Proposal for a National Mental Health Action Plan for Families, Children and Adolescents Exposed to War Events in Lebanon

Introduction

This document outlines a proposal for a national mental health action plan for children, adolescents and families exposed to war events in Lebanon. This proposal was developed by the Department of Psychiatry and Clinical Psychology at the St. George Hospital University Medical Center/ Balamand University, Faculty of Medicine in association with the Institute for Development, Research, Advocacy and Applied Care, IDRAAC, an NGO specialized in mental health in order to address the mental health needs of the population during and after war using the current resources and drawing on available expertise.

The team at the Department of Psychiatry and Clinical Psychology at the St. George Hospital University Medical Center in association with IDRAAC developed this plan based on its extensive experience in research, clinical and field work in Lebanon for over 25 years, including mass and community mental health interventions for children, adolescents and adults during the Lebanon wars (before 1991)1,2,3,4 and the Grapes of Wrath military operation in 1996 5,6,7,8,9, including long term follow up of war orphans 10,11. This plan was developed after reflecting on the findings from research done in Lebanon12,13,14 and drawing on various guidelines in the international literature from leading mental health organizations and institutes.

Findings from the recent epidemiological study by the Department and IDRAAC of psychiatric disorders in a nationally representative sample of the Lebanese15 have highlighted the lack of awareness and undertreatment of psychiatric disorders in Lebanon as well as their relation to prior war exposure. With the re-exposure of the population to this war, it becomes imperative to conduct a prospective follow up in order to inform policy in Lebanon.

This proposal presents the basic principles guiding the national action plan as well as the phases of implementation.

Basic Principles

This national plan provides an integrated vision which foresees different scenarios and develops contingency plans allowing for continuity and long term sustainability of the intervention efforts. It plans training of professionals and paraprofessionals to deliver services to individuals of all age groups, allocates human resources, creates treatment protocols and develops networks among collaborating agencies. The main principles guiding this national plan are the following:

1. Reaching the largest possible number of individuals exposed to trauma: while most of those exposed to war trauma are probably displaced, yet many are still in their regions. Among displaced families, most are located at schools or refugee centers, but there are many who have sought shelter at other relatives' and friends' homes, and thus need to be reached there as well. Special groups with high exposure to scenes of horror and atrocities including health and rescue workers, among others are also targeted. This plan will specify various tools to be used such as television, radio and printed material (handouts, brochures) in order to reach individuals and families where appropriate.

2. Reaching all geographic areas in Lebanon: this plan takes into consideration the wide geographic distribution of families in need, and incorporates a model where workers in all regions will receive basic mental health training.

3. Prioritizing interventions and tasks in step wise stages with immediate, intermediate and long-term phases of intervention for the entire community which follows a temporal progression based on successful achievement of tasks.

4. Empowerment and training of workers and agents in related fields and who are in contact with survivors of the war events to delegate therapeutic tasks to them. These workers and agents will be identified by various NGOs and agencies to be regionally, locally and geographically representative. Professionals targeted for basic training include social workers, teachers, nurses, allied health professionals and bachelor level students in psychology, education and social work. All the workers will receive basic training in delivering psychological first aid and teaching behavioral strategies to parents of children and adolescents as well as in screening for and identifying psychiatric disorders for referrals to specialized services. Advanced training in trauma management will target professionals with previous mental health experience in treatment of psychiatric disorders.

5. Early identification of cases that need immediate referral to psychiatric care by setting up a network of regional psychiatric treatment centers. These treatment centers consist of teams of trained professionals and paraprofessionals that serve the purpose of not only providing care to acutely ill individuals, but are also regional focal and resource points for training of field workers within their region. A hierarchy of networking of these centers implementing this plan is proposed starting with a central planning, coordinating and training team providing leadership and branching to regional and subregional local centers and teams.

6. Use of quantitative and qualitative validated tools for data collection: it is imperative to be able to collect data systematically in a uniform fashion across all sites participating in

this national program. The use of questionnaires and screening tools will be mainstreamed to facilitate analysis of outcome measures and provide feedback on the effectiveness of the interventions delivered.

7. Promotion of functional and adaptive attitudes during and post-war: building resilience among citizens through specific strategies. This helps avoid "pathologizing" people suffering from psychological symptoms commonly encountered in post war settings.

