Global Mental Health: The Carter Center Liberia Program

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The Carter Center

Presentation Outline

I. Global Mental Health

II. Social Determinants of Mental Health

III. Barriers to Access and Care

IV. A Call to Action

V. The Mental Health Liberia Program

Global Mental Health

The Emergence of Global Mental Health

- British Journal of Psychiatry (1972-1976)
- Alma Ata Conference on Primary Health Care (1978)
- *World Development Report* (1993) – Global Burden of Disease Report
- *World Mental Health: Problems and Priorities in Low-Income Countries* –WHO, World Bank and Harvard (1996)
- Mental Health Advisor at World Bank; Nations for Mental Health program at WHO
- US Surgeon General's Reports on Mental Health (1999/2001)

The Emergence of Global Mental Health

- Neurological, psychiatric, and developmental disorders: meeting the challenge in the developing world - US Institute of Medicine Report (2001)
- World Health Report, *Mental Health: New Understandings, New Hope* - WHO (2001)
- World Violence Report, WHO (2002)
- Convention on the Rights of Persons with Disabilities adopted by UN (2006)
- Lancet series (2007, 2011)
- MH GAP Action Programme – WHO (2007)

Leading Causes of DALYs

(Both sexes, all ages)

1	Perinatal conditions	6.5
2	Lower respiratory infections	6.1
3	HIV/AIDS	5.7
4	**Unipolar depressive disorders**	**4.5**
5	Diarrheal diseases	4.2
6	Ischemic heart disease	3.9
7	Cerebrovascular disease	3.3
8	Malaria	3.1
9	Road Traffic Accidents	2.6
10	Tuberculosis	2.3
11	Chronic obstructive pulmonary disease	1.9
12	Hearing loss, adult onset	1.7
13	Cataracts	1.7
14	**Self-inflicted injuries**	**1.4**
15	Measles	1.4
16	**Alcohol use disorders**	**1.4**
17	**Schizophrenia**	**1.1**
18	Diabetes mellitus	1.1
19	Falls	1.1
20	**Bipolar disorder**	**0.9**

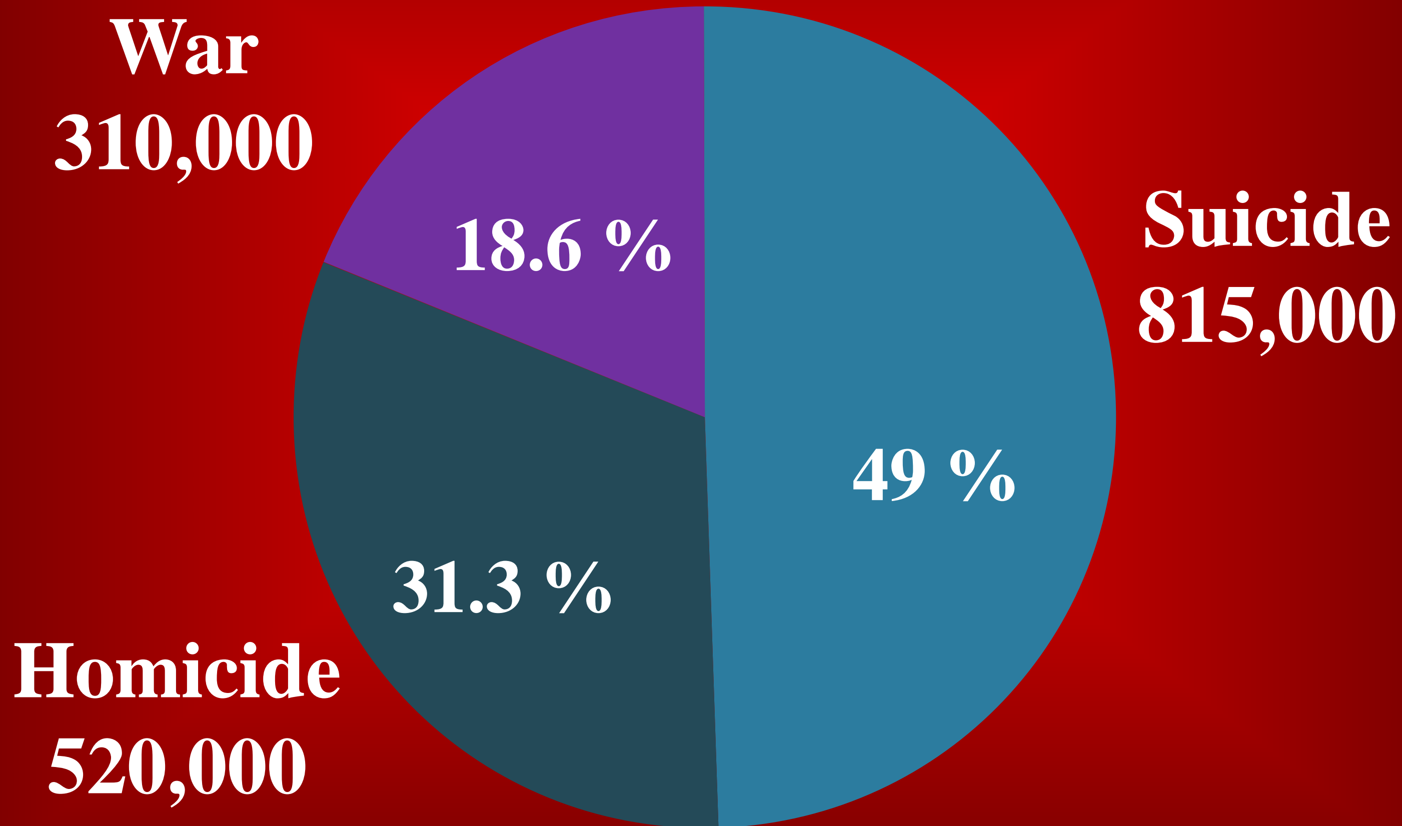
World Health Report, 2001

Leading cause of DALYs
(Both sexes, 15-44 years)

1	HIV/AIDS	13.0
2	**Unipolar depressive disorders**	**8.6**
3	Road traffic accidents	4.9
4	Tuberculosis	3.9
5	**Alcohol use disorders**	**3.0**
6	**Self-inflicted injuries**	**2.7**
7	Iron-deficiency anemia	2.6
8	**Schizophrenia**	**2.6**
9	**Bipolar affective disorder**	**2.5**
10	Violence	2.3
11	Hearing loss, adult onset	2.0
12	Chronic obstructive pulmonary disease	1.5
13	Ischemic heart disease	1.5
14	Cerebrovascular disease	1.4
15	Falls	1.3
16	Obstructed labor	1.3
17	Abortion	1.2
18	Osteoarthritis	1.2
19	War	1.2
20	**Panic disorder**	**1.2**

Source: World Health Report, 2001

Global Violence Related Deaths



World Report on Violence and Health, 2002

The Lancet Series on Global Mental Health

About 14% of the global burden of disease has been attributed to neuropsychiatric disorders, mostly due to depression and other common mental disorders, alcohol-use and substance-use disorders, and psychoses

- **No Health Without Mental Health[9]**
  - **Contributions of mental disorders to disability and mortality**
  - **Reproductive and sexual health**
  - **Maternal and child health**
  - **Injuries**
  - **Implications for policy and practice**

The Lancet Series Continued: A Call to Action

- 2/3 of people with a mental disorder receive no treatment
- Amount needed to provide services on the necessary scale:
  - $2 per person per year in low-income countries
  - $3-4 in lower middle-income countries
- Only 10% of the world's medical research addresses the health needs of the 90% of the global population who live in LAMICs (low-income and middle-income countries)

2011: *The Lancet* Follow-Up of Series on Global Mental Health

Purpose: Tracking progress since 2007 plus renewed call to action

Topics:

- Poverty and mental disorders in low and middle-income countries
- Child and adolescent mental health
- Humanitarian settings
- Scaling up services in low and middle-income countries
- Human rights violations

"We join the call for the inclusion of mental health in a comprehensive health agenda for the world's poorest populations."

