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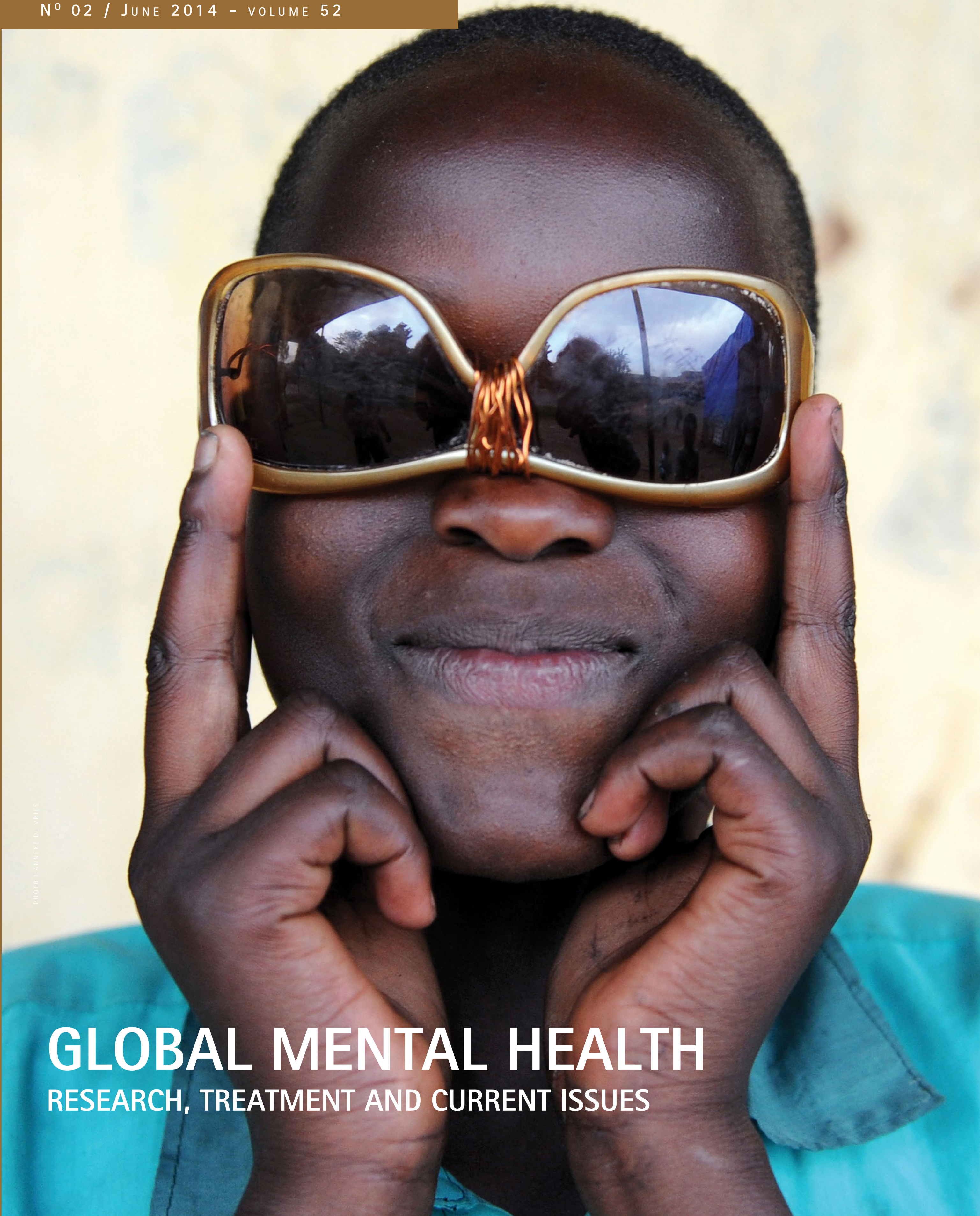

GLOBAL MENTAL HEALTH

RESEARCH, TREATMENT AND CURRENT ISSUES

CONTENT

2
EDITORIAL

3
REVIEW
WHO's response to the lack of available mental health services in low- and middle-income countries: mhGAP

12
Culture and mental health. Exploring the role of the cultural interview

7
OPINION
The Mental Health Treatment Gap: what is achieved in areas of mass violence?

20
Encounters with Mental Health Care in Kenya

9
PRACTICAL PAPERS
Global Mental Health and how to teach it: an example from Mozambique

14
Tackling the aftermath of trauma: The Narrative Exposure Therapy

16
Mental health and psychosocial support (MHPSS) in conflict affected areas

22
CONSULT ONLINE
Severe skin abnormality at birth

EDITORIAL

Finally an edition of MT*b* fully dedicated to mental health. Given the fact that 14% of the global burden of disease is attributed to mental health disorders and the current mental health gap, it is about time. This blind spot is not a surprise, as until late in the past century even renowned researchers were convinced that Africans were not suffering from psychiatric disorders[1]. As reported in a 1953 WHO publication: 'Africans are highly dependent upon physical and emotional stimulation, lacking in spontaneity, foresight, tenacity, judgment and humility, inapt for sound abstraction and for logic, given to phantasy and fabrication; and in general unstable, impulsive, unreliable, irresponsible and living in the present without reflection or ambition or regard for the rights of people outside his own circle'. It reflects long-held ignorance and colonial racism and may explain the lack of interest in dealing with these issues.

Things have changed. There is recognition of the universality of mental health disorders. What has not changed dramatically is a lack of access to mental health care and treatment. Most people affected by mental disorders – 75% in many low-income countries – do not have access to the treatment needed. Almost half the world's population lives in countries where there is one psychiatrist to serve 200,000 or more people[2].

Several articles in this edition of MT*b* address current actions in closing the mental health gap. Pim Scholte, psychiatrist with the Equator Foundation, illustrates the introduction of easy-to-implement treatment methods by non-specialists. Kaz de Jong, MSF mental health specialist, details what is achieved in dealing with the mental health gap in humanitarian emergencies. A step-by-step approach is promoted, distinguishing between different stages of emergency from acute to long-term crisis. Taking a multi-layered and comprehensive approach is also illustrated in the article of child psychologist Ria Stiefelhagen and cultural anthropologist Relinde Reiffers. In their article they describe the aftermath of the brutal attack on the school in Breslan, North Ossetia, ten years ago. Consequent actions to deal with the trauma included the development of a mental health and psychosocial support programme, using the school as an entry point.

The World Health report on mental health estimates that 1 in 10 people who experience traumatic events will have serious mental health problems, and another 10% will develop behaviour that hinders the ability to function effectively. Hans Rohlof, psychiatrist with Centrum '45, is an advocate of the use of cultural interview in mental health, especially among refugees and migrants. The article of Esther Jurgens explores the role of culture in diagnosis, coping and treatment of refugees.

In a blog, Roos Korste reports on her encounters with the mental health situation in Kenya. Rembrant Aarts, psychiatrist, details on the development of a mental health curriculum in Mozambique. The problem-based learning approach appears promising as a way to tackle serious mental health workers shortages. However, as several authors in this edition emphasize, understanding the local practices and the local *'idioms of distress'* are equally important steps in improving mental health around the globe. We hope this edition on mental health triggers the reader's interest in mental health issues. Many thanks go out to Peter Ventevogel for his valuable contribution to this edition of MT*b*.

ESTHER JURGENS AND JOOST COMMANDEUR

WHO's response to the lack of available mental health services in low- and middle-income countries: mhGAP

The website of the World Health Organization (WHO) on the WHO Mental Health Gap Action Programme (mhGAP) opens by stating that "mental, neurological, and substance use disorders are common in all regions of the world, affecting every community and age group across all income countries. While 14% of the global burden of disease is attributed to these disorders, most of the people affected - 75% in many low-income countries - do not have access to the treatment they need".[1] The term 'gap' refers to this lack of available services. The relative lack of mental health professionals in low- and lower-middle-income countries, as shown in figure 1, may serve as an illustration.

