Project 1 Billion

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BOOK OF BEST PRACTICES

TRAUMA AND THE ROLE OF MENTAL HEALTH IN POST-CONFLICT RECOVERY

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TRAUMA AND THE ROLE OF MENTAL HEALTH IN POST-CONFLICT RECOVERY

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FOREWORD

This *Book of Best Practices* places its emphasis on the two words *best* and *practices*. In the English dictionary, *best* refers to something most satisfactory or desirable, as well as something that surpasses all others. *Practices* refers to something that is done customarily or habitually, as well as an activity that is repeated in order to perfect a skill. In this volume, leading international authorities from the developed and developing world have contributed their scientific knowledge and experience to recommending the most satisfactory approaches to the care of traumatized people throughout the world.

Each of the essays in this volume is written by an acknowledged scholar, scientist, policy maker or clinician in areas related to mental health and post-conflict recovery.

The chapters follow closely the multi-disciplinary and multi-sectoral design of Project 1 Billion's *Mental Health Action Plan*. For example, chapters on policy and legislation are included with science-based mental health services and economic development.

Each author, in their respective area of expertise, wrote their discussion and recommendations aimed at influencing the policy of Ministers of Health. Of course clinicians, academicians and researchers will also find these chapters informative and helpful.

The Book of Best Practices and Action Plan are scientific documents. They were written together with each serving as a foundation for the other. They should be considered as a single voice, emphasizing the role of science in post-conflict recovery.

Cultural validity and geopolitical sensitivities have been considered in all chapters in the Book of Best Practices. Users of this Book must adapt the science-based practices cited to their own cultural settings and communities.

This Book of Best Practices and Action Plan are an historic first step in establishing a baseline guide for a global mental health agenda. No longer can lack of scientific knowledge be cited for neglecting, ignoring or only partially implementing feasible and sustainable mental health programs in even the poorest countries.

Over 1 Billion persons have been affected by mass violence in recent years; many have developed mental health related disabilities affecting their well-being, productivity and peaceful existence. This Book of Best Practices aims at achieving a rational, culturally sensitive and feasible comprehensive system of mental health care in post-conflict societies.

We look forward to this Book being used, critiqued and modified in the months and years ahead.

In conclusion, the editors would like to thank each of the authors for their extraordinary contributions and our readers for their involvement in this historic effort.

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December 2004

CHAPTER 1

OVERVIEW OF MENTAL HEALTH POLICY AND LEGISLATION
IN POST-CONFLICT RECOVERY

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ABSTRACT

Frameworks for mental health policy and programs are reviewed in this chapter. They need to address mental health needs and outline the effective strategies that will be put in place to address these needs. Infrastructure funding and workforce development need to underpin these policy and program developments and are outlined in this chapter. In addition policies need to be able to add a strong focus for the mental health impacts that occur in conflict-affected societies, or those damaged by other complex emergencies. Primary care is inherently the core framework through which mental health care is delivered in all societies, but nowhere is this more prominent then in developing countries where there are limited specialist mental health provisions.

Post conflict recovery and development must be supported by a strong and adequately resourced commitment to mental policy backing programs to address identified need. These programs in such settings will not only include delivery of core mental health components, but also care for the traumatized populations.

Using primary care indigenous systems will build mental health capacity broadly, and in culturally appropriate ways. Specialist mental health systems need also to be strengthened and to incorporate these issues, while supporting the primary care sector.

Financing to support resource development for mental health will require a high priority, to support workforce, education of the community and necessary infrastructure.

Mental Health legislation follows and links to such developments, but legislation may also be needed to mandate services, including those for trauma recovery. Information systems, research and evaluation, can extend the knowledge of what is good practice, leading to good outcomes. Strong leadership, strong belief in a requirement for mental health care, valuing this, removing stigma and making this commitment in partnership with the community can be the ultimate step for development and renewal.

Mental health policy represents commitment of the government of a country to actively addressing the issues of mental ill health within its population. To be of value any such policy must identify effective actions that could provide the basis for implementation of a mental health program to address identified needs. It must also be supported by a commitment of will and human and financial resources. It should include clear aims and objectives, such as those related to improving mental health, treating mental illness, and so forth.

The basis for mental health policy is in a population mental health model, providing the framework for meeting the mental health needs of the population identified as above and a structure for setting priorities within these (Raphael 2000). This is linked to a template, which quantifies the various components of service required to meeting different priority levels of mental health need (NSW Health - Mental Health Clinical Care & Prevention Model 2000).

Some of the core elements of such a mental health policy, or a blueprint or framework for one, will be described below.

Additional issues for mental health policy arise in countries that have been subjected to conflict, where there has been mass violence or disaster, and destruction of social and physical infrastructures. Mental health consequences arise in association with the psychological trauma, loss and dislocation in such conflict and post conflict settings and significantly interfere with the capacity for recovery, and for development. Mental health policies and programs need to build in capacity to deal with these problems, and also any

consequences for mental health of human rights abuse that may have occurred during the conflict. There may also be requirements for empowering the administrative authorities including health ministers and other Government agents, and for standards and monitoring.

Mental health legislation follows and is integrated with mental health policy where there are legislation requirements. Such legislation has been variable both within and between nations. Earliest forms of legislation have aimed to protect society from the "threat" or "dangerousness" believed to be associated with mental illness, whereas more recent laws tend to be focused on protecting the rights of those with mental illnesses and in some circumstances the right to treatment. A major issue in both policy and legislation relates to stigma and fear associated with mental illness and the discrimination those affected experience with regards to both the illness and the associated disabilities. Mental health legislation may also need to specify requirements related to post-conflict circumstances such as the need for and right to mental health care to address the psychological consequences, as well as issues such as regulating international agencies, donor and NGO roles.

NEEDS ASSESSMENT AS A BASIS FOR MENTAL HEALTH POLICY

Epidemiological studies can provide data on incidence and prevalence of mental disorders in national and regional settings and thus baseline information for policy and service frameworks. The recent WHO report on prevalence, severity and unmet need for treatment covers developed and developing countries in the Americas, Europe, Middle East, Africa and Asia (WHO Kessler et al 2004). It highlights the very high level of

unmet need for treatment of moderate and severe disorders in all countries, but this is most pronounced in less-developed countries. Variable prevalence rates were reported. The researchers highlight that while severity of disorder (and associated substantial role disabilities) were associated with greater probability of treatment in all countries, in developing countries between 76.3% and 85.4% of those with severe disorder had received no treatment in the year before the interview assessment. In publications to date this is not yet linked to presence of national policies and programs for mental health. Nevertheless it is clear that whatever is in place in such settings is inadequate in terms of the severe and disabling level of unmet need. This is also frequently reflected in lack of specialist mental health providers, lack of mental health knowledge and capacity in the primary care sector, as well as lack of priority for mental ill health when survival issues predominate, as they do in some developing countries.