2011: *The Lancet* Follow-Up Assessing Progress Since 2007

- Global initiatives launched since 2007
  - WHO's mhGAP intervention guidelines
  - Grand Challenges in Global Mental Health
  - Movement for Global Mental Health
- More countries developing plans to implement mental health policies and improve care
- Increasing presence of diverse stakeholder communities in leadership positions, especially in low and middle-income countries

2011: *The Lancet*
The Rights of People with Mental Disorders

1. To be treated by a professional that understands the disorder
2. To receive treatment in accordance with research and guidelines
3. To receive treatment in a decent, humane, and non-abusive setting
4. To live a fully affective and social life

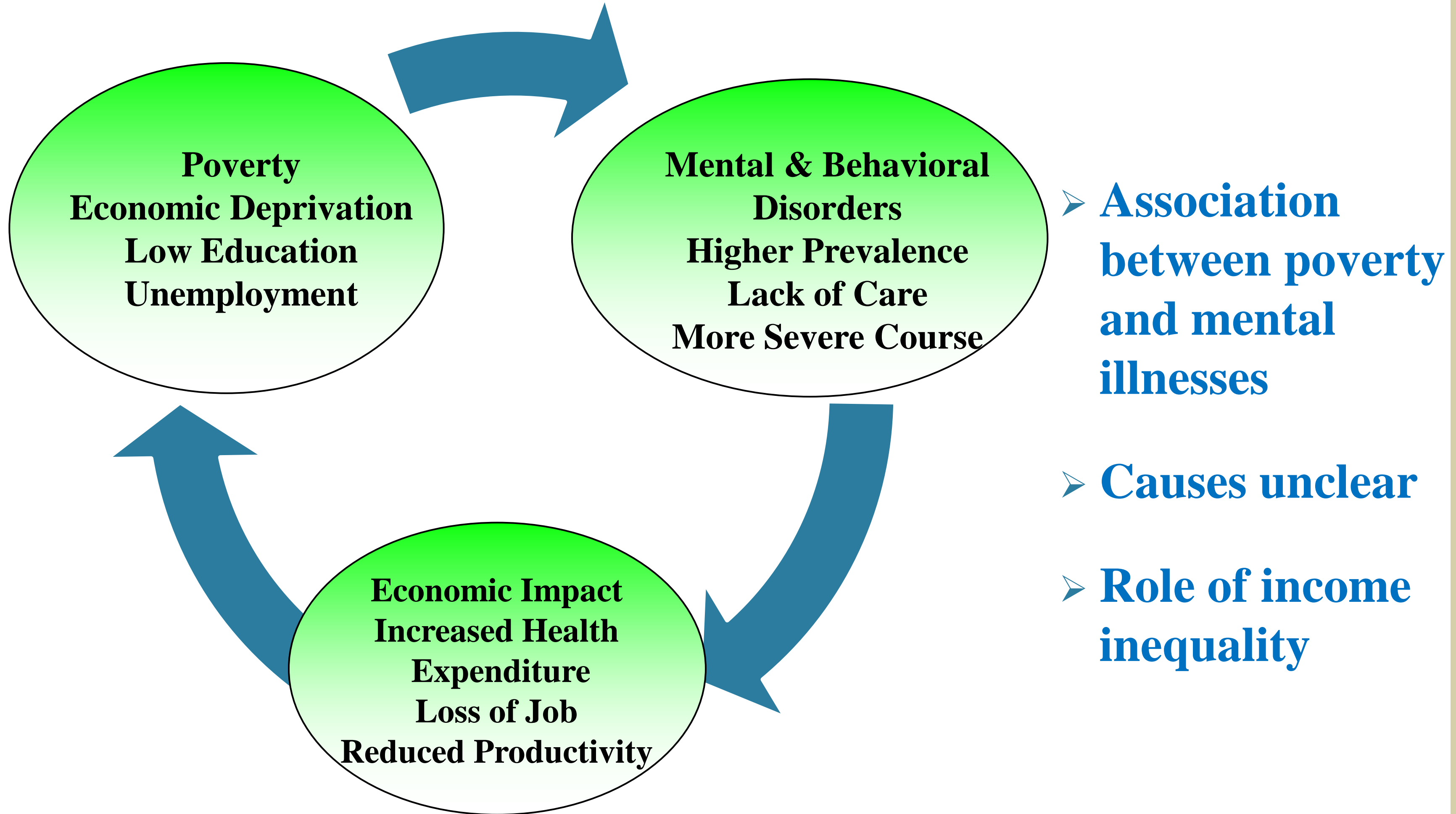
Mental, Neurological and Substance Use Disorders Worldwide

- Lifetime prevalence rates of mental disorders in adults: 12.2–48.6%
- 12-month prevalence rates: 8.4–29.1%
- 14% of the global burden of disease, measured in disability-adjusted life years (DALYs), can be attributed to MNS disorders
- About 30% of the total burden of non-communicable diseases is due to behavioral health disorders

MH Gap Action Programme, Scaling up care for mental, neurological, and substance use disorders, 2008

Social Determinants of Mental Health

Poverty and Mental Illness



- Association between poverty and mental illnesses
- Causes unclear
- Role of income inequality

WHO Investing in Mental Health, 2003

Poverty and Mental Illness: Lancet Series 2011

- Social Causation Hypothesis:
  - Conditions of poverty increase the risk of mental illness through heightened stress, social exclusion, decreased social capital, malnutrition, and increased obstetric risks, violence, and trauma.
- Social Selection or Social Drift Hypothesis:
  - People with mental illness are at increased risk of drifting into or remaining in poverty through increased health expenditure, reduced productivity, stigma, and loss of employment and associated earnings.