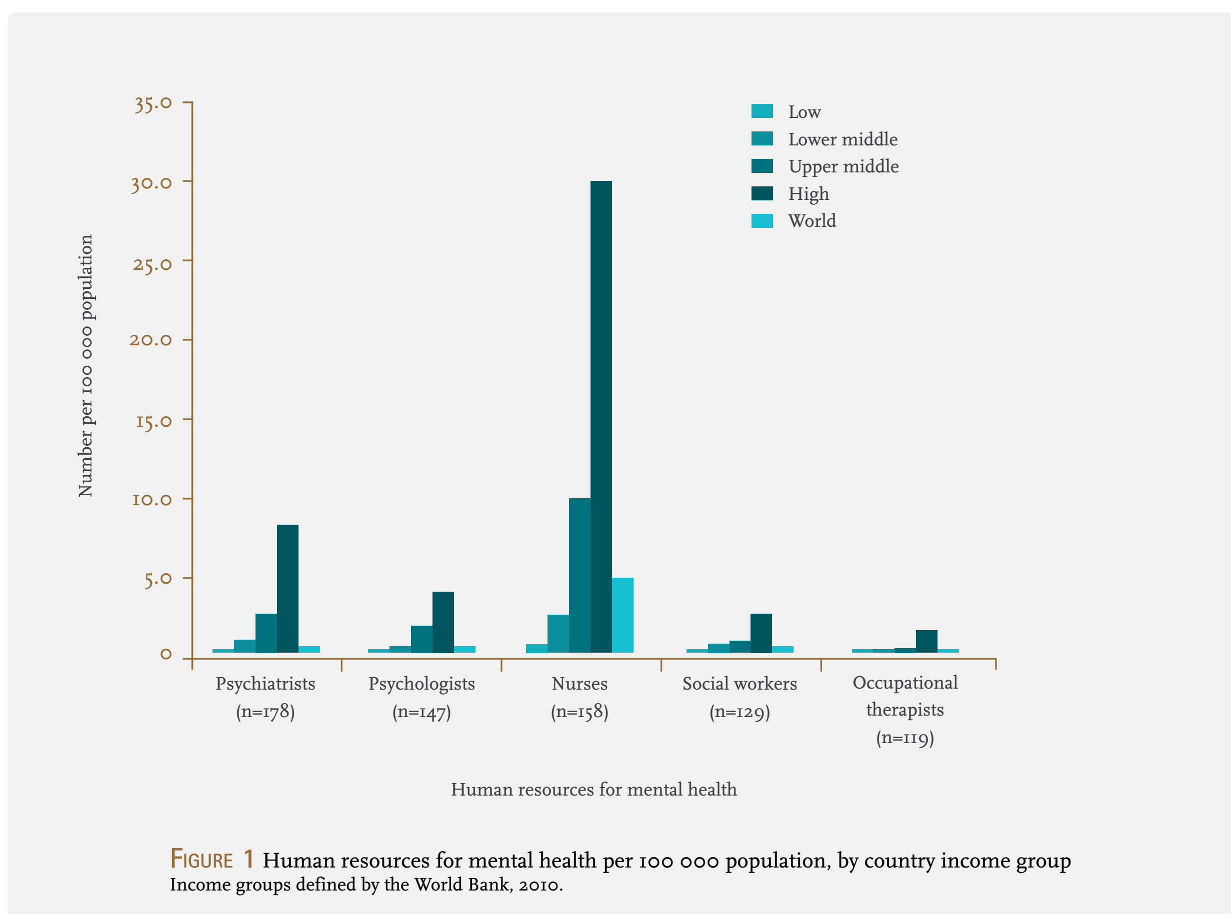

FIGURE 1 Human resources for mental health per 100 000 population, by country income group
Income groups defined by the World Bank, 2010.

The populations of low- and middle-income countries (LMIC) would need an extra 239,000 full-time mental health staff for just eight mental, neurological and substance abuse related problems in order to close the treatment gap.[2] It is not to be expected that this kind of capacity building will be achieved over the coming few decades. Meanwhile, tens of millions may not receive proper care, psychosocial assistance and medication. Notably, the WHO states that the reality is that most conditions in this field of expertise can be managed by non-specialist health care providers. What is required is increasing the capacity of the primary health care system for delivery of an integrated package of care by training, support and supervision.[3]

The latter is the very objective of mhGAP, an action programme that was launched by WHO in 2008. The priority conditions to be addressed initially by mhGAP were: depression, schizophrenia and other psychotic disorders, suicide, epilepsy, dementia, disorders due to the use of alcohol, disorders due to the use of illicit drugs, and mental disorders in children. In 2013, conditions specifically related to stress were added to this list. The WHO developed an intervention guide presenting separate modules for each of these conditions. It comprises protocols for clinical decision-making in integrated management.3 It was developed through a systematic review of evidence, followed by an international consultative and participatory process in which numerous experts from all over the world were involved. The selection process took the balance of benefits and harm into consideration, as well as value judgments (e.g. protection of human rights), resource use, and feasibility (availability of lab etc). The WHO suggests mental health workers in LMIC to conduct a situation analysis, identify local priorities and barriers to scaling up services, and to adapt the mhGAP Intervention Guide accordingly.

For two reasons it is quite remarkable that in the mhGAP Intervention Guide only evidence-based treatment methods are mentioned. Firstly, it is in line with the view that in LMIC, like in higher-income countries, no methods should be applied which have no proven effectiveness. This seems obvious, but unfortunately daily practice in LMIC is different, and understandably so. Secondly, it is in full concordance with the assumption that most conditions of this kind can be managed by non-specialists, a statement which western mental health professionals could consider as provocative in itself.

As if the editors wanted the Guide itself to underline this statement, its design is a soon to be classical example of user-friendliness. The health worker is first guided through a Master Chart listing the common presentations of all established priority conditions. As an example, figure 2 shows the Depression and Psychosis sections of this Master Chart. If features of one condition are present, the condition should be assessed; the worker is then guided to the module addressing that condition.

COMMON PRESENTATION	CONDITION TO BE ASSESSED	GO TO
Low energy; fatigue; sleep or appetite problems Persistent sad or anxious mood; irritability Low interest or pleasure in activities that used to be interesting or enjoyable Multiple symptoms with no clear physical cause (e.g. aches and pains, palpitations, numbness) Difficulties in carrying out usual work, school,domestic or social activities	Depression	DEP
Abnormal or disorganized behaviour (e.g. incoherent or irrelevant speech, unusual appearance,self-neglect, unkempt appearance) Delusions (a false firmly held belief or suspicion) Hallucinations (hearing voices or seeing things that are not there) Neglecting usual responsibilities related to work, school, domestic or social activities Manic symptoms (several days of being abnormally happy, too energetic, too talkative, very irritable, not sleeping, reckless behaviour)	Psychosis	PSY

FIGURE 2 Depression and Psychosis sections of Master Chart
(Source: mhGAP Intervention Guide. Geneva: WHO)

All modules consist of two sections. In the first section the ‘assess column’ clearly lists a condition’s diagnostic criteria. If criteria are met, the condition in question is likely to be present. The worker is then guided to the ‘manage column’, in which advice on psychological and psychopharmacological interventions is given. Figure 3 shows the first page of the Depression module as an example.

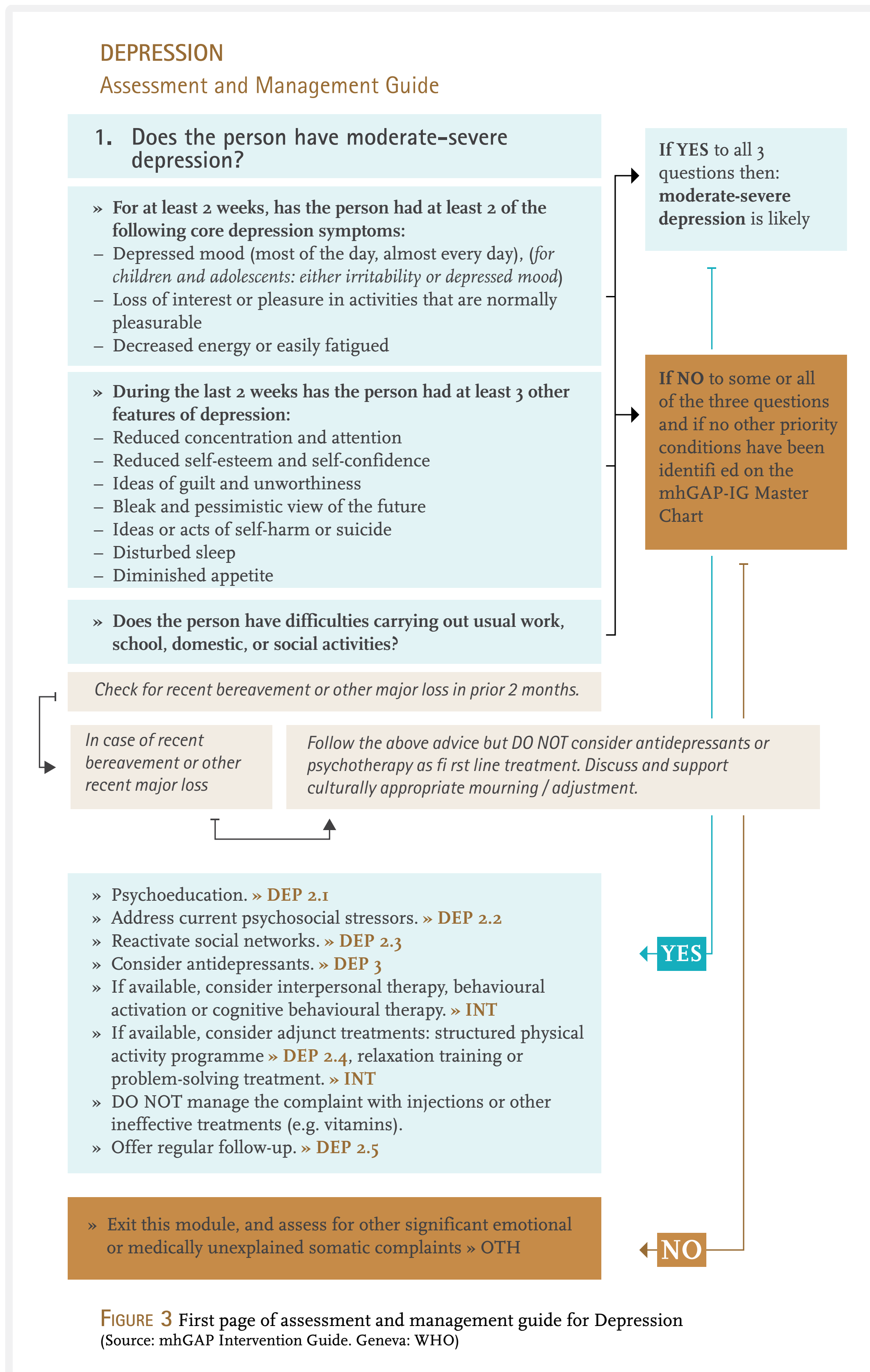

FIGURE 3 First page of assessment and management guide for Depression
(Source: mhGAP Intervention Guide. Geneva: WHO)