In addition there will be the needs associated with mental health impacts of conflict: consequences of ethnic cleansing, rape, loss of family, profound physical injury, displacement and loss of home, family, community and perhaps country and for some, refugee status. Whether or not a model of PTSD is seen as the most culturally appropriate framework in which to understand the morbidity and adaptive patterns that evolve, it is clear that the consequences of conflict are damaging to function and may have ongoing impacts beyond and on top of core mental health morbidity in the population (Silove 1999). Management of mental health impacts through and after conflict is likely to be essential to prevent as far as possible these disabling consequences and to promote psychological and physical recovery for individuals affected, as well as social recovery for the community.

The assessment of needs can be summarized as follows:

i. Population incidence and prevalence of disorders should be assessed taking into account disorder levels in children and adolescents, adults and older people.

ii. Information concerning risk and protective factors is important to inform promotion and prevention as well as targeting treatment. Variables include social disadvantage, inequity, trauma and social disruption

iii. Conflict trauma and disaster related needs may be estimated taking into account factors such as the numbers of premature violent deaths, population displacement, family loss and disruption and specific morbidities such as PTSD, depression and social impairments

MENTAL HEALTH POLICY

The World Health Organization has surveyed mental health policies across the world and provides a picture of some of the core elements of such policies, and their distribution and limitations (WHO 2001a). This report defines mental health policy as: "a specifically written document of the government or ministry for health containing the goals for improving the mental health situation of the country, the priorities among those goals, and the main directions for attaining them" (p10).

This WHO report notes that such a policy may have components such as advocacy, mental health promotion, prevention, treatment and rehabilitation (to optimize functioning). It indicates that a mental health policy is present in 59.5% of the countries and covers through these 85.1% of the world's populations. Most policies are comprehensive with 97% dealing with treatment, 93% with rehabilitation, 95% with

prevention, 89% with promotion and 80% with advocacy (WHO 2001a, p10). The vital importance of countries having such a mental health policy is emphasized, as is the need for this policy to be "in harmony with the overall health policy of the country" (p10). This reinforces the concept of mainstreaming with general health and highlights the importance of a focus on community-based care.

A range of international processes seeks to support mental health developments such as the World Health Report (WHO 2001b). There are publications and developments relating to epidemiology (as above), rehabilitation and guidelines for promotion, prevention, treatment services and so forth (2004b). The WHO focus has been strengthened with the recognition of the human and economic costs following the global burden of disease study with the World Bank (Murray & Lopez 1996).

Clearly defining policy components and their mix should relate to an evidence base of extent of morbidity/need, resources required to address this need, priorities within it and structures for monitoring and evaluation of effectiveness. There needs to be a cohesive framework linking both mental health problems that exist, evidence based ways of addressing these, and the links to the wide range of other government and non-government agencies essential to improving the mental health well-being of the community. Such a policy will provide the basis for a strategic plan for program implementation, and the monitoring of its implementation and outcomes. Consumers of services and their families and careers are key stakeholders who should be consulted in the process of policy development.

The key elements of a mental health policy thus include the following components:

i. Aims and objectives: these state what the policy hopes to achieve – for instance a reduction in mental health disorders or decrease in impairments associated with such illnesses. Timelines should be identified.

ii. A statement on leadership, management and clinical governance. This would deal with who is responsible, how the program would be lead and managed and how clinical as well as management accountability will be identified in terms of implementing the policy to achieve the aims set out.

iii. Identified needs within the population, how priorities will be determined, what is the evidence base or rationale that will inform strategies to address these needs and achieve the aims.

iv. Care systems that are in place or that will be put in place or changed to enable the aims to be met. The statement should include recognition of the roles of primary care, community care, NGO's and others, as well as those providing physical health care to those with mental illnesses. Specialized mental health services, the roles of mental health professionals such as psychiatrists, mental health nurses, clinical psychologists and allied health workers and the systems of care such as community mental health, inpatient, rehabilitation services need to be described. Holistic health concepts as are important in many cultures need to be encompassed, as should roles such as those of traditional leaders. Care for all age groups should be described.

v. The processes of clinical assessment and provision of effective interventions need to be defined, as they apply to children and adolescents, adults and older people as well as requirements for clinical records and documentation.

vi.   The spectrum of evidence-based (i.e. scientific) interventions should be identified including mental health promotion, prevention, early intervention, treatment rehabilitation and continuing care.

vii.   Partnerships with human services and other agencies such as childcare providers, schools, workplaces, aged care settings, emergency services, police, government and non-government as well as other relevant groups should be discussed.

viii.   Finances, funding and infrastructure requirements need to be   systematically identified as discussed later.

The WHO review of mental health policies across nations shows that there is not necessarily a national mental health program in association with each of these, and that frequently there are profound gaps with respect to both epidemiological data and reporting systems, and specialist mental health professionals to inform and provide care.

PRIMARY CARE AND MENTAL HEALTH

Primary mental health care is seen as the cornerstone of provision in both developing and developed countries. Primary care includes approaches such as community action and empowerment, social process, sociopolitical contexts and a broader biopsychosocial paradigm. It emphasizes the health of the population served as well as the individual. Primary care is usually provided in culturally appropriate ways, often with indigenous healers, and may be the only form of mental health care in developing countries.

Holistic, primary health care models that are responsive to local needs form the basis for care. Such models may encompass the trauma, loss and dislocation associated with colonization. They also require self-determination and indigenous, traditional and

spiritual understanding for healing (Swan & Raphael 1995). They often continue, even if covertly, through conflict and complex emergencies. Enhancing and strengthening mental health capacity to deal with post conflict psychological damage requires respectful consultation and engagement to support these strengths.

SPECIALIST MENTAL HEALTH CARE

This involves many levels of care but is frequently focused on those with "serious mental illness" or psychosis. Many services are institutionally based. The full spectrum of community care, general hospital inpatient services, other mainstreamed specialist treatment programs provided by mental health professionals, and components such as child and adolescent mental health services, forensic services and so forth may be very limited, with few other expert workers available to provide such care.

RESOURCES / INFRASTRUCTURE: TO TRANSLATE POLICIES TO EFFECTIVE PROGRAMS

The WHO Atlas surveying policies and programs worldwide also identifies the resources in terms of broad budget levels, as a percentage of the health budget of countries (WHO 2001a). This report indicated 36.3% of those countries surveyed spent less than 1% of their health budget on mental health, covering more than 2 billion people. It is also clear that less is spent in many of the developing regions, and certainly in those subject to conflict. Indeed in some there is no specified budget for mental health.