8. Addressing continuity of services and long term sustainability: an intrinsic aspect of this plan is the ongoing training and supervision of trainers and field workers such that the skills they acquire will continue to be useful to them in their direct contact with families in the long run. Additionally, the plan and training of field workers allows for continuity of service delivery even after population shifts have taken place. Once displaced families return to their hometowns and villages, they will be out of contact with the regional team that provided services to them initially. A mechanism is set up such that a family returning to its previous home or to a new one can be hooked up to the mental health team closest to it in its new location. Similarly, once the school year gets under way, many families may relocate from schools where they are taking shelter now, and services to them will continue uninterrupted in the new areas where they seek shelter.

In addition, the frame of application of these general principles will be as follows:

1. Collaboration and division of labor by various NGOs: this far reaching national plan cannot be carried out by one NGO or group of professionals alone. It assumes a national collaborative effort where tasks are divided by specialty or by geographic availability.

2. Use of evidence-based practices: this plan incorporates psychological interventions that are supported by scientific evidence of efficacy. There are many theoretical and practical approaches that have been proposed to use during war time and post disasters but unfortunately, many have proven to be either ineffective, have not been tested scientifically, or have the potential to cause more harm than good. This plan selects safe and effective interventions supported and endorsed by international scientific organizations specialized in mental health work and in post disaster management guided by local research findings and previous field experience in wars in Lebanon.

3. Culturally sensitive planning and delivery of interventions: one of the most common pitfalls of mental health relief plans is the blind application of techniques developed in a context vastly different from the one they are being applied in. This plan examines the specific cultural parameters of various groups in Lebanon and adapts interventions to make them culturally acceptable.

4. Developmentally appropriate interventions: since children and adolescents are targeted in this plan, interventions have to be developmentally based; eg interventions for preschoolers are different than those for school-aged children; those for younger adolescents are different than ones for older adolescents.

5. Facilitation of collaboration among various agencies and governmental organizations involved in the relief effort: availability and delivery of psychiatric medications and psychiatric hospitalization may be carried out by other agencies (eg Ministry of Public Health) and close coordination is needed. Collaboration with the Ministry of Education and school administrators will be needed as plans for the new academic school year gets

under way and school based mental health interventions delivered by trained teachers can be implemented.

Phases of Implementation of the National Mental Health Plan

This national plan will be implemented in 3 phases that follow successively: an immediate phase, a short term phase, and a mid to long-term phase.

Immediate Phase (2-4 weeks):

In this phase, the immediate tasks are to set up the network of regional mental health teams, disseminate basic information, refer emergency cases of already identified psychiatric patients and prepare the series of training workshops for the next phase. The goals for this phase will be achieved as follows:

A. Set up the central coordinating, planning and training team consisting of mental health professionals who will train and supervise regional supervisors and trainers.

B. Identify regional mental health professionals who will serve as focal treatment points and training teams for local field workers.

C. Identify local field workers from NGOs and rescue organizations by region and sub region who will receive training in implementing interventions.

D. Ask local field workers to identify and refer to the regional centers patients already identified with psychiatric disorders in urgent need of services for medication management and/or hospitalization as well as children and adolescents with developmental or severe behavioral disorders in need of the same.

E. Train regional supervisors in conducting systematic focus groups with local field workers/rescue workers to process with them their own reactions to traumatic events, their own perceptions and beliefs about what constitutes mental health relief services as well as collect information from them on their perceived needs gathered from their field experience. This is a crucial step in the process in order to gather information from the field about the needs which vary from one place to another, and to help identify local field workers who will be able to carry out the required tasks and to function as team players.

F. Plan for a series of workshops following the above focus groups to take place at set intervals (eg every 10-14 days) to complete basic training in mental health for local field workers. This basic mental health training will give workers skills in delivering psychological first aid, teaching behavioral strategies to parents of children and adolescents and in screening for and identifying psychiatric disorders for referrals to specialized services.

G. Disseminate basic information on normal or expected psychological reactions after war as they pertain to children, adolescents and adults. This dissemination effort will include media messages to reach the largest number of people possible, as well as simple handouts that can be given to parents and workers in the field. The media will play a very important role in alerting displaced families at relatives' and friends' homes to the availability of the regional mental health teams closest to them.

H. Begin implementing structured play activities with children and age-appropriate activities with adolescents and adults at displacement centers.