CONTINUE READING

In the flowcharts, relevant intervention details are identified with codes, guiding the worker to corresponding parts in the second section of the module. There, more information is provided on follow-up, referral, relapse prevention, more technical details of treatments, and important side effects and interactions of medication.

The guide presents a special section on 'advanced psychosocial interventions'. This term refers to interventions which are more complex and take more than a few hours to learn and also to implement. The mhGAP considers application to be possible in non-specialized care settings, provided that sufficient human resource time is available. Analogous to how professionals may be unhappy with the management of serious mental health disorders by non-specialists, one may argue that certain psychotherapeutical methods are not suitable for application by relative laymen. For example, in the western world professionals are only allowed to learn 'eye movement desensitization and reprocessing' (EMDR) or 'trauma-focused cognitive behavioural therapy' (TF-CBT) if they have a certain advanced degree in the mental health field. One may ask why to put such criteria aside when dealing with health workers in LMIC. On the other hand, one may also suspect/suppose paternalism in the stance to decline the transfer of such skills when there is a real demand.

The WHO has obviously made a remarkable move, not only by stating that the existing treatment gap in LMIC should be overcome by introducing easy-to-implement treatment methods. It has also decided that most evidence based treatment methods are easy enough to be implemented by non-specialists, and that therefore knowledge on evidence-based treatment methods should be – and can be – transferred to health workers in LMIC. I believe that with this publication the WHO has provided an extremely easy-to-handle high quality intervention guide.

The WHO mhGAP Intervention Guide can be dowloaded from: www.who.int/mental_health/publications/mhGAP_intervention_guide

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The Mental Health Treatment Gap: what is achieved in areas of mass violence?

The World Health Organization (WHO) estimated approximately 450 million individuals worldwide suffer from mental health disorders in their lifetime [1]. This high prevalence causes a substantial disease burden as many individuals with psychiatric and psychological disorders remain untreated despite the existence of effective treatments. In 2004 the WHO calculated the treatment gap for serious mental disorders such as depression, obsessive compulsive and anxiety disorders [2].They revealed treatment gaps varying from 32% (psychosis) to 78% (alcohol abuse and dependence). The treatment gap for mental disorders is universally large, though it varies across regions. In 2008 the WHO launched an action programme: the Mental Health Gap Action Programme. This programme: 'aims at scaling up services for mental, neurological and substance use disorders for, especially, low- and middle-income countries. It asserts that with proper care, psychosocial assistance and medication, tens of millions could be treated for depression, schizophrenia, and epilepsy, prevented from suicide and could begin to lead normal lives– even where resources are scarce'[3].

The call for a specific target action has the imminent risk of forgetting the achievements that have been made so far. Some major improvements are seen in the field of dealing with mental health issues in the areas of mass violence. At the end of the past century in mass crises as occurred in the Rwandan genocide the mental health community did not have answers to basic questions such as: how to assess and to address mental health needs, and whether interventions in dealing with mental health issues in such crises were effective. Nowadays, we can see advances, as the humanitarian community is more equipped to deal with mental health problems in crises such as in Syria, and the Central African Republic. This article gives a brief overview of what is achieved, presents an intervention model, and provides suggestions for future development.

ASSESSMENT

Many needs assessments in areas of mass violence used general indicators such as exposure to violence, witnessing violence or self-experienced violence. The psychosocial health consequences of the exposure to violence are usually measured by means of mental health symptoms or disorders. These indicators prove to be difficult. It appears that the level of violence does not always differentiate sufficiently between those suffering from disorders and those who do not. For instance, in our survey in Mogadishu (Somalia) we find the respondents experience an average of five potential traumatic events such as surviving bombardments, seeing people killed, or their houses being destroyed[4]. However, 'only'30% suffer from Post Traumatic Stress Disorder. The ability to describe a particularly upsetting event is associated with the suffering from PTSD symptoms. Seemingly, people living in areas of mass violence perceive violent events as potentially traumatic only when the events are out of proportion to the context, even if such events in other settings would be classified as traumatizing[5]. It shows the importance of the contextual component. In order to capture the psychological vulnerability of the individual, replacing the indicators on experienced violence, new alternative or proxy indicators such as currently feeling safe, being forced to move[6], time passed since the beginning of the conflict and difficult recovery environment[7] are proposed.

The use of scientific epidemiological data contributes to the acceptance of psychosocial and mental health services in areas of conflict. However, concern has also been expressed that the poor validity and reliability of mental health surveys have led to exaggerated outcomes. 'Methodological factors' (such as sample size, sampling method, type of measure, time of survey, diagnostic reference) are found to explain largely the wide variation of prevalence rates in different assessment surveys[7].

The application of Western questionnaires often not validated locally became common practice in the absence of culturally validated instruments. It has led to substantial validity and reliability limitations in most psychological assessment studies over the decades [8,7]. To address this problem Bolton and Tang [9] have described a method to develop local, validated psychological assessment questionnaires in areas of mass violence.

Furthermore, to tackle the methodological limitations, future assessments in areas of mass violence should use large sample sizes, cross-culturally validated instruments, and the clinical interview to identify needs[7]. For large, acute contexts of mass violence these criteria are not practicable and the application of proxy indicators can be used to reveal psychological vulnerability.

INTERVENTION MODEL

Currently an overall consensus on goals, strategies, and methods for delivering psychosocial support in areas of mass violence exists. The Inter-Agency Standing Committee psychosocial and mental health guidelines10 are widely accepted as the best practice intervention model. The SPHERE guidelines that set standards for humanitarian emergency interventions include mental health and psychosocial activities[11]. A standard psychiatric drug list for first line responders[12] as well as a best-practice treatment for stress-related disorders in emergencies is available[13].

In the Médecins Sans Frontières programme model for acute emergencies[14] the recruitment, training of national staff, and their involvement in programme design are essential. However, a balanced mix between national staff and (expat) mental health specialists remains necessary. Due to the Mental Health treatment gap experts are often needed to guarantee an appropriate quality level, beneficiaries are essential to translate interventions to local acceptable support.

An intense discussion in the mental health community has evolved around the dilemma how to best support the individual affected beneficiary: community interventions to improve the social ecology or applying an individual, trauma/mental health disorder perspective? From our perspective as a medical humanitarian organization, psychosocial programmes must support both individuals and communities. The individual mental health pathology or psychosocial problems sometimes requires individual (or group) attention in medical settings. However, communities also need support to improve their broken social ecology and to restore their natural healing and support systems. In both approaches the focus on mobilizing the resilience of beneficiaries within their communities is vital. The approach therefore is a combination of community activities and individual support services through the health system.

A step by step approach is promoted, whereas in acute emergencies psychosocial, mental health programmes should prioritize the medical, vertical approach to ensure survival of the most vulnerable. Psychiatric support, provided through primary health care services, for those affected acutely or for those in need of their regular medication is essential. On this foundation in the aftermath or when a chronic crisis emerges, more emphasis is put on people's ability to cope with and adapt to their new situation. Community interventions become increasingly important in this phase.

EFFECTIVENESS OF INTERVENTIONS?

Effect research in areas of ongoing mass violence is difficult and riskful at times. Most contexts of mass violence are in non-Western settings, posing an extra challenge to the cross-cultural validity of the research instruments. A general review of mental health programmes showed that interventions to strengthen community and family support systems are effective in improving the mental health status of populations in humanitarian contexts [15]. A review, specifically on psychosocial interventions in contexts of ongoing mass violence, also demonstrates the effect of certain interventions[16].