Policy and programs require such financial resources to provide for the infrastructure and systems to deliver care, to fund human resources, facilities, psychotropic medication and other necessities for effective assessment and treatment. Without adequate financial

commitment a policy, regardless of its quality, cannot be effective. A strong fund model is necessary to provide basis for resource allocation.

Human resources in terms of the expertise to support primary care and provide specialized mental health services are frequently limited. They require workforce development, education and training. Funding is necessary to support such programs. The WHO Atlas survey reported for instance, that the overall numbers of mental health nurses in many developing countries was less than one per hundred thousand population-clearly inadequate as these are core professionals. Nearly 70% of the world's population has less than one psychiatrist per hundred thousand. Both these figures highlight the vital role of primary care and the need to ensure education and training as well as support for these mental health providers.

Information gathering systems are another key infrastructure. These are essential for epidemiological data, service provision data and reporting on mental health care. While described as present in general reporting of mental health in over 70% of countries, far fewer data systems exist for epidemiological data and for quantifying service provision and its outcomes. Evaluation is another big component.

In summary critical infrastructure includes:
i.   Financial resources proportional to need and priorities, funding models and cost effective and efficient services delivery models, capital and other infrastructure funding streams, as well as research and development.

ii.   Workforce to deal with priority mental health needs, and the processes to support workforce development planning, recruitment, retention, and education and training to build skills and expertise.

iii.   Information systems to provide data on need, clients, activities, outcomes and evaluation cycles.

PROGRAMS FOR IMPLEMENTATION

Mental health programs at a national level are variable. The WHO Atlas report defines a national mental health program as "a national plan of action that includes the broad and specific lines of action required in all sectors involved to give effect to the policy". These are to achieve the policy objectives, by indicating what has to be done, why, who has to do it, in what time frame and with what resources.

The survey found that 69.7% of countries, covering more than 92.8% of the world's population had such national mental health programs; with the majority having some form of community-based mental health care, which was seen as being appropriate for those chronically affected by mental illnesses. The need to increase the availability of such community-based care was emphasized, particularly for countries where existing services were grossly inadequate.

Further dissection of available programs showed that these variously covered minority groups, refugees, indigenous peoples and more frequently dealt with populations of children (59.9%) and the elderly (47.8%). Disaster affected populations were covered in 37.2% of programs according to these reports.

POLICIES & PROGRAMS FOR MENTAL HEALTH IMPACT OF CONFLICTS, COMPLEX EMERGENCIES, DISASTERS & TERRORISM

While some general mental health policies and programs encompass these issues, either in clinical services responding to individuals or with broader initiatives directed specifically to affected populations, they are critical in terms of the community's capacity to recover, and to utilize the opportunities for development.

In developing countries subject to complex emergencies there may be specific risks to survival for those with pre-existing profound and disabling mental illnesses. So programs put in place must not only address emergency mental health issues that result from the conflict, but also provide for the care of those with existing mental illnesses. Sometimes the provision of mental health programs in response to the emergency may drive the further development of more broadly based mental health policies and care.

The World Health Organization has provided specific policy guidelines to inform response in such settings (Mental Health in Emergencies 2003; Mental Health of Populations Exposed to Biological and Chemical weapons 2004a), as have other agencies, for instance for early response to mass violence (NIMH 2002).

Key components of mental health programs that should be embedded in post conflict/emergency health and recovery programs include: provision of psychological first aid and triage in the emergency; provision of acute mental health care for those at high risk or with high priority need - such as the traumatized, dislocated and bereaved; mental health care alongside physical care for those injured; provision and care for those chronically mentally disabled; and community programs to facilitate recovery from the

psychiatric impacts of trauma, grief and dislocation. Rehabilitation programs will also be critical, including those for child soldiers. Models should be built through primary care development and capacity building for local providers such as described by Gupta for children following the Rwanda genocide, or community education programs about coping with trauma (Gupta 1999).

It is critical that such programs are developed in partnership with local communities, are culturally attuned and not super-imposed in western models of traumatology. Furthermore they should be planned with intent of early handover to a longer term management by local communities.

The critical role of effective interventions for this type of morbidity is identified for Colletta and Cullen (2000) in their report on lessons from Cambodia, Rwanda, Guatemala, and Somalia. These case studies highlight the importance of mobilizing communities in their own active recovery and renewal/development processes, while at the same time making available community-based mental health interventions that can impact on vulnerabilities and morbidity to lessen disability and other adverse outcomes. The requirements for mental health programs to deal with conflicts, complex emergencies, disasters and terrorism include:

i.   Identifying extent and level of need and best available evidence of effective strategies to address these specific needs. Exposure to multiple deaths, dislocation and destruction, as well as ongoing threat indicate potential for mental health impact alongside the gross need for essential physical resources such as food, safety, shelter, treatment of injury.

ii. Programs developed in partnership with communities including Psychological First Aid, trauma and grief programs for those at higher risk, population based programs for instance with schools and communities and special programs to deal with human rights abuse impacts.

iii. A focus on capacity building within communities and in terms of policy and programs for mental health.

MENTAL HEALTH LEGISLATION

The World Health Organization has also surveyed mental health legislation across the world. It defines mental health legislation as: "legal provisions for the protection of basic human and civil rights of people with mental disorders". It includes provisions such as restraint, regulation of compulsory treatment, protection of the rights, appeals and so forth. Most legislation encompasses the capacity for containment to ensure the protection of the individual from himself (preventive of self harm and suicide) and protection of others who may be at risk of harm from him because of the impacts of mental illness.

Other legislation is also relevant for people who may be mentally ill – for instance protection from discrimination, e.g., equitable access to disability benefits, community resources and treatment.

Mental health legislation has been reviewed many times and an instrument developed in Australia identifies the key elements of "ideal" mental health legislation (University of Newcastle 1994). This incorporates the U.N. Principles for the Protection of Persons with Mental Illness and for the Provision of Mental Health Care (1991), and the National

Statement of Rights and Responsibilities (1991) developed for the National Mental Health Policy in Australia. Key elements cover principles and objectives; definitions and fundamental concepts; voluntary admission to a mental health facility; involuntary admission; emergency admission; review of involuntary admission; authorisation of treatment; regulation of specific forms of treatment; involuntary treatment in the community; forensic patients; patients rights and complaints mechanisms; and other administrative and review functions.

On the other hand the World Health Organization (1996) has described ten basic principles of mental health care law, which include service provision components. These provide a useful framework through which core mental health legislation can be developed. This report also recognises needs for legislative provisions in other sectors such as housing, employment, social security, education, child protection, drugs and alcohol, and others. The ten principles overlap to a degree with standards for care. They include substantive provisions such as the principle of least restrictive care; confidentiality; informed consent; voluntary and involuntary admission; voluntary and involuntary treatment; independent review; competency and guardianship.