Intermediate Phase (from 1-3 months):

During this phase, field workers will complete their training and will begin mental health interventions and screening. The goals of this phase will be met as follows:

A. Local field workers, under the supervision of regional mental health teams, will start providing psychological first aid measures to children, adolescents and adults. They will hold group meetings at their local centers to educate parents and children and adolescents about healthy means of coping and normalization of activities.

B. Local field workers will deliver training sessions to parents in behavioral techniques that they can use with children. Evidence based behavioral strategies will be taught to parents to prevent development of dysfunctional and disruptive behaviors in the children and to improve communication. These parenting skills also diminish the magnitude of externalizing and internalizing symptoms among children with these disorders, improve parent-child relationships and decrease the severity of parent-child conflicts that are likely to arise during this period, thus decreasing the need for immediate referral to more specialized services. These strategies are preventive in nature and serve to prevent the progression of war-related psychological distress into severe and persisting disorders. These parental training sessions are manual based with specific step by step instructions and ”exercises" to perform in between sessions. Ongoing supervision of workers will take place by the regional teams who in turn are supervised by the central team.

C. Once they complete their training, local field workers will start systematic screening efforts to detect undeclared cases of Anxiety and Depressive Disorders, Post-Traumatic Stress Disorder (PTSD), traumatic grief reactions, hyperactivity, and conduct disorders. This screening process will use quantitative questionnaires and rating scales filled by parents as well as by children/adolescents themselves. This case detection relies not only on rating scales and objective measures, but also on the capacity to describe symptoms and identify children at risk based on tools the workers acquired in their training workshops.

D. The process of referrals to the regional mental health teams will continue as more and more cases are identified through mental health screening at the local level.

E. Families not at schools or refugee centers but residing with other family and friends will learn about these efforts through the media and will be directed to contact the regional teams who will assign them to the proper local intervention team closest to them.

F. Individuals with high risk behaviors eg suicidality, aggression, psychosis, extreme risk-taking or substance use will be referred to more specialized services immediately upon identification.

Long-term Phase (3-12 months):

In this phase, consolidation of the activities planned in the two earlier phases continues. Local workers continue to gain more skills and expertise in identifying and working with psychological conditions. Mainstreaming of referrals to regional and the central team takes place. Advanced training of mental health professionals in trauma management allows a greater number of individuals to be reached on a local level. This phase also offers the opportunity to conduct a nationwide study to follow up on a nationally representative sample of Lebanese. The goals of this phase will be accomplished as follows:

A. As the local field workers continue to build their skills and deliver their interventions under supervision, these skills will be fine-tuned and workers can improve their ability to deliver services further. Workers who were not able to reach a group of families at a local center may now reach them, or assign them to other workers in other regions in coordination with the regional teams if families relocate.

B. Advanced training in more specialized psychological techniques will be offered to mental health professionals with experience in treating mental disorders. This advanced training enables more professionals to deliver either individual or group services to adults, children or adolescents locally without having to refer them to the regional teams. This includes the efforts to reduce the severity of existing problems to prevent these difficulties from assuming a chronic course.

C. Cases with delayed onset disorders or those with persistent psychological distress despite receiving psychological first aid and group interventions locally will need to be referred to the regional and central teams for more specialized services.

D. This phase offers a unique opportunity for research that feeds into policy planning for Lebanon. IDRAAC has recently conducted the first national epidemiological study of psychiatric disorders in a nationally representative sample[15]. The first results of this study were published in the Lancet in March 2006 and other publications are on the way. The study was conducted in association with Harvard University and the World Health Organization (WHO), Geneva[16, 17]. Early results revealed that psychiatric disorders in Lebanon are very common but there's a huge unmet need for treatment among affected individuals. Additionally there was a relationship between exposure to previous war events and current disorders. With this unfortunate war in Lebanon, large segments of the population have been re-exposed to war events, and this presents a chance to conduct a naturalistic prospective study of the mental health of the Lebanese population by re-interviewing a convenience sub-sample of those originally interviewed before this war.

References

1- Cross-National Collaborative Group. The changing rate of major depression: Cross-national comparisons. JAMA, 1992; 268:3098-3105.

2- Karam EG. Post-Traumatic Stress Disorder. The Lebanon Wars. United Nations Development Programme / Department of Humanitarian Affairs, 1994. UNDP/DHA Disaster Management Training Programme.