A Bosnia study shows a marked improvement of two thirds of our 5056 clients. Most effective interventions for PTSD such as Narrative Exposure Therapy (improvement of 71% of the clients), flexible and reconciliation counselling include exposure as a key ingredient (all showing significant improvement of clients). Culturally adapted problem focused counselling and cognitive behavioural interventions showed important improvement of anxiety and depression. For example: both in Uganda and Afghanistan significant symptom improvement post therapy; for Afghanistan even at three months' follow-up. Various forms of lay counselling, such as problem solving and stress reduction counselling (e.g. Nepal: significant improvement at five months' follow-up) showed proof of enhancing the client's functioning. These outcomes confirm the importance of psychosocial interventions in areas of ongoing violence. Symptom reduction and improvement of the individual's ability to function are crucial for the survival of both the individual and the group.

THE MENTAL HEALTH GAP

A wrong conclusion after reading this article is: the mental health gap is addressed! It is not! It is true we know much better what to do. There are agreed upon formats for interventions and best practices. The Non Governmental Organizations are willing to address the mental health gap. But this is not enough. In most areas of the world including Western countries and countries with emerging economies the accessibility of mental health support, availability of drugs and specialized professionals remain absent. To give an example: psychiatric patients in many institutions all over the world lack proper care, they are subjected to low quality medical support, and they are subjected to human rights abuse.

The Mental Health Gap Action Programme is essential to activate governments to take up their responsibility for some of the most vulnerable in their communities. Isn't there a saying that the level of civilization of a society is measured by the way the most vulnerable are treated?

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Global Mental Health and how to teach it: an example from Mozambique

INTRODUCTION

Mozambique gained its independence in 1975, more than a decade after the other countries in the region. A devastating civil war followed, which led to almost 1,000,000 casualties and 1,700,000 refugees. Especially the educational and health care infrastructure was demolished. By the time the Rome Peace Accords were signed in 1993 Mozambique was among the poorest countries in the world. Founding the Catholic University of Mozambique (UCM, 1996) in Beira was a direct result of the Peace Accords, mediated by the Catholic Church, with the objective to develop higher education in the Central and Northern region of the country. The Medical Faculty of the UCM started in 2000. Its first Medical Doctors graduated in 2007.

MENTAL HEALTH (SERVICES) IN MOZAMBIQUE

The local situation concerning mental health services can be compared to the situation in the East African region as described by Njenga.[1] The mental health care system can be broadly divided into three sectors: services found in primary care facilities, mental health hospital services and traditional healers.

In 2012 Mozambique had an estimated population of 25.2 million.[2] The total number of psychiatric beds per 100,000 inhabitants is 2.16 and the number of psychiatrists per 100,000 inhabitants is 0.04. In 2011 there were 0.28 psychiatry technicians per 100,000 inhabitants.[3] Many psychiatry technicians, as well as other health care professionals, have left government services to work with local or international NGOs.

In 2003 the Ministry of Health conducted a mental health community survey in which the prevalence of psychoses, mental retardation and epilepsy in the urban area was 1.6%, 1.3% and 1.6%, and in the rural area 4.4%, 1.9% and 4.0%, respectively. The majority of patients had frequented local traditional healers and a significant part of the patients attributed their mental disorder to a supernatural power.[4] Other epidemiological data on mental health in Mozambique is scarce.[5,6]

TEACHING MENTAL HEALTH IN THE UCM CURRICULUM

Given the global burden on society caused by mental illness and the lack of mental health services available in many low-income countries, it is important to focus on mental health education and local human resource management in mental health.[3,7] The adoption of a Western curriculum in low-income settings has been questioned.[8] However, because of the shortage of local human resources and the lack of capacity to develop a new curriculum, that of the Medical School of Maastricht University (MU) was adopted. The MU medical curriculum uses the educational method Problem Based Learning (PBL). Therefore the faculty continues to reshape its curriculum as a whole and in mental health in particular to the specific context. With a

PHOTO ALBERTO LOYO

community- and family health programme, in which the students work on community level following a group of families along the years, the medical school tries to fulfil this challenge. With a focus on public health and family medicine the faculty prioritizes preventive medicine and health promotion in the curriculum. The psychiatrist's holistic approach of body and mind, the usefulness of skills learned in psychiatry for medicine in general, and the overall high prevalence of mental illness fit very well in this philosophy.[9] In this paper we will take a closer look at some of the aspects applied.

MENTAL HEALTH BLOCK

Mental health is taught in a 6 weeks' pre-clinical block in the 3rd year. The block features self-directed learning using predefined cases about the various topics in mental health. Twice a week small groups of students meet to analyse the cases, identify where their knowledge is lacking, and report after appropriate self-study. A tutor accompanies and facilitates the learning process. Due to a lack of staff not all tutors are expert in mental health, a concern debated in recent literature.[10] Tutor meetings are the main source of knowledge growth. Besides, there are skills training on psychiatric history and mental state examination, visits to the central hospital psychiatry ward, as well as some supportive lectures. According to the guidelines in teaching a "core curriculum in psychiatry" the faculty fully implements a self-directed and problem based learning style.[9] There are no locally produced (visual) teaching aids available. Therefore we use a Western film to introduce the block and generate a general discussion afterwards. [11] The use of film has proven very useful and has been evaluated positively by the students over the years.[12] Some mental health topics are dealt with in other multi-disciplinary blocks in the 1st and 4th year of this study, like epilepsy and mental retardation. The students follow a clinical mental health rotation at the central hospital in their final years of training. The focus in the curriculum is on the most prevalent and salient disorders, namely psychosis, alcohol and drug related disorders and affective disorders. Alcohol abuse and dependence are specific major local problems. Organic mental disorders are also addressed in the curriculum due to the high prevalence of HIV, malaria and other infectious diseases.

SKILLS TO BE ACQUIRED

According to the PBL teaching model, the content of the theoretical knowledge will consist of tutorial groups, skills training, discussions as well as some lectures. Problems arise when training programmes precede the development of adequate clinical services where trainees can get experience.[8] The faculty has access to local hospital psychiatry services for training but they are of poor quality and may have a demotivating impact on students. Therefore psychiatry clinical skills are also embedded in local faculty primary care services (faculty clinic) and the community- and family health programme. Students should be able to recognize the most common mental disorders within a primary care context, as well as identify the most devastating problems, to further implement preventive measures. To develop such capacities, the setting supplied by skills and discussion groups appears to be the most convenient. All students visit a local traditional healer during the block and discuss afterwards about the role of traditional healing of mental illness. Another approach to be proposed might be to create a complete register of the data from the files in the psychiatry ward. Having data about: diagnosis, course of disease, age, gender, length of stay, suicide rates and methods, treatments, re-admissions etc, the student will develop a more complete overview of what mental health is in an inpatient setting, as well as becoming familiar with quality monitoring processes. Psychiatric symptoms and syndromes and their treatment are to be taught and learned in the context of an integrated biological, psychological and social approach. This is referred to as *knowledge objective* in the core psychiatry curriculum. Aspects included in *attitude objectives* can be divided into attitudes towards medical practice in general, towards the patient and family or towards psychiatry and psychiatric disease. *Skills objectives* in mental health have a great overlap with skills learned in other areas of medicine.[9] Table 1 is presented with a general overview of the skills objectives and the way in which these objectives are reached.

ASSESSMENT

Assessment should be done in the way in which the students are taught, or in other words, it should be congruent with the educational philosophy. As PBL focuses on skills, attitude and knowledge, this is reflected in the way assessment is organized. Progress Testing and Objective Structured Clinical Examination (OSCE) have been implemented.[13,14] Both exams can be seen as formative assessment methods and serve the student to receive immediate feedback about their skills performance and growth of knowledge over the years in the different areas including mental health.

The OSCE mainly focuses on skills and the Progress Test on long-term memory factual knowledge. The UCM "professional behaviour" programme focuses on attitude learning objectives. The programme is longitudinal during 6 years and involves the student's evaluation of interest, active participation and preparation on different occasions by all teaching staff. The programme, although suffering from administrative constraints, is transparent and a good platform for feedback about the student's behaviour and attitude. The faculty has in the past tried to implement the student's portfolio as another formative assessment method to stimulate the student's self reflection, but unfortunately due to a lack of human resources to implement the programme this has not proven sustainable. Summative assessment consists of the mental health block test directly after the 6 weeks of teaching in mental health.

ONE SIZE FITS ALL?

Teaching mental health implies an effort to adapt to the social and cultural context in which the process takes place; otherwise there is a great risk of Western bias.[8] But literature on global mental health has focused mainly on the lack of human and financial resources and the need of structural changes in local mental health care systems. The authors stress the need for understanding local practice, cooperation with local caregiv-

ers and the need for understanding concepts like 'idioms of distress' and 'explanatory model'.

Emphasizing community- and family health competences the faculty continues to reshape its mental health curriculum to the local situation and culture, thereby creating tomorrow´s medical doctors with a warm interest in mental health in its primary health care local context.