The Ten Basic Principles of Mental Health Care Law are as follows:

1. Promotion of Mental health & Prevention of Mental Disorders

2. Access to Basic Mental Health Care

3. Mental Health Assessments in Accordance with Internationally accepted Principles.

4. Provision of Least Restrictive Type of Mental Health Care

5. Self Determination

6. Right to be Assisted in Self Determination

7. Availability of Review Procedure

8. Automatic Periodical Review Mechanism

9. Qualified Decision Maker

10. Respect, e.g., the Rule of Law.

How provisions deal with both the need for basic mental health laws, and the need for legislation to address human rights abuses and other consequences conflict and complex emergencies is an evolving field.

While the detailed consideration of these issues will inform debate, some developing countries, including those where there has been substantial conflict, may not have specific mental health laws, or health laws which include relevant mental health requirements (WHO 2001a). Mental Health Care law according to this report can be found in 75.3% of countries covering 65.8% of the world's population.

The majority of countries have some form of disability benefit. These may be very limited in provisions and less beneficial than for physical disabilities.

Special legal provision does not appear to cover disaster or conflict affected populations, where specific requirements for such programs could be identified, as well as for humanitarian aid.

A recent review publication has examined mental health legislation and policies and human rights across a number of developed and developing nations (Morrall & Hazelton 2004). These authors consider particularly the relevant issues for human rights and their violations. They also note that stigma and discrimination remain very significant themes and that even in many developed countries with policy and legislation, there is inadequate redress. In addition they report that financial issues such as funding systems and levels may lead to inequities as in the USA. Or lack of government commitment with inadequate health funding generally and low priority for mental health may make it impossible to provide necessary levels of care, even with legislation and policy in place.

In such circumstance both policy and legislation may require government commitment to an identified baseline which should enable efficient and effective focus, for instance for those with highest risk and highest need. Then there may be a balance in legislation between law and order with a greater emphasis on containment, vis a vis human rights and civil liberties. Political use of psychiatry and mental health interventions and containment may not be regulated against to a degree that can protect citizens from a determination that their beliefs reflect mental illnesses requiring containment and treatment, or that they reflect "evil", requiring punishment.

A clear example of mental health issues in a post war society, Mozambique, is provided by Igrega in Morrall & Hazelton (2004). It is reported that the impacts of colonialization, internal armed conflicts, corruption, poverty and failed policies meant that only privileged urban members of the community could receive mental health care while those in rural and disadvantaged areas relied on family groups, traditional and religious healers.

It is on such an inadequate base that special programs to address the psychosocial suffering of trauma survivors were provided.

Even as health systems developed, mental health was not given a priority in this. The first national mental health program only evolved in 1996. This specifically included substance abuse, epilepsy, infant disorders, chronic mental illnesses and psychosocial effects of war and other catastrophes. This also recognized the roles of traditional healers. There is a very active advocacy and non-government sector.

While a national epidemiological survey had not been available as the basis for the overall mental health program, such a study was conducted in one of the former war zones, assessing the effects on mental and physical health (Igrega in Morrell & Hazelton 2004). While a high degree of post-traumatic reactions correlated with high levels of exposure to war and drought stressors, there were concerns about the appropriateness of western measures of mental health impact and their cultural relevance. The authors also indicated that high levels of psychological distress might not be able to be evaluated independently of disruption of social, family, community culture and political systems. Concepts of psychological trauma, for instance are frequently criticized for their cultural relevance and validity. The agricultural cycle was also seen as important, as were the disruptions of social and political systems.

In conclusion, the authors emphasised that both the lack of cultural understanding and the contributions of traditional healers to addressing trauma related mental health impacts as well as in mental health more broadly, were key issues. As they conclude: "lack of

financial resources and culturally sensitive knowledge represents the main stumbling block in the provision of more humane and decent care". (p180, Igrega in Morrell & Hazelton 2004).

RESEARCH AND MENTAL HEALTH DEVELOPMENT

Research is critical in terms of supporting mental health policy and program development, and in terms of evaluating the degree to which needs are met. It is also essential in terms of assessing the mental health impacts of social processes from development to conflict and traumatization; from environmental and climate change to resilience, adaptive and survival strategies.

Some research priorities include:

i. Development of basic mental health need assessment and monitoring tools relevant at primary care levels that can be widely used and are relevant and acceptable across cultural settings.

ii. Examining models relevant to psychological traumatization, adaptations and outcomes in different cultural and social settings.

iii. Time and change processes analyses of the impacts and outcomes of mental health policy and program implementation, including the core elements that are likely to drive effective processes in terms of achieving outcomes aligned with policy aims.

iv. Children, young people, families should be assessed to examine mental health issues with this population, as well as impacts of trauma. Prevention and early intervention programs and impacts, particularly in relation to education access and development are relevant.

v.   Development of data for mental health impact statements, looking at relationships of factors such as levels of conflict, social disruption, status of women and so forth.

CONCLUSIONS

Mental Health policies and programs are critical components of health care in all societies. The advancement of mental health in developing and developed countries will rely on a real and lasting commitment to these in terms of leadership, financial resources and equity. Such policies can help to address this great area of unmet need. Conflict, complex emergencies, disaster and terrorism will further adversely affect mental health so that policy and program response, beginning with the strengths of primary care, must also be ready to meet these further needs, building hopefully for the future.

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CHAPTER 2

FUNDING MENTAL HEALTH IN POST-CONFLICT COUNTRIES

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ABSTRACT

As mental health in post conflict countries as a quasi-public good has significant externalities, early interventions aiming to reduce post traumatic consequences should be eligible for public financing. A nation's ability to use any modality for financing mental health care effectively depends on its infrastructure and competency in public and private management. Mental health in post conflict is not only a medical problem as it affects a country's ability to economically recover. Early posttraumatic interventions that target anxiety and depressive symptoms identified by mental health practitioners can be helpful only if they there are preconditions for healing.

WIDESPREAD PSYCHOLOGICAL TRAUMA IS A REAL PROBLEM FOR DEVELOPMENT

By all standards most authors agree that mental health is a major economic factor affecting the development of conflict/post-conflict societies and post-natural disaster societies. In 1990, the World Bank/WHO Global Burden Disease Study (GBD) revealed for the first time in developing nations the importance of depression. GBD found in its original survey that depression was the fourth leading cause of disability as compared to all other health conditions. The article in Scientific American (v.28, June 2000: 54-57) by Professor Mollica of Harvard reveals the scientific basis of an historic shift in conflict/post-conflict societies away from solely considering the mental health care of the seriously mentally ill (which represent a small percentage of affected individuals) to a concern for the overall mental health status of the general population.