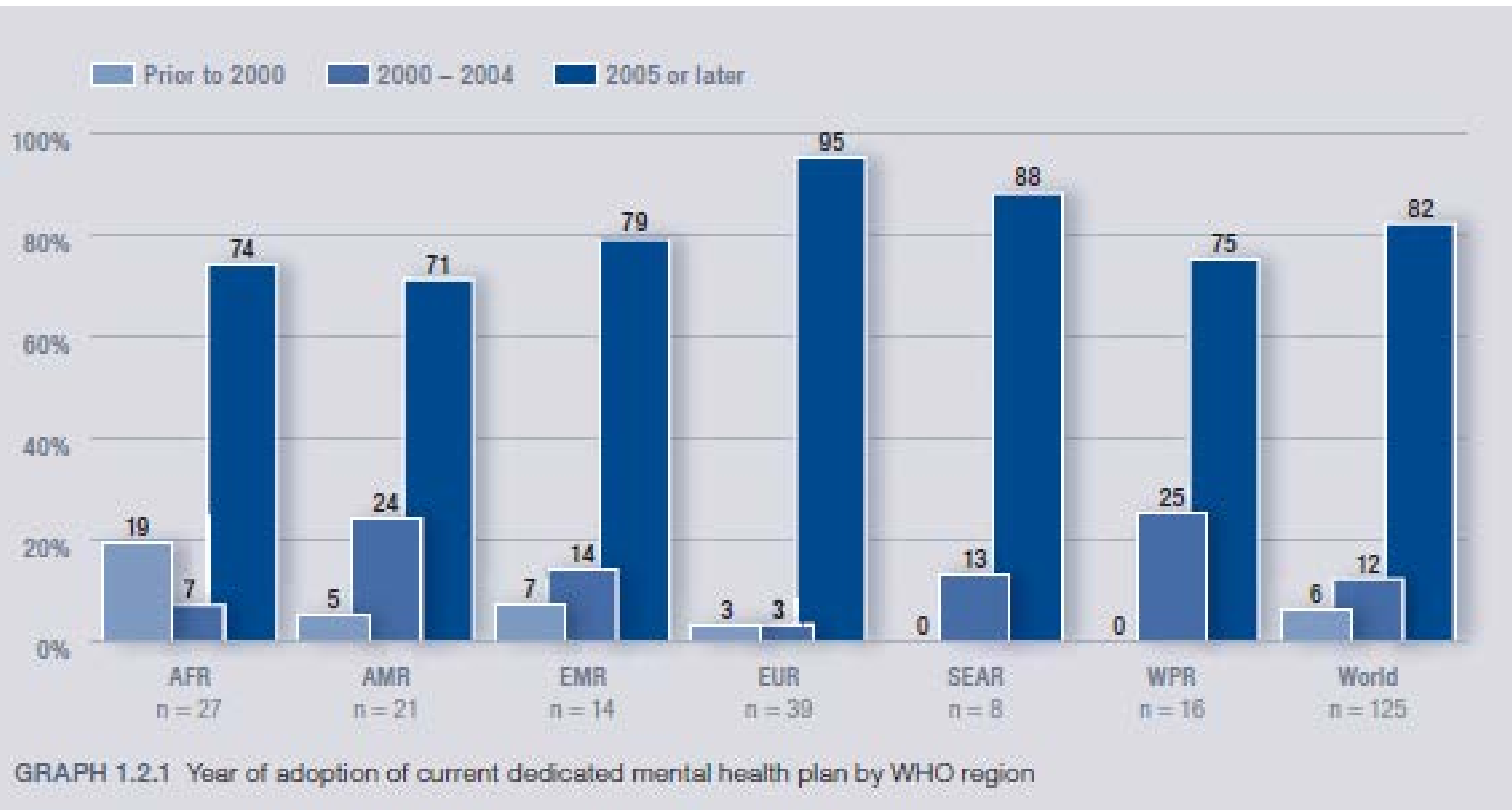
Patel et al., Lancet, 2011

Barriers to Access and Care

Barriers to Care

- Stigma
- Institutional: funding, insurance schemes
- Lack of public information on prevalence and effectiveness
- Quality of services: challenge of research
- Political will
- Cultural differences
- Limited resources: workforce, clinicians
- Limited advocacy
- Social Factors

No recent increases in national mental health plans…



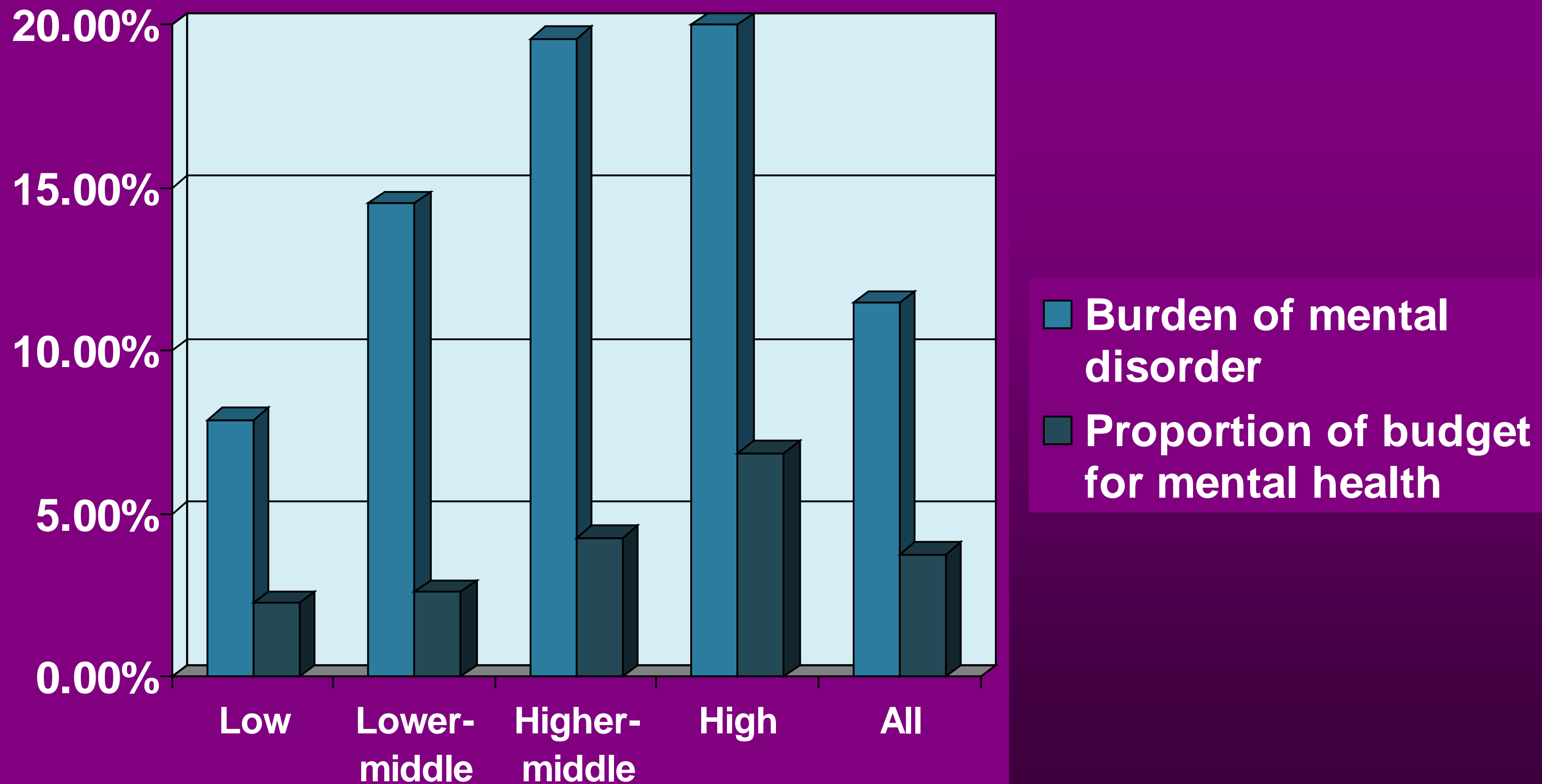
GRAPH 1.2.1 Year of adoption of current dedicated mental health plan by WHO region