TABLE 1 Skills objectives as described in the core curriculum of psychiatry at UCM Medical Faculty (9)

Objective	How is it reached
Doctor patient interpersonal skills	Communication skills programme year 1-4 Faculty clinic year 3 and 4
Information gathering skills	Communication skills programme year 1-4 Faculty clinic year 3 and 4 Skills training mental state examination Skills training HIV/AIDS counselling Community- and Family health programme
Information evaluation skills	Community- and Family health programme Faculty clinic year 3 and 4 PBL tutorial groups year 1-4
Information giving skills	Community- and Family health programme Faculty clinic year 3 and 4 Clinical rotations year 5 and 6
Reporting skills	Faculty clinic year 3 and 4 Clinical rotations year 5 and 6
Treatment skills	Clinical rotation year 6 Faculty clinic year 3 and 4
Learning skills	PBL tutorial groups year 1-4
Teamwork skills	PBL tutorial groups year 1-4 Community- and Family health programme

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CULTURE AND MENTAL HEALTH. EXPLORING THE ROLE OF THE CULTURAL INTERVIEW IN DEALING WITH MENTAL HEALTH PROBLEMS AMONG REFUGEE POPULATIONS

Access to mental health care of refugees/migrants is a long-standing problem. This article puts the spotlight on a method which recognizes the role of cultural dimensions in the diagnosis and treatment of refugees and migrants with mental health complaints. The article draws on an interview with psychiatrist Hans Rohlof, one of the leading forces behind the development and promotion of the cultural interview in mental health, and a literature review

BACKGROUND

According to the World Health Report on mental health (2001) it is estimated that in the situations of armed conflicts throughout the world, "10% of the people who experience traumatic events will have serious mental health problems and another 10% will develop behavior that will hinder their ability to function effectively. The most common conditions are depression, anxiety and psychosomatic problems such as insomnia, or back and stomach aches". The interest in how to deal with these conditions has grown, in part because of increasing numbers of asylum seekers in industrialized countries, with consequently an increasing pressure on the health services in those countries. One of the methods of dealing with mental health issues is the cultural interview, which aims to untangle cultural connotations in mental health, especially among refugee populations.

The Cultural Formulation Interview (CFI), or Cultural Interview (CI) is rooted in anthropological theories and insights. It is a method of considering and incorporating sociocultural issues into the clinical formulation. It explores the patient's own expression and evaluation of symptoms and dysfunction, including his/her explanatory models or idioms of distress, whilst assessing them against the norms of the cultural reference group. The method also helps to identify treatment experiences and preferences – including alternative medicine and indigenous approaches – and to assess cultural factors related to psychosocial stressors, available social supports, and levels of function or disability. In addition, it is useful to recognize the role of family, religion and spirituality in providing emotional, instrumental, and informational support. [1]

The 1994 version of the Diagnostic and Statistical Manual of Mental Disorders (DSM-IV) introduced the Outline for cultural formulation of diagnosis, which provided a framework for clinicians to organize cultural information relevant to diagnostic assessment and treatment planning. For some years this Outline remained relatively obscure, in part because of its location deep in the appendix section

of the Manual. [2] This gradually changed with the development of practical tools. In 2000 a group from the Centrum '45-de Vonk, spearheaded by Hans Rohlof, developed the first edition of a cultural (formulation) interview. [3] From there on the CFI found its way to a wider audience. Its first edition was published in 2002 and translated into English. [4] To illustrate, in the Netherlands some 25 institutions work with the cultural interview. In 2014 the CFI was included in the DSM-V.

EVIDENCE-BASED

Since its introduction in the DSM-IV some 20 years ago, the effectiveness of the cultural formulation of diagnosis (CFD) has been subject to research. The study 'Culture in Diagnostics of Refugees: the Cultural Formulation of Diagnosis' looked into the use and effect of CFD. The authors found 112 research studies and 28 case histories, of which 9 qualitative and 7 quantitative studies were suitable for further analysis. The CFD was used in quite diverse populations, among them refugees. The qualitative studies propagated the use of the CFD, and recommended several improvements. The quantitative studies found difference in treatment effect and improvement of therapeutic competencies in therapists. Overall it showed that CFD is used successfully in diverse populations, though there are improvements to be made, such as recognizing the influence of culture (on the therapist and patient alike), and of discrimination and a possible distorting effect of using translators. [5]

An evaluation of the Outline for Cultural Formulation of Diagnosis showed that although it provides a framework for clinicians to organize cultural information relevant to diagnostic assessment and treatment planning, its use has been inconsistent. [6] Findings indicated that in a significant number of cases, language barriers and the cultural complexity of the cases, as well as discrimination, had prevented adequate access to mental health care.

A study by Kirmayer et al. (2011) in Canada addressed the challenges in recognizing and appropriately treating mental health problems among new immigrants and refugees in primary care. Specific challenges in migrant mental health include communication difficulties because of language and cultural differences; the effect of cultural shaping of symptoms and illness behaviour on diagnosis, coping and treatment; differences in family structure and process affecting adaptation, acculturation and intergenerational conflict; and aspects of acceptance by the receiving society that affect employment, social status and integration. The authors suggest that these issues can be addressed through specific inquiry, the use of trained interpreters and culture brokers, meetings with families, and consultation with community organizations. [7]

CULTURE IN THE DSM-5

The plea for more attention to culture in the fifth edition of the Diagnostic and Statistical Manual of Mental Disorders (DSM-5) was heard. In its latest edition a more prominent place is reserved for cultural connotations in mental disorders and ways to operationalize their assessment in daily practice. Though the debate on the universal applicability of the criteria of the DSM has not stalled, what is certain is that the DSM offers a standardized classification system, useful for communication between professionals, epidemiological profiling, and for making political choices in mental health. [8, 9] By using cultural formulation, patients feel encouraged to formulate their definition of the complaints, and to illustrate background and stress factors leading to the problem. The introduction of the cultural formulation interview in the DSM-5 is a logical step in this process. However, a CFI alone is not enough. The need remains for a categorical dimension system which reflects on perceptions of illness, behavioural aspects in dealing with sickness and health, and attention to cultural aspects in neuroscience. Most likely such a paradigm shift will need time, perhaps until the next revision of the DSM.

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9. For example, what would be the use of diagnosing a post traumatic stress disorder (PTSD) in an African country which recently escaped from a gruesome civil war? What appears is that 80% of the population suffer from a PTSD while there are no means to treat such a large group, and other priorities prevail such as rebuilding the society. Is it useful to conclude a depression (following the DSM criteria) amongst people who are near starvation? In such situations, in these particular countries, other questions need to be asked such as which interventions gain the largest health outcomes. De Jong suggests a three-pronged approach of cultural formulation, a dimensional approach of personality disorders and further dimensional diagnostics. (See: De Jong J T V M (2012). DSM-5 en cultuur. In: Tijdschrift voor psychiatrie 54 (2012) 9 (in Dutch).

Tackling the aftermath of trauma: The Narrative Exposure Therapy

Patrick Adonga* is a 45-year-old farmer living in a small village in Northern Uganda. He is married with four teenage children. Recently he has been in a traffic accident with his motorcycle. He sustained only minor bruises, but became anxious after the incident. For as long as he can remember he has recurrent nightmares of drowning and while drowning, the water turns into blood. He believes he is cursed. As a teenager he was abducted by a rebel army and forced to become a child soldier. During his time with the rebel army he was forced to loot, rape and kill people, including some of his friends. At the moment, however, he hardly remembers anything about his time with the rebel army. He never talks about his experiences. In the beginning of his married life he often had 'attacks' when he would become very aggressive towards his wife. Afterwards he would not remember anything about the events. Since the motorcycle accident these attacks have come back and his recurring nightmares have become more frequent and intense. He is unable to work on his land during the day, because he is too exhausted from the nights.

When working in a (post) conflict setting, as a doctor, nurse, psychiatrist, researcher or project coordinator, one often encounters people who have experienced several adversities and are dealing with numerous mental health and psychosocial challenges. Especially after war, conflict, violence and natural disasters mental health symptoms (distress, anxiety, worrying, intrusive memories, grief, sadness, sleeping problems and aggression) are widely prevalent. People who have experienced adverse events (e.g. witnessing or experiencing violence or forced migration) can feel easily scared, irritable, or have intrusive memories, flashbacks or nightmares. In some cases these difficulties can result in a posttraumatic stress disorder (PTSD). People avoid to talk or think about past adverse experiences, it is simply too painful and difficult to talk about. How can you find the words to verbalize such horrible and inhumane experiences?

The current evidence based practice states that PTSD can best be treated with trauma-focused exposure treatment. This means that the best way to overcome adverse experiences is to actively remember and re-experience these events. In Europe and the US academically schooled and highly trained counsellors and therapists offer individual psychotherapy such as Eye Movement Desensitization Reprocessing (EMDR) or Cognitive Behavioural Therapy (CBT) to people with PTSD. However, in (post) conflict areas the expertise and human resources to offer such specialised treatments are often absent. Furthermore, long-term treatments are not feasible because people are often on the move and are unable to commit to regular appointments due to other obligations (e.g. working on the land, logistical issues, taking care of family members). When working in these contexts professionals are often faced with people like Patrick Adonga: people who have experienced several adverse events and are possibly suffering from PTSD, but with no or limited treatment methods available.