The estimates of prevalence of psychological trauma in post-conflict situations vary, though the survey results show consistently high figures. According to Conservation of Resources (COR)[1] theory, it is expected that the prevalence of post-traumatic psychological trauma is extremely high in post-conflict and disaster situations, and in fact almost the entire population may be affected. Recent large-scale epidemiological surveys have shown that in traumatized populations, depression can be up to seven-fold the baseline level in non-traumatized societies; post-traumatic stress disorder (PTSD) can be up to ten-fold the baseline. The absence of a clear and widely accepted policy on early interventions for post-conflict and disaster situations makes it difficult to provide good reference on what sources of funds to use in order to address mental health problems.

MEDICAL INTERVENTIONS ALONE, OF THE SORT VERTICAL PROGRAMS, ARE LIKELY TO BE INEFFECTIVE, AND NOT FINANCIALLY SUSTAINABLE.

As the objectives of financing of early interventions for mental health in post-conflict situations are to reduce stress and prevent the development of serious chronic psychological trauma of population and its consequences in terms of loss of productivity, mental health should not be seen only as a medical problem, particularly given the overwhelming evidence that most of the factors that contribute to healing processes in post-conflict situation are outside classical medical interventions. Most up-to-date literature dealing with mental health financing is limited to funding strictly for the most commonly used medical interventions, such as psychological debriefing (PD) and the early provision of cognitive-behavioral therapy (CBT). Certainly, provision of these interventions in post-conflict or disaster situations proves to be logistically difficult to

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[1] The Conservation of Resources (COR) theory is based on the premise that people strive to obtain and protect resources (Hobfoll, 1989). These resources can include material goods, life conditions (e.g., marriage or occupation), or personal resources (e.g., self-esteem or perceptions of competency). According to COR theory, stress ensues when there is a threatened or actual loss of resources.

implement. Furthermore, new researchers argue that these interventions are even harmful in most cases[2]. To date, early interventions have not sufficiently taken into account the social factors in the recovery environment that promote or hinder recovery from trauma. An individual's recovery from trauma is facilitated by the availability of positive social supports[3].

Often, mental health is seen as a vertical program rather than part of the overall system, doctor-patient relationship, part of community health work and a proxy for health care quality. Although having a budgetary line item for mental health might be useful for national policy development and some national public health interventions, it might not be a good idea to have budget line item for mental health that separates all mental health activities from other primary health care activities. Instead, it seems that policies that have integrated mental health into the daily routine of primary health care workers have produced the best results. Incentives built into payment mechanisms to address mental health of population deserve special attention, as there is often reluctance on the part of primary health care providers to deal with mental health.

Decentralization is also one of the trends in reforming the public sector in today's post-conflict countries. Although decentralization might have many advantages in terms of efficiency of collection and management of public resources, it also might create many difficulties if implemented prematurely without developing adequate skills, and without carefully planned devolution of authority and responsibilities. On the other hand, the

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[2] A National Center for PTSD Fact Sheet by Brett Litz and Matt Gray, National Center for PTSD, Richard Bryant, University of New South Wales, & Amy Adler, Walter Reed Army Institute of Research
[3] Forbes & Roger, 1999; Foy, Sipprelle, Rueger, & Carroll, 1984; Harvey, Orbuch, Chwalisz, & Garwood, 1991; Keane, Scott, Chavoya, Lamparski, & Fairbank, 1985; King, King, Fairbank, Keane, & Adams, 1998; Martin, Rosen, Durand, Knudson, & Stretch, 2000; Pennebaker & O'Heeron, 1984

hierarchical systems of central planning could limit the ability of providers to react to both developments in the field as well as environmental challenges[4].

LOTS OF ATTENTION NEEDS TO BE FOCUSED ON IMPROVING OBJECTIVE REALITY AND SAFETY, OTHERWISE MEDICAL THERAPY IS NOT GOING TO WORK

In many countries in the world, mental health services are poorly resourced. Inadequate funding for mental health is largely due to the historical legacy where mental health care is not considered to be a high resource priority in health system funding. Among the many other factors that contribute to low funding are: poor economic conditions in the countries concerned; inadequate recognition of mental health problems and their consequences; unwillingness or inability of individuals with mental health problems (or their families) to pay for treatment; and failure by policy-makers to understand what can be done to prevent or treat mental disorders, resulting in a belief that funding for other services is more beneficial to society[5]. The World Health Report of 2001 dedicated to mental health only briefly discusses the issue of mental health in post-conflict situations. Only few studies discuss incentives for primary health care providers to deal with mental

Creating sense of normality:
Cleaning the rubble and fixing facades of buildings in Sarajevo

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[4] Tomov T (2001) mental health reforms in Eastern Europe. Acta Psychiatrica Scandinavica, Vol. 104(410):21-26.

[5] World Health Organization 2003 Mental Health Policy and Service Guidance Package

health. Moreover, there are few mental health economics studies in psychiatry for the region[6]. The subsequent lack of adequate economic evaluations of resource allocation may hamper the cost-effective use of the few mental health resources that are available.

In the case of post-conflict and natural disasters, victims often lose their homes, money, and social network. The inability of countries in post-conflict situations to organize a speedy recovery and to resolve these underlining causes of stress further contributes to the prolongation of the conditions that lead to the development of psychological trauma. The LSMS survey conducted in Bosnia eight years after the end of conflict still shows very high prevalence rates of depression and anxiety among the population[7]. Similar results are obtained from several, smaller scale studies in other countries. Resolution of the most pressing needs to resolve legitimate concerns of the trauma survivors about physical well-being, safety, shelter, or significant financial problems is a necessary precondition to an individual's capacity to benefit from early interventions addressing psychological variables following trauma. Therefore, Hobffoll et al. (1995) argue that early posttraumatic interventions that target anxiety and depressive symptoms employed by psychologists have not been especially helpful, because they attend exclusively to psychological variables and not other domains of resource loss.

In order to attempt to achieve the objective of adequately financing mental health, we therefore argue that at an early stage in post conflict, much attention has to be paid to creating the preconditions for healing to start and to minimize the effects of prolonged

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[6] Shah A (2000) The state of mental health economics in the countries of Central and Eastern Europe and Central Asia. Eurohealth, Vol. 6(2). Special Issue. Spring:61-62.
[7] World Bank Internal report - Scott at all. 2003

stress. This includes activities that would address personal security issues, housing, job creation, restoring administrative functions, the establishment of a functioning education and health system, and in general the creation of a sense of normality in the country in post conflict-countries. Although these arguments shift much of the attention to mental health outside the health sector, there is a role for medical interventions in post-conflict situations, as is described in other chapters of this book. Once again we must repeat that disagreements over what these interventions are, present the major obstacle in determining the most efficient ways to finance and allocate very scarce resources in post-conflict situations.