WHO World Mental Health Atlas, 2011

Overall Lack of Mental Health Policies

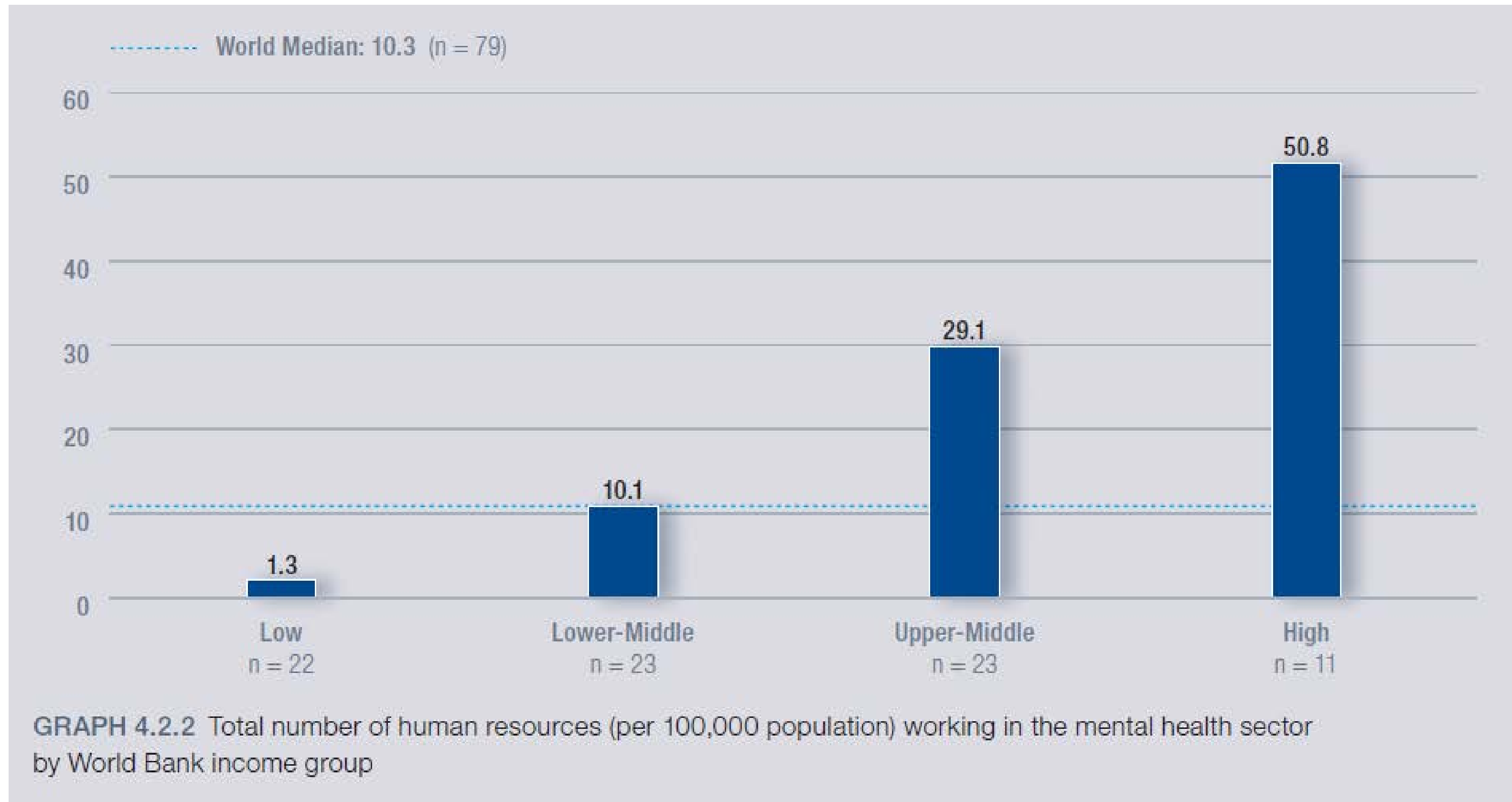
- A dedicated mental health policy is present in approx. 60% of countries covering roughly 72% of the world's population.
- 23% of countries mention MH in their national health plan, but lack separate MH health policy
- Policies are more present more often in high income countries (77.1%) than in low income (48.7%).
- Eight percent of countries have no mental health policy coverage whatsoever

Burden of Mental Disorders vs. Proportion of Mental Health Budget



The Lancet Global Mental Health, 2007

Total Number of Human Resources in MH sector by Income Group



GRAPH 4.2.2 Total number of human resources (per 100,000 population) working in the mental health sector by World Bank income group

WHO Mental Health Atlas 2011

A Call to Action

10 Recommendations for Action
The World Health Report 2001

1. Provide treatment in primary care
2. Make psychotropic drugs available
3. Give care in the community
4. Educate the public
5. Involve communities, families and consumers
6. Establish national programs and legislation
7. Develop human resources
8. Link with other sectors
9. Monitor community mental health
10. Support more research

2011 Lancet: Renewed Agenda for Global Mental Health

Main Challenges:

- Human rights abuses
- Health systems need increased resources to scale up care
  - Budgetary allocations
  - Make sure we are increasing resources for most vulnerable populations
- Learn how to deliver effective treatments in the real world
  - Evidence based interventions, weed out ineffective
  - Increase human resources
- Natural disasters and conflicts
  - Establish a unique opportunity to improve care

Patel et al. 2011

Scaling up Care: Framework for Country Action

- Political Commitment
- Assessment of needs and resources
- Development of a policy and legislative infrastructure
- Delivery of intervention package
- Strengthening of human resources
- Mobilization of financial resources
- Monitoring and Evaluation
- Building effective partnerships

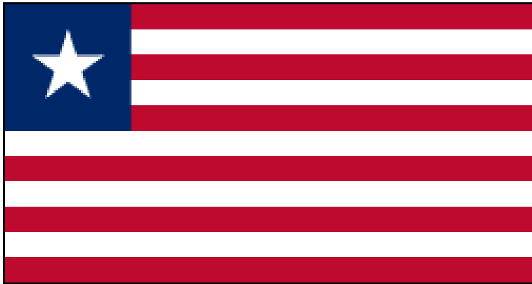
Scaling up care for mental, neurological and substance use disorders, mhGAP Programme, 2008

Increasing Human Resources

- Task Sharing
  - Occurs when non-specialist providers become involved in the delivery of mental health care
- Increase number of mental health providers and psychiatrists

The Mental Health Liberia Program

https://www.youtube.com/watch?v=BwTs-tEa03k



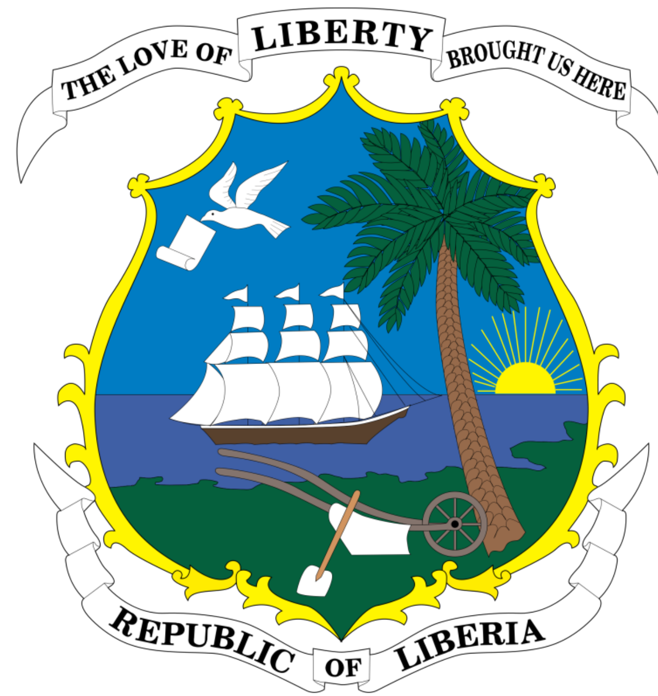
LIBERIA

"The treatment and prevention of mental health problems is of paramount importance in the Liberian context…unless appropriately managed, these problems will continue to undermine the recovery and development of the country."