To tackle the challenge of offering appropriate treatment to people suffering from PTSD with limited resources available, Narrative Exposure Therapy (NET) was developed by the international NGO Victim's Voice (Schauer, Neuner & Elbert, 2011). NET is an individual, culturally sensitive and short-term psychological treatment aimed at recovery from adverse/traumatic experiences and associated symptoms of PTSD. This alternative trauma focused therapy was especially created for professionals working in (post) conflict settings. It has been developed, designed and tested in several countries (Uganda, Sri Lanka), where it proved to be an effective method to reduce PTSD symptoms, both for children and adults (Catani et al., 2009, Neuner et al., 2008a, 2008b, 2004, Ruf et al., 2010, Schaal, Elbert & Neuner, 2009).

NET aims to put the traumatic experiences in the context and chronology of a person's life. All that is needed is a rope, flowers and rocks in different shapes and sizes. During NET the patient, together with the counsellor/therapist, uses the rope to symbolize the lifeline of the individual, starting with the day he or she was born and ending at the present day. The end of the rope is rolled up representing the future of the individual. Alongside the lifeline the patient places flowers and rocks. The flowers symbolize positive or happy events in one's life and the rocks symbolize distressing or traumatic events. Each event is given a title and date of occurrence. Taken together, this lifeline with the flowers and rocks gives a clear symbolic overview of what a person has experienced in his or her life.

This method offers the patient an overview of the chronology and the context which is helpful in overcoming upsetting memories. The first session is dedicated to putting down the

lifeline, with in the following sessions the detailed discussion of the identified rocks and flowers. Especially the traumatic events are discussed in detail, such as the emotions, thoughts, physical reactions and details of the context in which the events happened. This trauma-exposure helps the person to overcome his/her fears that are part of the memories and over time helps the client to overcome his/her current traumatic symptoms. All events are written down by the counsellor which offers the client a full story of what he/she has been through. This creates a narrative of a person's life, matching the cultural values of storytelling or oral traditions.

The NET treatment lasts between 8-12 sessions depending on the number of traumatic events a person has experienced. A session lasts around 90 minutes and can be done with a trained translator. This trauma focused therapy can result in a temporary increase in memories and fears during the treatment as part of the recovery process. In most cases, people report a reduction in PTSD symptoms during or immediately after the NET. The full recovery of PTSD symptoms happens in the period after therapy, where improvements of mental health issues can be observed 6-12 months after therapy (Neuner et al., 2010 & 2008b).

In Northern Uganda we as expat psychologists offered a 4-week training course to local lay counsellors in NET (Ghafoerkhan R & Hoogstad M, 2014; Neuner et al., 2008b). After this training they received further on-the-job-training and regular clinical supervision on the NET treatment they offered.

In our work we followed the international guidelines on mental health and psychosocial support services in emergency setting (IASC, 2007). In order to build adequate and long-term mental health resources in a post-conflict setting these guidelines also emphasize the importance of working closely with other organizations and local government within a referral structure.

Based on our experience in the field we have seen that Narrative Exposure Therapy is an effective and valuable tool. NET has proven to be a useful method for newly trained counsellors in treating people suffering from psycho-trauma related symptoms by reducing their PTSD symptoms and improving their overall mental health status.

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* *Name has been adjusted to ensure client's privacy*

MENTAL HEALTH AND PSYCHOSOCIAL SUPPORT (MHPSS) IN CONFLICT AFFECTED AREAS

A MHPSS SCHOOL-BASED PROGRAMME IN THE NORTHERN CAUCASUS

Postercontest, text on the poster: "School, protector, helper and friend"

MENTAL HEALTH AND PSYCHOSOCIAL SUPPORT

Emergencies, humanitarian disasters, have implications for individuals and communities, also in their aftermath. In mental health care approaches, both the individual mental well-being and the context of the family and community are important elements to be taken into account. Because of their comprehensive approach, such programmes are categorized as mental health and psychosocial support (MHPSS) programmes.

Taking a multi-layered and comprehensive approach in MHPSS is propagated in the IASC Guidelines that were developed by the Inter Agency Standing Committee (IASC, a consortium of international NGOs) on Mental Health and Psychosocial Support in Emergency Settings. Despite being developed for emergency settings, the guidelines are applicable for general humanitarian settings as well. Their multi-layered approach is reflected in the intervention pyramid for mental health and psychosocial support in emergency settings. (figure 1)

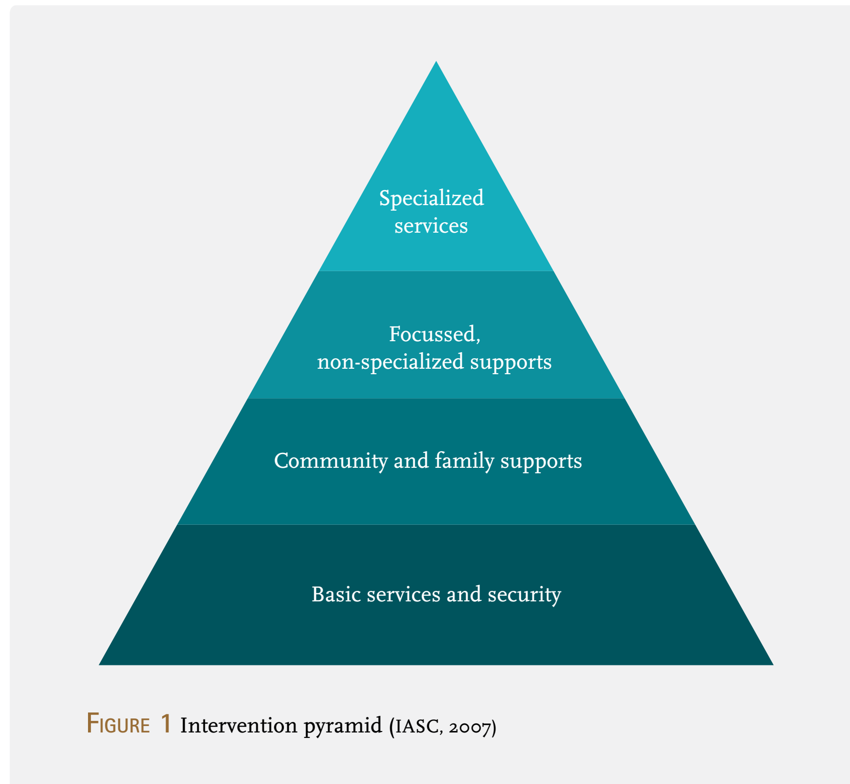

FIGURE 1 Intervention pyramid (IASC, 2007)

This pyramid reflects the needs of people in emergency settings. [1] The base layer refers to basic services and security such as water, food and shelter referring to the protection of the well-being of the population, as well as basic psychosocial assessment and help. The second layer refers to needs of those people who are able to maintain their mental health and psychosocial well-being, provided they receive help in accessing community and family supports. The third layer, the focused, non-specialized supports, represents specific interventions for individuals, families, groups by workers that are trained and supervised. The fourth layer includes psychological or psychiatric services for those whose suffering is intolerable or for people with severe mental disorders. [1] The intervention pyramid suggests that by fulfilling basic needs, less people will need help in a higher layer. Also, offering psychiatric help in emergency settings when people are traumatized, anxious or depressed may not be useful when support at the base layer is also needed.

In (post)disaster situations it is important to adhere to the local setting and values. Taking into account local customs and views is likely to make an intervention more suitable and acceptable. Embedding health care and aid programmes into a local structure, will assist people to find the way to these services and interventions. Moreover such initiatives will be more sustainable. The NGO 'War Trauma Foundation (WTF)' works by this philosophy, and invests in capacity building of local care givers, such as teachers, counsellors, social workers, doctors, nurses, parents, refugees. [2]

A good example of a combined layer 2 and 3 approach is the programme in the Northern Caucasus. Teachers and school psychologists were trained in supporting children in difficult situations and in caring for themselves and each other. With layer 2 relating to bringing people together to share and solve problems, while layer 3 relates to focused individual and group interventions.

A MHPSS SCHOOL-BASED PROGRAMME IN THE NORTHERN CAUCASUS

In September 2004 School nr. 1 in Beslan, North Ossetia was taken hostage by a terrorist group. More than 300 children, teachers and policemen lost their lives. This traumatic event had a huge impact on the whole republic of North Ossetia, and motivated child psychiatrist Anica Mikuš Kos and the local NGO Dostizhenia to start a psychosocial programme in schools. Since 2006 WTF has got involved in this programme in Beslan, and in collaboration with local NGOs expanded it to Chechnya, Ingushetia, Dagestan and Kabardino Balkaria.