Post-conflict situations also present opportunities for change, and much attention should be paid to these changes that would lead to less traumatic situations than was the case before the conflict. The introduction of active learning instead of ex-cathedra lecturing in the education system, or the establishment of community-based rehabilitation centers instead of redevelopment of large mental health institutions in many post-conflict countries represent good examples of such practices.

PROGRAMS THAT CAN BE SUSTAINED NEED TO BE COMMUNITY BASED AND/OR INTEGRATED INTO A REFORMED PRIMARY HEALTH CARE SYSTEM.

Opportunities for improving the ability of the health system to respond to mental health problems of the population are numerous. They range from funding for medical education and retraining of primary care providers, development of a family medicine model, public health education on mental health issues, support for peer groups, to screening of susceptible individuals and many more. Those activities might have the

highest rate of return and could be an integrated part of the overall efforts to reform the health care system. However, "verticalization" and "medicalization" of mental health care present a constant threat for effective implementation of mental health programs and the development of a sound and financially sustainable mental health policy.

In developed countries the process of deinstitutionalization during the last three decades has led to reductions in the populations of mental hospitals and to the closure of many of these institutions. However, this has not been accompanied by sufficient provision of community-based services, which are often inadequate and unevenly distributed.[8]

THERE ARE LOTS OF REASONS WHY PROVISION OF MENTAL HEALTH SERVICES NEED PUBLIC FINANCING AND CANNOT BE LEFT TO THE MARKET.

According to the traditional position of most researchers, and strictly in economic terms, mental health is not a public good. In post-conflict situations, however, where the majority of the population is affected by psychological trauma resulting in significant increases in domestic violence, crime rates, substance abuse and major work disability, we argue that mental health does in fact have significant externalities and therefore is a quasi-public good eligible for public financing.

Individuals with depression often are not willing to pay for their treatment, and often do not seek treatment even if it is free of charge. This means that introducing a market-based model for mental health would in fact not be an effective way to address the needs of the population. Co-payments often introduced in post conflict countries in the attempt

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[8] Organization Of Services For Mental Health; World Health Organization, 2003

to either reduce overuse of services or to increase revenues could further discourage patients to seek help in the primary care.

It is really not well documented if the poor are disproportionately more affected than the rich by mental health problems in post-conflict situation, but based on COR theory it is most likely that the poor will have much harder time to recover in post-conflict situations than the rich. Although in general post-traumatic mental health problems do not inflict catastrophic costs for medical treatment, disability caused by depression, high rates of disability and premature death associated with chronic medical illnesses such as cardiovascular disease, increases in substance abuse, and increases in crime rates associated with psychiatric morbidity in traumatized populations, all can lead to poverty and significantly reduce the ability of individuals to recover and leave the vicious cycle of poverty.

PUBLIC FINANCING FOR MEDICAL INTERVENTIONS

Countries that have relatively stable political conditions with good governance differ from those that have experienced years of political terror and instability on how the problems of health sector and mental health are defined, and the kinds of solutions that are most likely to work. Post-conflict nations, on average, have their economies unstable and crippled compared to pre-war levels with a much higher percentage of their economic activities falling into the category of the shadow economy, making it very difficult to collect taxes or social insurance contributions. This makes health resources very scarce, raising concerns over equity in access, particularly with an expanding unregulated private sector and increasing corruption. Therefore, there are arguments that

financing for mental health should come from general government revenues, as they are more an equitable source of financing, rather than from social insurance schemes, where there is a threat that the uninsured might be left out. On the other hand, there are arguments that social insurance schemes should also cover mental health activities for the insured. These arguments go back to discussions and continuous disagreements about mental health as a quasi-public good.

In light of rather implicit recognition of the importance of mental health during the last decade, there was also an increase in donor funding for mental health activities in post-conflict countries. Usually, funding for these activities was through non-governmental organizations (NGOs) targeting specific groups or specific interventions. However, there are disagreements with regard to the effectiveness and overall outcomes of these programs and interventions. Absence of sound policies on mental health coupled with weak government institutions often result in these programs being implemented without strategic and overall guidance. Further more, implementation of these programs managed outside the public sector draw human resources away from the typically lower paid public sector and further weaken public institutions.

Years after the conflict ends, funding usually moves away from external donors and becomes increasingly dependent on local sources, either government-based through state budgets or health insurance sources, or from the private sector, through growing numbers of local foundations and charities. However, the high level of co-payments paid directly by patients for medical services, including mental health care, seems likely to continue. Moreover, the downward pressure on state funding for mental health care and the decentralization of mental health financing (e.g. insurance funds on the municipal

government level) may threaten both the availability of resources in the long-term and the delivery of care[9].

Although there is value in developing partnerships with the non-governmental sector, vertical mental health programs often implemented in post-conflict situations, instead of being designed and developed along with other major reform efforts are frequently difficult to sustain. Too often, those who are implementing mental health projects are neither aware of nor skillful in understanding the broader context of reform processes that might have significant implications for the delivery of mental health services in primary health care settings.

CONCLUSION

A nation's ability to use any modality for financing mental health care effectively depends on its infrastructure and competency in public and private management. Institutional capacity to collect taxes and to efficiently allocate resources in post-conflict situations is usually diminished and even exacerbated given the increased needs and scarcity of both human and financial resources. Therefore, in selecting both sources of funding as well as what interventions to finance, it is essential to be selective and to take into consideration the country's overall implementation capacity.

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[9] Balicki M, Leder S, Piotrowski, A (2000) focus on psychiatry in Poland: Past and Present. British Journal of Psychiatry, Vol. 177:375-81.

CHAPTER 3

SCIENTIFIC OVERVIEW OF THE ROLE OF
MENTAL HEALTH IN COMPLEX EMERGENCIES*

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ABSTRACT

The role of mental health in complex emergencies (CEs) is emerging from its scientific infancy to become a core public health response. This review presents a culturally valid mental health action plan based on existing scientific knowledge capable of addressing the mental health impact of CEs. Coordination of the action plan's components can lead to the proper utilization of effective evidence-based interventions. The *de facto* mental health system of primary care providers, traditional healers, and relief workers, if properly trained and supported, can provide cost-effective quality mental health care. This plan emphasizes the need for standardized approaches to the assessment, monitoring and outcome evaluation of all related activities. Critical to the improvement of outcomes during the crisis and the availability of lessons learned to future CEs is the on-going dissemination of plan results. A research agenda is included that will fill knowledge gaps and reduce, until additional CE research is forthcoming, the mental health impact of CEs, and will guide interventions, and maximize utilization of resources.