- Republic of Liberia, National Mental Health Policy

A Nation Scarred by War

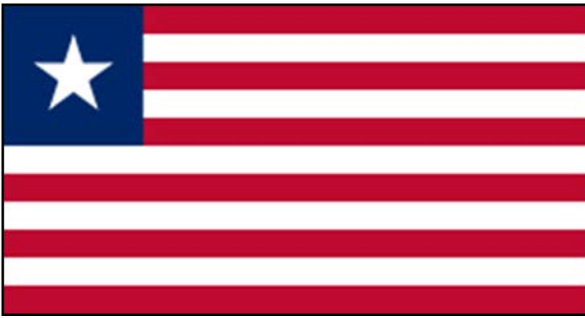
- A total of 2 civil wars in the span of 13 years.
  - Founded in 1847 by freed American slaves, 'Americo-Liberians'
  - A military coup in 1980 sparked civil unrest and a period of war, resulting in approx. 250,000 dead and a torn economy
  - Peace finally reached in 2003



Urgent Need for Mental Healthcare

- **3.7 million population (2005)**
  - 1 psychiatrist, 36 in-patient Mental Health beds
  - Only 41% had access to health services
- **MH Disorders are prevalent throughout the population after the country's 14 years of civil war**
- **MH Disorders also prevalent among ex-combatants**
  - **PTSD: 40%**
  - **Depression: 40%**
  - Suicidal behaviors: 11%
  - Substance abuse: 14%

Johnson et al, JAMA, 2008
Population and Housing Census, LISGIS 2008



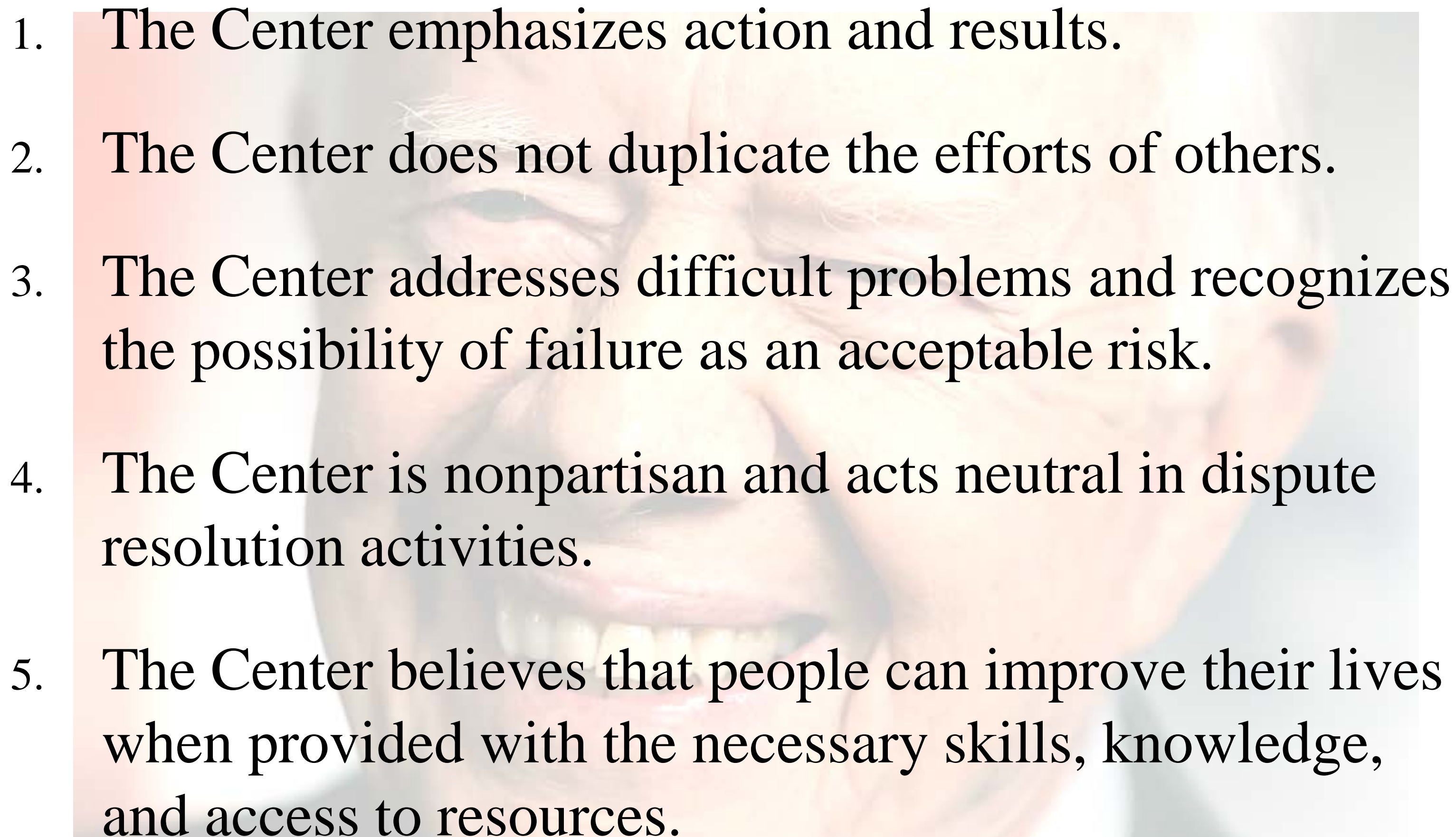
Challenge: Healthcare Infrastructure

- Liberia's government has a compromised health care system with a fragile infrastructure.
- Limited resource capacity (financial, human, supplies, facilities, etc.).
- Lack of qualified health care workers (HCW).
- Inadequate supply of mental health services.

Challenges: Resources

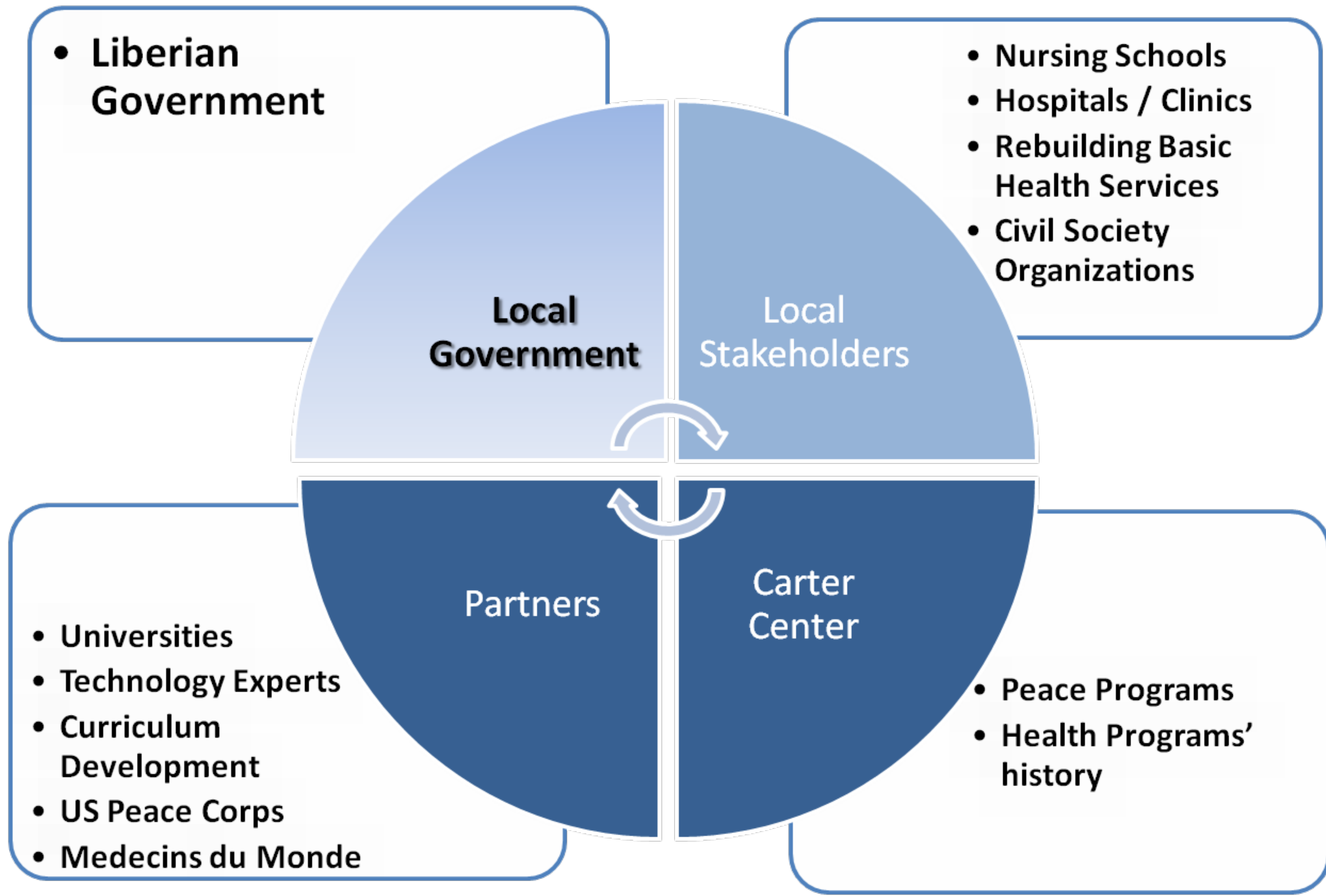
- **Financing**
  - Funding partners
  - Proper incentivizing
- **Environment**
  - Rural access
  - Semi-unstable political environment
  - Infrastructure
- **Brain drain/ qualified faculty**
- **Identifying research needs and capacities**
  - Services research capacity
  - Epidemiological research