The general objective of the school-based programme was to improve the psychosocial climate in schools, as a well-functioning school offers a safe, supportive and motivating climate and help for children with special needs. According to Mikuš Kos, the school - after the family – is the most important life space for school-aged children, with an enormous potential to impact on the quality of life, healthy development and psychosocial well-being of children,

especially for children in difficult circumstances. Also, the school is embedded in daily life and the community. The programme aimed at reinforcing protective factors and addressing risk factors and daily stressors in the life of children and teaching staff. Some of the protective factors include good and supportive relationships with teachers and peers, good achievements, and being competent and successful in sports or in other activities. [3]

STRUCTURE AND CONTENT OF THE PROGRAMME

The 'Capacity Development Programme' used the trainers model, in which local trainers and counsellors were trained by international trainers related to WTF. With ultimately trained teachers and local trainers organizing outreach seminars in schools for school counsellors and teachers. They in turn would disseminate the content and messages that came out of the training to colleagues, parents and children. An important message of the programme was what a difference a dedicated teacher and school counsellor can make in a child's perception of life and his hope for the future. The training emphasized looking for solutions, strengthening existing skills, and coping and resiliency. A guidebook with the most important subjects served as curriculum for the participants.

The majority of the trainers were psychologists, who especially because of their long-term involvement gained knowledge and (training) skills. The teacher training focused on protection and risk factors within schools, but also paid attention to the teacher's own mental health and psychosocial well-being, and how to deal with children with behaviour/emotional problems and/or learning problems. Furthermore relations and communications with parents were addressed. For example, 'what can we do for a child living in a dysfunctional family?' Also attention was paid to dealing with a crisis situation in schools and how to improve the school psychosocial climate.

REFLECTION AND LESSONS LEARNED

The programme was well received in the three republics. With regard to their own well-being and mental health all participants (trainers, teachers and school counsellors) mentioned that they felt calmer and more relaxed, were more tolerant and felt more self-confident. In addition, they mentioned becoming more sensitive to the needs of children and more proactive in taking on a more proactive role. Improved skills and knowledge helped to communicate better with children and parents, as well as with other school team members. Although all subjects were valued, in particular they appreciated the themes on prevention of burnout, the hyperactive child and the underachieving child. One of the teachers illustrated this as follows:

> “A PROBLEM CHILD IN MY CLASS RAN AWAY FROM HOME. I TOLD THE POLICE THAT THIS BOY HAD NO FRIENDS AND NO RESPECT AT SCHOOL, AND THAT ALL HIS CONTACTS WERE BASED ON AUTHORITY. THEN AT THE SEMINAR I REMEMBERED HIM DURING THE TOPIC: 'PROBLEM CHILDREN'. I REALIZED I DID NOT TRY TO UNDERSTAND WHY A CHILD FROM A GOOD FAMILY CAN BE CONSIDERED TO BE A PROBLEM. THE TRAINING HELPED ME TO SEE THE SITUATION FROM THE OTHER SIDE. I DECIDED TO GIVE THE BOY MORE RESPONSIBLE WORK AND TO INCLUDE HIM ACTIVELY INTO CLASS. AFTER A FEW MONTHS HE STOPPED COMING LATE TO SCHOOL, STARTED TO VISIT CLASSES, BEGAN TO DISCIPLINE HIS CLASSMATES AND CORRECTED HIS GRADES IN SCHOOL. TEACHERS CAN DO A LOT FOR CHILDREN. BY INCREASING THE BOY'S SELF-ESTEEM, HE STARTED TO BELIEVE IN HIMSELF AND FOUND THE STRENGTH TO CHANGE HIMSELF.”

The programme also inspired participants to initiate new events at schools, such as additional meetings with parents and extra activities for children, the development of a first aid manual in case of bomb attacks, and a training for youth on assertiveness to prevent the recruitment by rebels.

The volatile situation in the North Caucasus posed one of the greatest challenges. In terms of logistics, participants had to travel more as trainings were relocated because of bomb attacks causing uncertain and insecure situations. On a more psychological level, the long history of insecurity in the Caucasus requires (re)building of trust in 'the other'. Bringing participants from different republics together was a challenge, also because of political connotations. The hostage taking of school nr.1 in Beslan and other violent acts are blamed on (amongst others) Chechnyan rebels. Chechnya and Ingushetia have a predominant Islamic religion and culture and there tends to be an anti-Russian attitude, whereas North Ossetia has a Russian orthodox or pagan religious culture and a pro-Russian attitude. It was quite unique that people from different republics participated in a joint programme and found that they actually have lot in common and much to share.

In conclusion, community-based mental health care and psychosocial support are extremely important for individuals and communities affected by war and organized violence. Schools are excellent community institutions to take as an entry point for mental health and psychosocial support. By focusing on the safe and protective role schools have in the life of children, such programmes have the potential to contribute to the mental health of their families and the wider community. They are important elements in prevention and reinforcing resilience, in individuals and within the communities.

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RECOMMENDED READING

Intervention, Journal of Mental Health and Psychosocial Support in Conflict Affected Areas is published by War Trauma Foundation.

www.interventionjournal.com

mhGAP intervention guide for mental, neurological and substance use disorders in non-specialized health settings: Mental Health GAP Action Programme (mhGAP). World Health Organization, 2010.

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The Tree of Sorrow, a monument on the memorial Beslan cemetary erected in 2005 for the victims of the Beslan tragedy

Encounters with Mental Health Care in Kenya

Roos Korste is a clinical psychologist and freelance trainer for Médecins Sans Frontières (MSF) of local counsellors and community health workers in low-resource settings. She runs a website on global mental health and possible innovative solutions for the immense treatment gap in mental health care in low-resource settings [1]. This website contains an extensive blog post about Roos' encounters with the mental health care situation in Kenya. This article contains a number of fragments of her impressions and the challenges she met.

MENTAL HEALTH CARE SITUATION IN KENYA

The mental health care situation has been improved over the last 15 years in terms of capacity. Nowadays there are 3 national referral hospitals with 1,114 mental health beds. The total number of psychiatrists grew from 16 in 2001 to approximately 80 in 2013. However, only a few of them work in the rural areas; outside Nairobi there is 1 psychiatrist available for 3 to 5 million people. Currently 250 trained psychiatric nurses are deployed: 70 in Mathari National Hospital and 180 in the districts and provinces, resulting in less than 1 psychiatric nurse per district only. Mental health care in Kenya is predominantly government funded, but remains extremely limited in terms of infrastructure, manpower and finances [2,3]. Therefore the specialist service for nearly all regions and districts is largely delivered by extremely overstretched mental health nurses.

USERS AND SURVIVORS OF PSYCHIATRY KENYA (USPKENYA)

1

USPKenya is a Non-Governmental Organization (NGO) whose major objective is to promote and advocate the rights of persons with psychosocial disabilities [4]. USPKenya is 100% peer managed and peer led. They run support groups in Nairobi and a few in the rural districts.

"On a Saturday I had the opportunity to visit a two-weekly peer support group meeting of the USPKenya. Eighteen 'experts by experience' and caretakers came together in a hired room in the heart of the Nairobi city centre. In a quiet, gentle and respectful atmosphere they talked about their ups and downs, ways of coping with the mental problems, work, side effects of medicines, going off medication, experiences with psychiatrists, feelings of hopelessness, but also about getting to terms with their mental condition and hope."

MATHARI STATE HOSPITAL NAIROBI

2

The Mathari Hospital, the only psychiatric hospital in Kenya, has a bed capacity of 700, including 200 for law offenders with a mental illness and 45 for drug and substance abusers. The hospital currently has 400 members of staff including 7 psychiatrists, 70 trained psychiatric nurses, but no clinical psychologist or psychotherapist. The hospital has huge debts, accumulated over the past years because the state subsidies are far below the real costs and patients frequently do not have health insurance coverage and are otherwise unable to pay for their treatment.

There is no psycho-therapeutic potential in the hospital and occupational therapy and rehabilitation services are very limited. They cannot offer the patients the new generation (and more costly) antidepressants (like SSRIs), anti-psychotic drugs (like Risperidon) and modern anesthetics (for ECT). Therefore patients or caretakers have to buy them elsewhere.

"When arriving at the Mathari hospital I found out that there was no electricity in the whole area, driving the pharmacist (worries about her fridge) and anesthetist (preparing an ECT treatment) to despair. In all this disorder and chaos I met psychiatrist dr. Catherine Syengo Mutisya. She didn't seem impressed by the turmoil and took time to explain to me the current practical and treatment challenges and invited me to join her on her round this morning in the forensic department.

I really appreciated the opportunity Catherine offered to look around and write about the Mathari hospital, after a lot of negative (and one-sided) attention the hospital received in a CNN documentary 'Locked Up and Forgotten'[5].

In the forensic clinic 15 patients were waiting to be seen and assessed by Catherine. A few of them were there for medication, but most of them needed a report for court: were they able to plea or not? Some of them were very confused and disorientated patients. Although Catherine was running out of time, she remained patient and polite, going through all the 15 files and letters, trying to understand all the individual patients, their stories and their struggles, deciding what would be the best next step. Catherine and I discussed what could be done to improve the hospital care. Staff could try to trace more relatives who could pay for treatment."

With improved treatment and more positive attention in the media, the hospital could be a place where people send their relatives for treatment, and not only as a last resource. This could attract more people who can pay for their treatment. Recently the hospital was appointed National Teaching and Referral Hospital and this will improve the financial allocation, which gives room for optimism.