INTRODUCTION

Mental health is becoming a core public health response in CEs.[i] Many historic milestones have contributed to this situation.[ii] Initially, studies on veterans of war revealed the serious mental health toll of conflict.[iii] It was found that psychological casualties exceeded physical casualties by two to one in World War I, and that 33% of all medical casualties were due to psychiatric causes in World War II. Research on U.S. Vietnam Era veterans has revealed that ten years after the war, 15% were still affected by PTSD.[iv] These findings eventually came to be applied to war-affected civilian populations.

In the late 1980s, the humanitarian relief community acknowledged the mental health crisis in their relief effort to more than 300,000 Cambodian displaced persons living on the Thai-Cambodian border for over a decade following the Khmer Rouge genocide (1975-1979). Deteriorating social conditions among camp residents led to a landmark meeting in July 1988 of UN, Thai and voluntary relief organizations to discuss the deteriorating mental health conditions in the camps.[v]

The first on-site refugee mental health survey was conducted in the largest Thai border camp, Site 2, in 1988[vi], followed by the UN's acceptance of a mental health plan to relieve the mental health crisis.[vii] The next mental health milestone was initiated by the humanitarian relief community during the Balkan conflict where hundreds of psychosocial programs were implemented.[viii]

An urgent need exists for the elucidation of culturally competent evidence-based mental health practices for CEs. This review meets this demand by offering a mental health

action plan and an agenda for future research.

CONCEPTUAL FRAMEWORK

CEs are a social catastrophe of affected populations marked by the destruction of their political, economic, socio-cultural and healthcare infrastructure.[ix] Figure 1 illustrates the linkages between mass violence, mental health impairment and services and the existing damage to economic development, social capital, and human rights. While these macro-level forces create health and mental health impairments and barriers to mental health service delivery they can also be mobilized to foster resiliency and mental health recovery.

Economic destruction that characterizes CEs is associated with the physical destruction of businesses and hospitals, and the displacement of populations to camps where work opportunities are limited. The inability of traumatized populations to be economically self-sufficient has a major impact on their psychological well-being.[x] Social capital, the "features of social organization, such as trust, norms (or reciprocity), and networks (of civil engagement), that can improve the efficiency of society by facilitating coordinated actions"[xi][xii] is greatly damaged in a CE.

Restoring social capital, reducing hatred and revenge are at the core of post-conflict reconciliation.[xiii] A World Bank report states:[xiv] "The easy part of any Bank operation is reconstructing the bricks and mortar; the hard – but more essential – part is restoring the institutional societal bases of post conflict society." Evidence is emerging that links the mental health sequelae of mass violence to the destruction of social capital.(Reference 2) Cullen and Coletta have put forth case studies illustrating how the rebuilding of social

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capital can provide a framework for recovery and economic development.[xv]

Research documents the serious human rights violations that occur in CEs.[xvi xvii xviii xix xx] Gender-based violence is common during CEs and has potent mental health effects.[xxi] Evidence has been forthcoming as to the dose-effect relationship between cumulative trauma and psychiatric morbidity.[xxii]

The primary objective of a mental health action plan, therefore, is to address the domains of human suffering associated with health and mental health from the perspective of patient, community and provider. [xxiii xxiv] Herein, mental health symptoms, which are signs of emotional distress, must be distinguished from psychiatric illnesses and disabilities.[xxv xxvi xxvii xxviii] In resource-poor environments such as CEs, characterized by high levels of emotional distress, thresholds must be set for defining those individuals in need of mental health services. Emotional distress combined with impairment in social and physical functioning creates a reasonable clinical standard for eligibility for clinical care. Input from the local community is necessary for determining the cultural norms needed for establishing these clinical standards.

Figure 1. Conceptual framework for mental health action plan for CEs
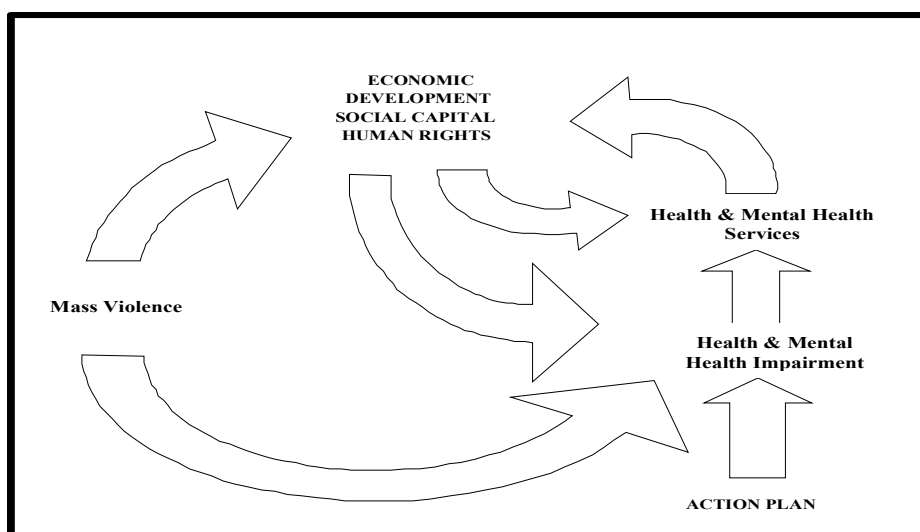
MAGNITUDE OF THE PROBLEM

The landmark Global Burden of Disease study [xxix] established for the first time the significant burden of mortality and disability associated with mental illnesses. Depression, the fourth leading cause of disease burden in 1990, is predicted to move to second place in 2020. Of the ten leading causes of disability worldwide, five were psychiatric conditions. Since this study did not focus on traumatized populations, it is estimated that the mental health effects of psychiatric disorders are much higher in CEs.

Despite methodological challenges in determining the prevalence of mental illness across cultures and in insecure environments, recent progress has been made in assessing the psychological and social impact of CEs. Indeed, the lack of accurate population estimates and culturally validated screening instruments had to be overcome to make culturally valid mental health assessments.[xxx] [xxxi] Validated measures for assessing economic and social productivity and social capital in CEs, however, are still needed. Numerous recent studies that underscore the severe mental health sequelae resulting from mass violence in various contexts are summarized in Table 1.

