psychotic disorders.

Where Is The Family in Global Mental Health?

Societal Level



Individual

Western
Public Health Programs,
Psychotherapy,
Psychiatry

Societal Level



FAMILY



Individual

Non-Western
Indigenous Healing
Systems

Slovia, a Village in Kosovo



Kosovo: A Setting for Conflict



Kosovo: A Setting for Conflict



1999 Ethnic Cleansing

- Murder of male family members
- Rape of women
- Burning family homes and toppling their chimneys so homes could not be re-built
- Destruction of Albanian cultural institutions, property records, and historical artifacts
- Forced migration— 900,000 displaced people out of total 1,200,000 total population

Legacies of Ethnic Cleansing

Kline, Kosovo



Legacies of Ethnic Cleansing

Slovia, Kosovo



Legacies of Ethnic Cleansing

Neighbors Re-Burying Bodies from Mass Grave
Near Macedonian Border



Kosovar family in Slovenia survived deaths of nearly all male family members during ethnic cleansing. A surviving daughter with schizophrenia became agitated and violent, bringing attention to the family's plight.



The Kosovars' Priority—
Care for Overwhelming
Numbers of Severely Mentally Ill
Who Had Decompensated
(Not Treating PTSD, as had
been Americans' expectations)

The Kosovar Family Professional Educational Collaborative (KFPEC)

What to do in Europe's poorest country with few mental health professionals and no psychiatric hospital?

- Mobilize strengths of families to provide a stable emotional environment for patients
- Adopt a strength-based approach, rather than diagnosing and treating psychopathology
- Create collaborative partnerships with local professionals that build their capacities.

Why Might This Approach Work?

Schizophrenia is a brain disease.

But it is a disease that is
exquisitely sensitive to
communications and relationships.

Features of Family Environment that Protects from Psychosis Relapse

- Affect is kept relatively warm
- Communication is clear and simple
- Change is kept to a minimum
- The impact of life events is cushioned
- Graduated expectations are set at a level consistent with the patient's changing levels of symptom severity and disability

Developing Community Mental Health Services in Kosovo

Ministry of Health mandated care for chronically mentally-ill in communities in each community mental health center:

- Family Psychoeducation
- In-Home Family Support, Crisis Intervention, and Medication-Monitoring by Community Nurse Teams
- Monthly Multi-Family Psychoeducation Groups
- Protective Residential Housing for Patients without Families

Planning Community Care for Homeless Mentally-Ill in Gjakova, Kosovo, 2003



Program Interventions and Outcome

- Low dose antipsychotic medication
- Stable family life with emotional warmth, low intensity emotions, stable routines— supported by nurse teams
- Integration into work life of family and community— “Every person has a place, every person has a job to do”

Successful Hand-Off to Kosovars

December, 2005 “Conference on Kosovar Families” formalized full turnover program to Ministry of Health of Kosova and Department of Psychiatry at the University of Prishtina

Developing Community Mental Health Services in Kosovo

- Family psychoeducation and multi-family groups mandated care for chronic psychoses by the Kosovar Ministry of Health
- 1,000 Families engaged currently, with ongoing recruitment of new families
- Patients selected due to repeated hospitalizations, living homeless in communities, treatment non-adherence, threats of violence.

Cost of Project

- Approximately \$150,000 over four years from Emergency Fund for Kosovo of Jewish Joint Distribution Committee and other foundations and organizations
- In-kind contributions of travel time from 16 American consultants from university faculty and professional private practices during approximately 15 two-person training and supervisory visits

Program Summary

Low Dose Antipsychotic Medication



Relational Stability of Family



*Integration Into Contributory Role in
Family and Community
(to Counter Stigma)*

Questions & Answers



*Thank you for joining us on
World Mental Health Day*