Carter Center Five Principles



1. The Center emphasizes action and results.
2. The Center does not duplicate the efforts of others.
3. The Center addresses difficult problems and recognizes the possibility of failure as an acceptable risk.
4. The Center is nonpartisan and acts neutral in dispute resolution activities.
5. The Center believes that people can improve their lives when provided with the necessary skills, knowledge, and access to resources.

The Carter Center Model



Genesis of Interest in Liberia Mental Health Initiative

- The Carter Center has a long history of relations with Liberia through our Conflict Resolution Program that includes:
  - Peace mediation
  - Election monitoring
  - Access to justice
- Lancet Series
- Liberia's need for a functioning mental health system

The Carter Center
Mental Health Liberia Program Objectives

To work with the Liberian government in implementing 3 key components of its Strategic Plan:

1) Training a sustainable mental health workforce
2) Implementing the national mental health policy and plan
3) Reducing stigma and empowering Liberians with mental illness and family caregivers

Strategic Partnership
Liberian Ministry of Health and Social Welfare

- Mental health is a top priority
- Created ministerial Task Force for Mental Health
- Affirms support for proposed Carter Center activities
- Supports inclusion of mental health questions into the National Health Management Information System

Major Service Providers

Tiyatien Health at Martha Tubman Hospital, Zwedru (MDD, EPS)

Grant Hospital, National Referral Hosp. In-patient and outpatient (OP) services

MDM at CB Dunbar Hospital, Gbarnga
Mobile Services in Bong, Comprehensive OP Svs

Training a Sustainable Mental Health Workforce

Partner with Nursing Schools to establish new cadre of health worker

- Nurses and Physicians Assistants who become Mental Health Clinicians return to their primary care settings with new credential and new skills

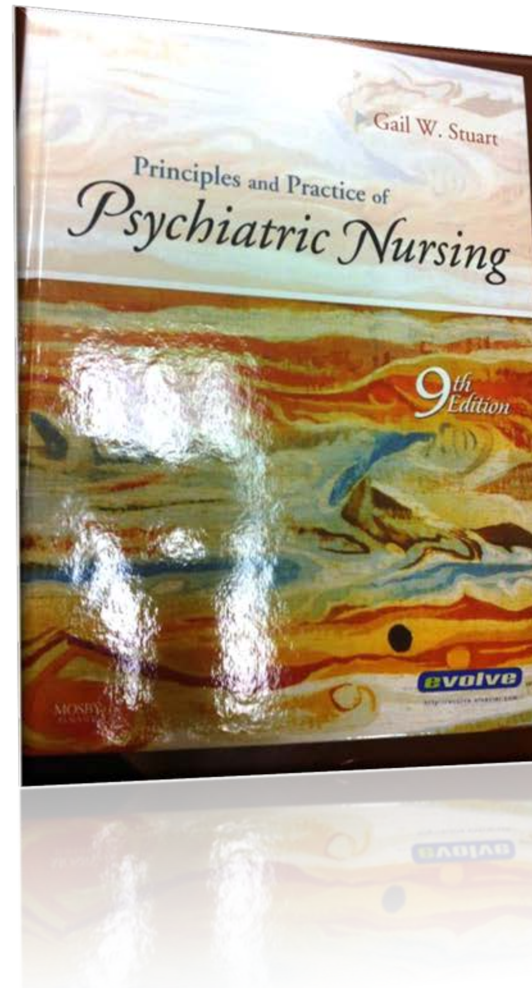
Training Program Design

- Curriculum designed in Liberia, with Liberians health educators and health professionals -reviewed yearly

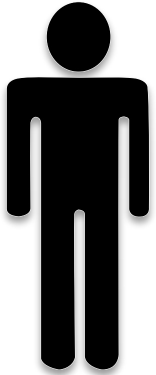
- Uses local nurse education infrastructure/faculty
- Creates culture of high standards & expectations
- Builds a cadre of educators to sustain work
- Train clinicians to support lower cadre workers in identification and referral
- Train for leadership

Training Curriculum

- Six months length of study
- Classroom study - 440 hours
- Clinical practice - 300 hours
- Specific end of course competencies
- Multiple evaluation strategies
  - tests
  - clinical demonstrations
  - class discussions