3- Weissman M, Bland R, Canino G, Faravelli C, Greenwald S, Hwu HG, Joyce P, Karam EG, Lee CK, Lellouch J, Lépine JP, Newman S, Rubio-Stipec M, Wells JE, Wickramaratne P, Wittchen HU, and Eng-Dung Y. Facing Depression: Women's increased Vulnerability to Major Depression: Cross-National Perspectives. World Psychiatric Association Press, WPAP, 1994; 2 (4):1-3.

4- Karam EG, Noujeim J, Saliba S, Chami A, Abi-Rached S. PTSD : How Frequently Should the Symptoms Occur? The Effect on Epidemiologic Research. Journal of Traumatic Stress, 1996; 9(4):899-905.

5- Karam EG, Karam A, Mansour C, Melhem N, Saliba S, Yabroudi P, and Zbouni V . The Lebanon Wars Studies: The Grapes of Wrath Chapter. Phase I. The Final

Report. UNICEF, 1996; Beirut, Lebanon.
6- Karam EG, Al-Atrash R, Saliba S, Melhem N, Howard D. The War Events Questionnaire. Social Psychiatry & Psychiatric Epidemiology, 1999; 34 (5): 265-274.
7- Karam A, Karam EG, Zebouni V, Yabroudi P, Cordahi Tabet C, Fayyad J . Traumatismes de Guerres. Prévention Psychologique à Large Echelle en Milieu Scolaire. Stress et Trauma, 2002 ; 2(3) : 169-177.
8- Fayyad J, Karam EG, Karam A, Cordahi Tabet C, Mneimneh Z and Bou Ghosn M. PTSD in Children And Adolescents Following War. In Raul R. Silva (Ed.), Posttraumatic Stress Disorders in Children And Adolescents. Handbook. W.W. Norton and Company: 2003; 306 –352.New York.
9- Fayyad J, Karam EG, Karam A, Cordahi Tabet C, Melhem N, Mneimneh Z, Zebouni V, Kayali G, Yabroudi P, Rashidi N and Dimasi H (October 2002). "Community Group Therapy in Children and Adolescents Exposed to War". Research presentation at the 49th Annual Meeting of the AACAP (American Academy of Child and Adolescent Psychiatry), San Francisco, USA.
10- Cordahi Tabet C, Karam EG, Nehme G, Fayyad J, Melhem N, Bou Ghosn M, and Kabbara H. (October 2002)."Orphans of War: A Four Year Prospective Longitudinal Study". Research presentation at the 49th Annual Meeting of the AACAP (American Academy of Child and Adolescent Psychiatry), San Francisco, USA.
11- Cordahi Tabet C, Karam EG, Nehmé G, Fayyad J, Melhem N, Rashidi N. Les Orphelins De La Guerre Experience Libanaise et Méthodologie D'un Suivi Prospectif. Stress et Trauma, 2002 ; 2(4) : 227-235.
12- Fayyad J, Jahshan C, and Karam EG. Systems Development of Child Mental Health Services in Developing Countries, In Myron Belfer (Ed), Cultural and Societal Influences in Child and Adolescent Psychiatry, Child and Adolescent Psychiatric Clinics of North America, 2001;10(4): 745-762. W.B. Saunders Company. Philadelphia, Pennsylvania.
13- Karam EG, Cordahi Tabet C, Fayyad J, and Karam A (May, 2003). "War Trauma" and "Mental Health Sequelae of the Lebanon Wars" . Research Presentation at the 156th American Psychiatric Association (APA) Annual Meeting, San Francisco, USA.
14- Karam EG (December, 2004). "War Sequelae and Mental Health: A research from Lebanon". Research Presentation at the International Congress of Ministers of Health for Mental Health and Post-Conflict Recovery, Project 1 Billion, Rome, Italy.
15- Karam EG, Mneimneh Z, Karam A, Fayyad J, Nasser S, Chatterji S, Kessler R. Prevalence and treatment of mental disorders in Lebanon: A national epidemiological survey. The Lancet, 2006; 367 (9515): 1000-1006.
16- Kessler RC, Ustun TB. The World Mental Health (WMH) survey initiative version of the WHO-CIDI. International Journal of Methods in Psychiatric Research 2004; 13:95-121.
17- The WHO World Mental Health Survey Consortium. Prevalence, Severity, and Unmet Need for Treatment of Mental Disorders in the World Health Organization World Mental Health Surveys. JAMA, 2004;291:2581-2590.