Looking at the Mathari hospital in a broader, nationwide context, it would perhaps be better to decentralize the care to smaller facilities in every county and to have more cooperation with, and implementation of community based mental care. This would be in line with current international policies and allow people with mental disorders to live close to their relatives and prevent them from being abandoned and forgotten. [4]

BASICNEEDS KENYA

BasicNeeds is an international NGO with projects in low-income countries. They use an approach which is called the 'Model for Mental Health and Development', helping people with mental conditions and their family members to form or join self-help groups. Not only does this offer support but it facilitates income generating activities as well, like poultry and pig rearing, egg selling, farming dairy goats, soap making and the production of craft and bead products. There are currently 120 self-help support groups all over Kenya, with a cumulative impact of 12,000 affected people.

"I met Joyce King'ori, country programme manager of BasicNeeds Kenya, at the office in Nairobi West [9].The thorough and well-tested principles and methods of BasicNeeds , together with Joyce´s 'thinking outside the box' gives me the impression that this is what community based mental health care is all about: to do more, and reach more people, with the same budget. By building on what exists, going to the people´s homes and empowering them.

On top of Joyce´s wish list for the future is creating mental health facilities for children and youth, because there is still nothing for these groups in Kenya. They want to use the new media in targeting and involving youth. BasicNeeds Kenya is already using bulk SMS services for mothers (antenatal care) and farmers (about crops, rain, advice), but would like to have an internet-SMS platform for youth as well. Another wish is to reach very remote groups like nomads and the people in the districts not yet covered."

CHALLENGES FOR THE FUTURE

It seems that a plan built on a conventional, medical western model of mental health care is prone to failure. Training enough staff with this model will take a century or more. The hope that government or international funding will increase enough to expand the mental health care as it is now, is not realistic either. One must try to reach more people with the same resources and number of mental health specialists. One must build on what is already in place and integrate mental health care, support and awareness campaigns in existing groups, communities and organizations.

Therefore, a shift in thinking seems necessary and one can see above that there are already movements in the right direction.

ACKNOWLEDGEMENTS

I would like to thank all the persons mentioned above, who took the time and effort to provide me with the necessary information. I hope, in due time, I can do something in return.

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Severe skin abnormality at birth

Fig. 1

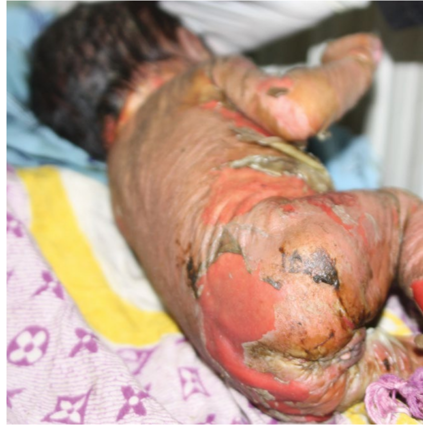

Fig. 2

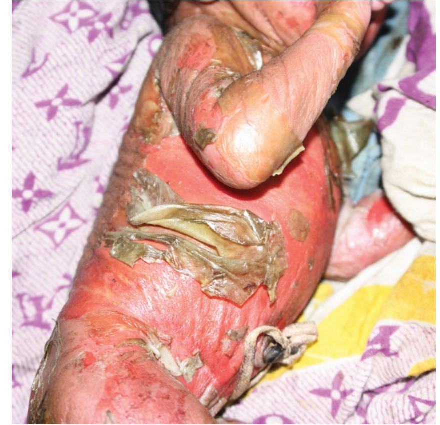

Fig. 3

SETTING

Bale Robe is situated in south-central Ethiopia in the Oromia region, approximately 430 kilometers from the capital, Addis Ababa. This region is known for its fertile highlands used for agriculture and livestock breeding. The Bale Robe District hospital has an annual catchment population of approximately one million people with a low HIV prevalence of 2 to 3 percent. The medical staff exist of one surgeon, one gynaecologist, one tropical doctor and nine general practitioners. The closest referral hospital is five hours' travelling from Bale Robe.

CASE

A 34-week-pregnant HIV uninfected woman, gravida 2 para 1, was referred to the Bale Robe Hospital in Ethiopia because of severe pre-eclampsia. Despite treatment with magnesium sulfate, hydralazine and dexamethasone, the high blood pressure persisted and ascites developed. Subsequently, labour was induced by priming with misoprostol and a girl was delivered without complications or signs of fetal distress. The birth weight was 2200 grams and APGAR scores at 1 and 5 minutes were 8 and 9, respectively. There were no signs of infection in the newborn infant.

The midwife reported a white translucent skin, appearing as a membrane covering the infant. Immediately after birth the membrane detached and blisters developed all over the body surface . Two days later the membrane was dried, wrinkled, gray and it peeled off from most of the skin surface and at these sites a moist, red skin was observed. The trunk and extremities were mostly affected. The head, face, mouth and genitals were relatively unaffected. The infant cried forcefully and appeared to be in severe pain when manipulated. Further physical examination showed no other abnormalities and no fever.

The pediatricians and dermatologists were asked for their advice via Consult Online.

ADVICE FROM SPECIALISTS

Within a matter of hours the dedicated specialists gave their opinion, resulting in a vivid discussion about the possible illness of this child. Several diagnoses were suggested.

COLLODION BABY SYNDROME

The diagnosis first emerging from their e-mails was the Collodion baby syndrome due to the translucent so-called "collodion" membrane covering the infant's body. This is an uncommon clinical presentation of several genetic conditions resulting in abnormal cornification of the skin. Most patients are ultimately given the diagnosis lamellar ichthyosis or congenital ichthyosiform erythroderma characterized by onward skin thickening due to hyperkeratosis. As patients age the scale will become thicker mainly on the soles of hands, feet en flexion areas.

In this child, however, the blisters were a predominant feature, as can be seen in the pictures. Therefore the rare condition congenital bullous ichthyosiform erythroderma was suspected, which is characterized by collodion membrane followed by widespread blisters and erosions. Several mutations in the many keratin genes have been associated with this condition.

The main challenge in all infants with Collodion baby syndrome is the immediate risk of dehydration and infection due to an impaired skin barrier. [1,2]

EPIDERMOLYSIS BULLOSA

An important differential diagnosis was Epidermolysis bullosa, characterized by generalized blistering and erosions induced by minor trauma, caused by a number of specific mutations in the keratin genes. Severe forms present at birth with extensive blistering; milder variants can be detected in the first years of life or even in adulthood. [3]

STAPHYLOCOCCAL SCALDED SKIN SYNDROME

Although in this case the first symptoms were present at birth and no fever was detected, an infectious cause was also considered. The severe Staphylococcal scalded skin syndrome (SSSS) is known to cause generalized blistering due to toxins produced by S. Aureus. Typically, presentation occurs at 3 to 7 days of age with a generalized erythema beginning around the mouth. Flaccid blisters arise one day later, predominantly affecting skin areas exposed to mechanical stress. Treatment consists of immediate antibiotic therapy. [4]

TOXIC EPIDERMAL NECROLYSIS

TEN is considered the more severe variant of Stevens-Johnson's syndrome and is characterized by necrosis of the epidermis and mucous membrane involvement induced by a variety of drugs including sulfonamides, anticonvulsants and NSAIDs. Clinically erythematous skin lesions with a darker centre arise evolving into vesicles and bullae. It may be difficult to distinguish from SSSS.

TEN is a very rare but fatal condition in early infancy, only a few cases have been reported, all after administration of drugs to the child itself. [5]

DISCUSSION

The dermatologists and pediatricians agreed that based on clinical presentation the Collodion baby syndrome was the most probable diagnosis, presumably caused by congenital bullous ichthyosiform erythroderma. There is also a fair possibility the infant suffered from Epidermolysis bullosa. It would have been helpful to distinguish from this condition by rubbing the skin and to observe whether a blister would arise. Unfortunately it was not possible to carry out this test due to a delay in presentation and correspondence with the specialists.

As mentioned before an infectious cause like SSSS is less likely because the child presented with skin abnormalities at birth and did not have a fever. Obviously an infection would at least need a few days for incubation.

The remaining condition, TEN, is less likely because no drugs had been given to the infant prior to the development of skin abnormalities.

A skin biopsy would have given the ultimate confirmation of the diagnosis,

but as in many district hospitals a lack of resources impaired proper histopathological analysis. Despite the lack of a precise diagnosis all specialists underlined the dehydration and infection risks of a major skin defect. Therefore they advised adequate hydration, systemic antibiotic treatment and topical treatment for the skin defects as if they were burns.

FOLLOW-UP

The infant was placed into kangaroo mother care. Although the mother was very anxious when manipulating her child she did a good job with breast-feeding and keeping the child close to her chest. The child urinated regularly so dehydration did not seem to be a major problem. Because of a high infection risk the infant was treated with gentamycin, ampicillin and topical nitrofuzone.

The following days the skin condition did not change. The child gave the impression of being in a lot of pain and nothing but paracetamol was available. Unfortunately the child died several days later.

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