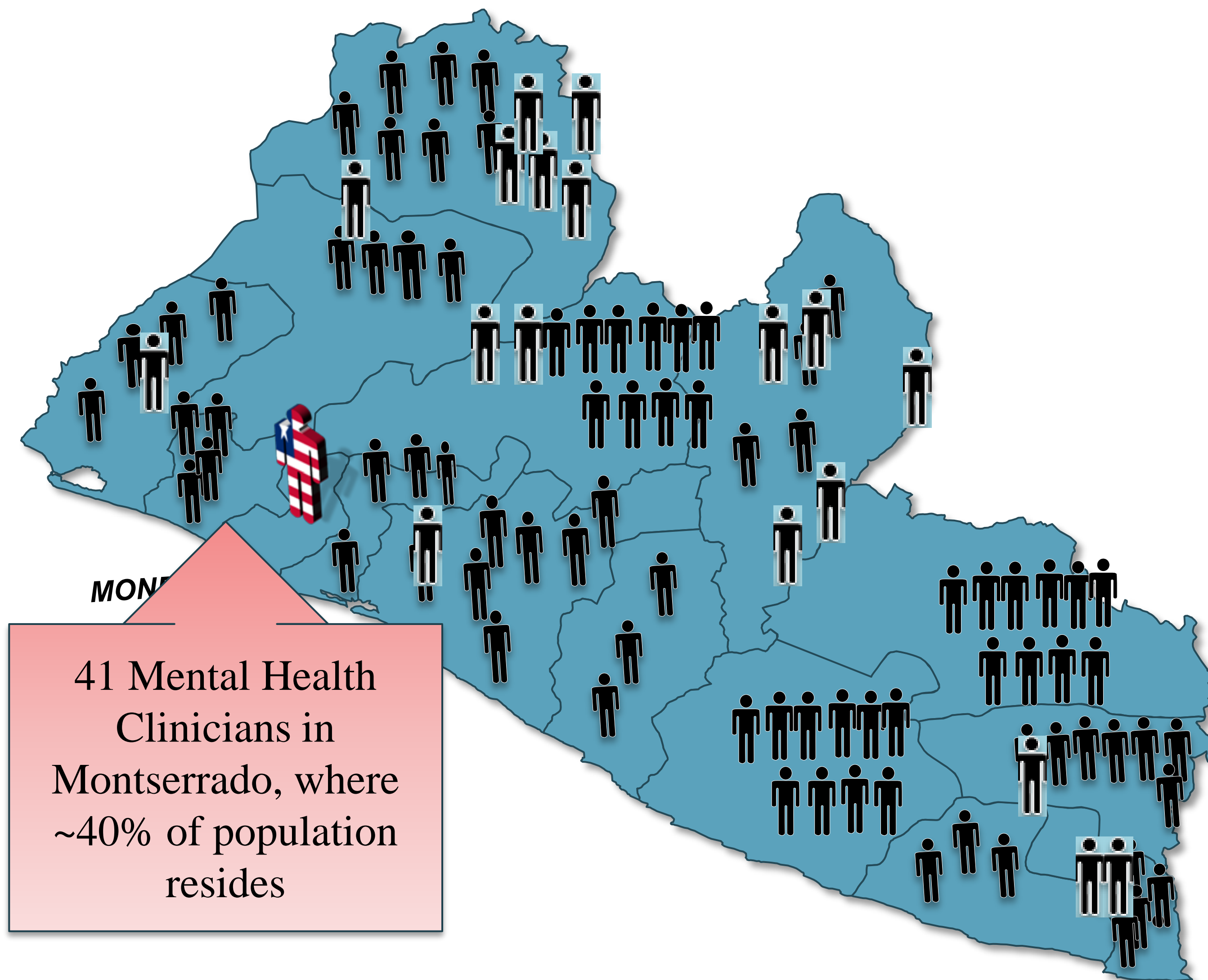


Workforce Prior to 2010



One psychiatrist for the entire country

Distribution of Credentialed 144 Mental Health Clinicians after 7 cohorts (August 2014)

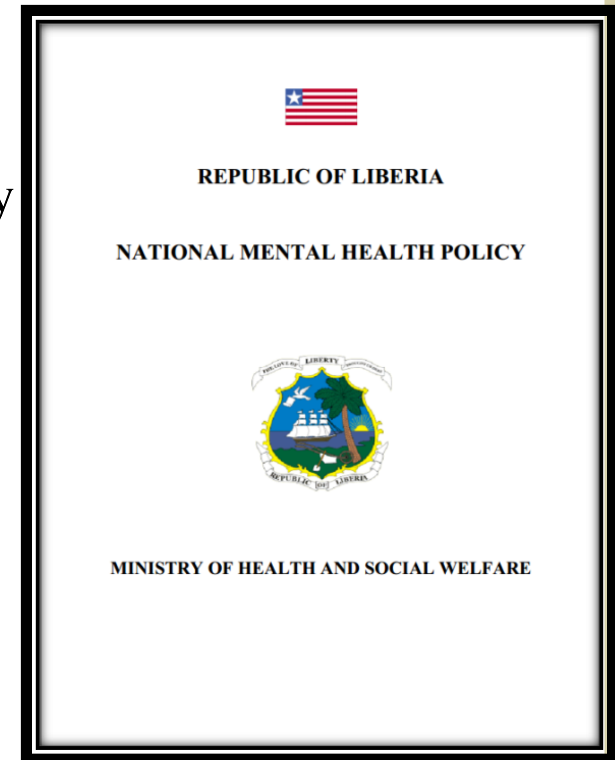


Targeted Implementation of National MH Strategy and Plan

Liberian National MH Policy: 2007

- **Goal:** "…to address the mental health needs of all Liberians through high quality, culturally appropriate, evidence-based, equitable and cost-effective care."

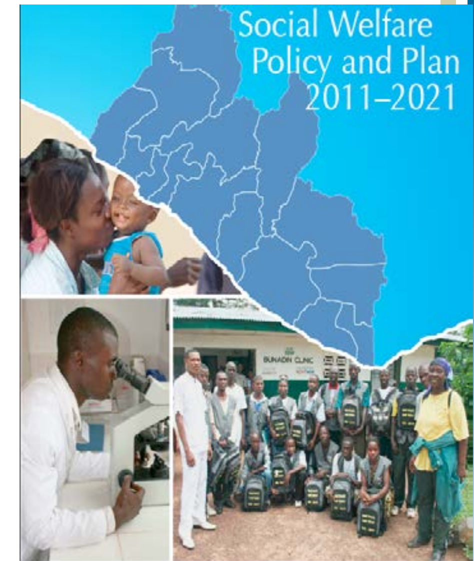
- **Foundations:**
  - Integration into the primary health system
  - Confidential services, free of cost
  - Decentralized care
  - Equitable access to treatment
  - Increased educational opportunities
  - Stigma reduction



Mental Health in 10 Year Health Plan

- 2011– mental health provisions in the Essential Package of Health Services

- **Major Benchmarks related to mental health:**
  - ✓ Increase access to MH and substance abuse services to 20% by 2013
  - ✓ Increase Health and MH in prisons
  - ✓ Increase availability of psychotropic Rx
  - Increase access to mental health medications
  - Increase anti-stigma campaigns in 50% of health facilities
  - Increase workforce capacity by 25%



Mental Health Legislation

- Necessary next step to protect the rights of Liberians living with mental illness
- Mental Health legislation has been drafted and submitted to President Ellen Johnson-Sirleaf
- President indicated her plans to introduce mental health legislation in her January 2014 State of the Nation address

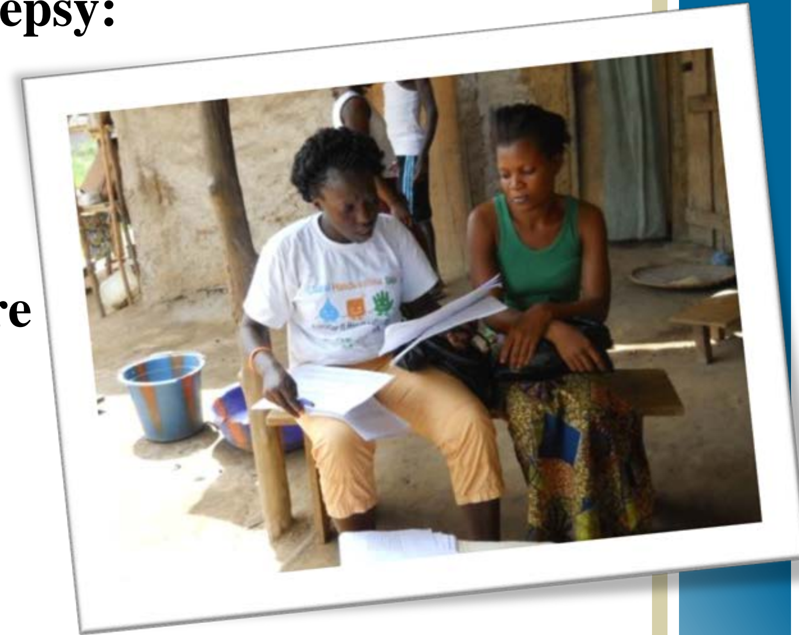
Formation of Family Caregiver Support, MH Advocacy & Anti-stigma Activities

Common beliefs about mental illness and epilepsy:

- Caused by witchcraft
- Punishment for wrongdoing
- Contagious

Understanding and working within the culture

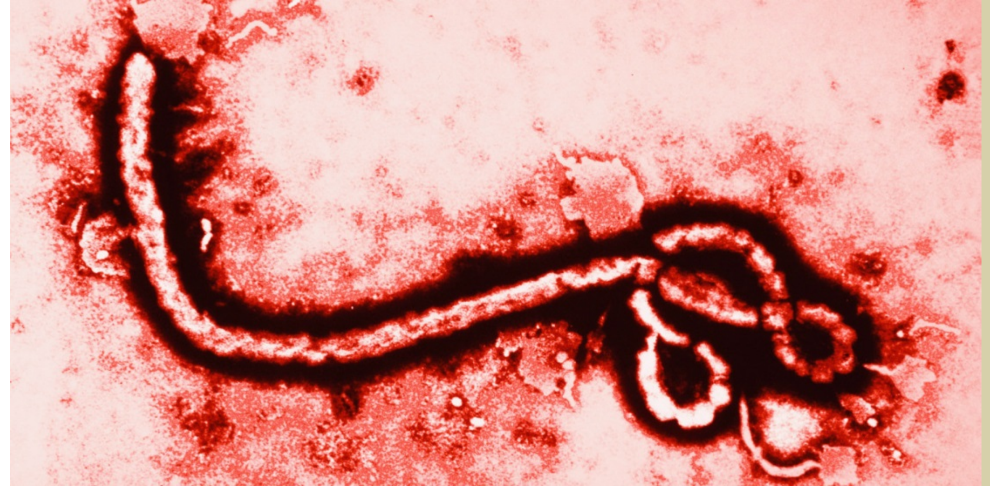
- Essential to achieve behavior change



Development of Social Engagement Anti-Stigma Manual

Manual includes:

1. **Social Engagement** – guidance on narratives, and promotion of general interaction; **essential to have service user involved**
2. **Skill Building** to address causes of stigma
    1. E.g. reduce fear of violence, fear of contagion
    2. Basic Communication Skills to reduce stigma
    3. Skills for De-escalation with culturally specific role plays
    4. Skills for handling seizures
    5. Skills for handling persons with suicidal behavior
3. Appropriate **Referral Pathways**
    1. Role plays for appropriate and inappropriate referrals
    2. Framework for building referrals with greatest likelihood of success



The Impact of Ebola

https://www.hightail.com/download/UlRSSlI1bWdubVdVQU1UQw

Current Situation: Morbidity & Mortality

- Worldwide: 14,098 reported Ebola cases in eight affected countries* since the outbreak began, with 5,160 reported deaths.
  *(*Guinea, **Liberia**, Sierra Leone, Mali, Nigeria, Senegal, Spain and USA)*
- "Weekly case numbers fell in Liberia from mid-September to the end of October. This decline has since stabilized, and a reversal of this trend is possible. Liberia reported 97 confirmed and probable cases in the previous week. Efforts to control the disease remain critical, particularly in the capital of Monrovia."
- More than **120 HCW** in **Liberia** have **died** from EVD.
- **Survival rate** = conflicting data

Source: WHO Roadmap SitRep - 12 November 14

Challenge:
Urgent Need for Mental Healthcare

Ebola is having a profound impact on the mental and psychosocial health of the country.

- Triggers of unresolved trauma from past civil wars
- Loss of family, friends and co-workers
- Compromised spiritual and religious rituals/practices due to health and safety protocols
- Inability to bury the dead
- Cultural mores and community traditions abated
- Stigma

Mental Health Program Liberia's Response

- $20K Carter Center donation to the Ministry of Health and Social Welfare in Liberia to support Ebola response activities.
- Project lead, Dr. Janice Cooper, has been seconded to the Ministry of Health and Social Welfare.
- Co-chairing the Government of Liberia's Ebola Taskforce Psychosocial Committee since August.
- Co-chairing the Training sub-committee.
- Contributed to the development of the National Psychosocial Response Strategy for Persons and Communities Affected by Ebola.
- Transported and distributed 300 *Psychological First Aid for Ebola* manuals.

Mental Health Program Liberia's Response

- Provided technical assistance to mental health officers of the Public Health Commission Corps deploying in mid-October.
- Coordinated the transportation of donated Clorox kits obtained by Development staff for disinfectant use in Liberia's health clinics.
- Training program faculty members conducted an informational session on psychosocial response to the regional Ebola outbreak at a workshop held by the MOHSW.
- Exploring additional psychosocial Ebola response activities including de-escalation training for the Liberian National Police, refreshers for MHCs, psychosocial support to first responders and health care workers in the emergency treatment units.
- Seeking funding to provide additional psychosocial training and support.

Carter Center Trained Mental Health Clinicians in Action

- Nearly 20% of the Mental Health Clinicians (N=26) are working in 5 different Ebola Treatment Units in Montserrado (4 clinics) and Lofa (1 clinic) Counties, including a recent graduate of Cohort 7 who works with MSF in Monrovia.

MONROVIA

Carter Center Trained Mental Health Clinicians in Action

Dozens of other MHCs are:

- Working in community clinics maintaining essential health services for non-Ebola related health needs;
- Working with County Health Teams to provide psychosocial supports for family members, assist with reintegrating survivors, with the contact tracing teams;
- Collaborating with Social Welfare Team to provide essential food and nonfood items to survivors, family members and quarantined communities; and
- MHCs are providing 10-week group psychosocial therapy sessions in three counties for over 80 Ebola survivors and affected family members.

Photo - NY Times: PHOTOGRAPH BY DANIEL BEREHULAK, THE NEW YORK TIMES/REDUX

Hitting Home

In memory…

Oratio T. Hindeh, RN
Cohort 5 - August 2013 graduate
Lofa County Health Team, Foya Borma Clinic, Lofa County
Ministry of Health and Social Welfare (MoHSW)
Died - July 17, 2014

In honor…

Klubo Mulba, PA
Cohort 1 – August 2011 graduate
Clinical Supervisor E.S. Grant Hospital & TCC Training Site
Clinical Supervisor
Diagnosed, treated & released - September 2014

Next Steps – Sustainability

- Aim for complete handover of project to Government and other Liberian stakeholders - planning for sustainability has been key consideration since beginning
- A formal request from the Liberian government to The Carter Center to extend its support for an additional 3-5 years has been received
- Initial discussions with Ministry under way and we are examining key details for success.

"Duration is a critical variable and cuts across all aspects of reconstruction. Based on the cases we examined, no effort to rebuild health after major combat has been successful in less than five years."

Jones, Seth G., et al. Securing Health: Lessons from Nation-Building Missions. RAND Center for Domestic and International Health Security. 2006: p. 29.

Next Steps – Replication

Sierra Leone

- Formal request from the government of Sierra Leone for full replication of the Liberia project has been received
- Discussions are ongoing
- Internal planning has begun

Lessons Learned

Partnerships

- Cement ministry relationships
- Form collaborative relationships that build on strategic advantages
- Do not engage in internal politics
- Learn what others are doing in the field & don’t duplicate

Technology

- Leap frog into most current, relevant technology

Know your environment

- Culturally, economically, politically, etc.

Finance flexibility

Utilize midlevel providers

Design with end in mind

Track impact with data

Contact Information

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