A longitudinal study of Bosnian refugees (1996) revealed for the first time, the serious disability associated with the mental health effects of mass violence. While 45% of those studied met DSM-IV criteria for depression, PTSD, or both, co-morbidity for these disorders was associated with high rates of physical disability (i.e. 25%).[xxxii] In 1999, this population revealed unremitting psychiatric disability and premature death in the elderly. [xxxiii] Other studies support these results, suggesting that suffering continues long after the crisis has ended.[xxxiv xxxv]

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Table 1: Prevalence of Mental Health Disorders among Adult Populations Affected by CEs

STUDY	PTSD	Depression	Non-specific psychiatric morbidity	Screening Tool	Source
CE Population					
Cambodian refugees in Thailand	Point 37.2%	Point 67.9%	N/A	HTQ HSCL-25	Mollica et al. (1993)[xxxvi]
Bosnian refugees in Croatia	Point 26%	Point 39%	N/A	HTQ HSCL-25	Mollica et al. (1999)[xxxvii]
Kosovar Albanians in Kosovo	Point 17.1%	N/A	43% (11 mean score)	HTQ GHQ-28	Lopes Cardozo et al. (2000)[xxxviii]
Serbian minority in Kosovo			(12.8 mean score)	GHQ-28	Salama et al. (2000)[xxxix]
Rwandan Refugees in Tanzania	N/A	N/A	50% (14 mean score)	GHQ-28	De Jong et al.[xl]
Karenni (Burmese) refugees in Thailand	Point 4.6%	Point 41.8%	N/A	GHQ-28 HSCL-25 HTQ SF-36	Lopes Cardozo et al. (2004)[xli] (Repeat of Reference 13)
Cambodia	Lifetime: 28.4%	N/A	N/A	LESHQ CIDI	De Jong et al.[xlii]
Algeria	Lifetime: 37.4%	N/A	N/A	LESHQ CIDI	De Jong et al. [42]
Ethiopia	Lifetime: 15.8%	N/A	N/A	LESHQ CIDI	De Jong et al. [42]
Gaza	Lifetime: 17.8%	N/A	N/A	LESHQ CIDI	De Jong et al. [42]
Baseline Population					
US Population	Lifetime: 1%	12-month 3.7% Lifetime 6.4 %	N/A	DIS	ECA Study [xliii]Depression: Robins et al. (1991) [xliv] PTSD: Helzer et al. (1987)
U.S. Population	Lifetime: 7.8%	12 month: 6.6% Lifetime: 16.2%		CIDI (modified)	NCS, Depression [xlv](Kessler et al. (2003) NCS, PTSD[xlvi] (Kessler et al. (1995))
15 Developing countries	N/A	N/A	2-6 (mean score)	GHQ-12	Goldberg et al. (1997)[xlvii] (Repeat of Reference 31)

Harvard Trauma Questionnaire (HTQ); Hopkins Symptom Checklist – 25 (HSCL-25); General Health Questionnaire (GHQ); Epidemiological Catchment Area (ECA); Diagnostic Interview Schedule (DIS); Life Events and Social History Questionnaire (adapted version) (LESHQ); WHO's Composite International Diagnostic Interview (CIDI); National Comorbidity Study (NCS)

Table 2 highlights the prevalence of mental health disorders in children and adolescents affected by CEs. This research demonstrates the high prevalence of PTSD, depression and anxiety among affected children and adolescents [xlviii xlix l li lii liii liv lv lvi lvii lviii lix lx lxi] as compared to a baseline of non-traumatized children in the U.S.(References 76 and 77) In

contrast to adult studies (Table 1), the generalizability of these results to CEs is limited since few of the studies sampled a general population of children involved in a CE[53] or compared the subjects to a comparable non-traumatized control group.[54]

Table 2: Prevalence of Mental Health Disorders in Children and Adolescents Affected by CEs

Study	PTSD	Depression	Total Problem Score % in Clinical Range	Screening Tool	Source
CE Populations					
6 Year follow up of 30 Young Khmer refugees	50% 1984 38% 1990	41% 1987 6% 1990	N/A	K-SADS-E	Sack WH et al (1993)[lxii]
170 Cambodian adolescent refugees	26.5%	12.9%	N/A	K-SADS-E	Sack WH et al (1996)[lxiii]
480 Croatian refugee children	N/A	11.28%	N/A	CDI	Zivcic I et al. (1993)[lxiv]
59 Young Cambodian-Americans	Point 24% Lifetime 59%	19%	N/A	SCID-NP	Hubbard J et al (1995)[lxv]
182 Cambodian refugee camp adolescents and their parents	N/A	N/A	CBCL 53.8% YSR 26.4%	CBCL YSR	Mollica RF et al. (1997)[lxvi]
209 Khmer Adolescents	12.9-41.2%	N/A	N/A	SSADS SCID	Sack WH et al. (1995)[lxvii]
99 Cambodian refugees	Point 31.3% Lifetime 37.3%	Point 68.4% Lifetime 86%	N/A	SSADS Interview	Savin D et al (1996)[lxviii]
Cambodian refugees in US	Point 28.6% Lifetime 37.1%	Point 17.1% Lifetime 37.1%	N/A	SSADS Interview	Reference 68
12 Bosnian adolescents in US	25%	17%	N/A	CTEI	Weine S et al (1995)[lxix]
147 Bosnian children refugees	N/A	25.90%	N/A	Self Report	Stein B (1999)[lxx]
492 Israeli children during Scud missile attacks	24.9%	N/A	N/A	SRQ	Schwarzwald J et al. (1993)[lxxi]
150 Palestinian mothers and their children	N/A	N/A	58.8%	CBCL	Garbarino J et al. (1996)[lxxii]
234 Children in the Gaza Strip	Point 40.6% 1 Year 10%	N/A	N/A	CPTS-RI	Thabet AA et al. (2000)[lxxiii]
Baseline Populations					
Children (US)	N/A	Point 2%	N/A	DSM-III-R Interview	AACAP (1998)[lxxiv]
9-17 year-olds (US)	6 month 2%	6 month 6%	N/A	DISC-2.3	Shaffer D (1996)[lxxv]

Kiddie Schedule For Affective Disorders And Schizophrenia (KSADS); School Children Version Schedule For Affective Disorders And Schizophrenia (SSADS); Child Depression Inventory (CDI); Child Behavioral Checklist (CBCL); Youth Self Report (YSR); Communal Traumatic Experiences Inventory (CTEI); Child Posttraumatic Stress Reaction Index (CPTS-RI); Stress Reaction Questionnaire (SRQ); American Academy of Child and Adolescent Psychiatry (AACAP).

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MENTAL HEALTH ACTION PLAN

A mental health action plan for CEs (see Panel 1) should be grounded in recommendations of the landmark mental health reports of the World Health Organization (WHO)[lxxvi lxxvii] and the U.S. Surgeon General. [lxxviii]

1) **Coordination of Mental Health Care**

Early intervention in CEs must focus [lxxix lxxx] on immediately establishing centralized coordination of mental health activities – there is no evidence that this has ever occurred in a CE. In most CEs, there are hundreds of organizations implementing varying mental health programs (e.g. Bosnia, Kosovo). (Reference 8) Little information exists on the coordination, monitoring, and effectiveness of these programs.

The experiences of relief and assistance organizations, including the US Federal Management Agency (FEMA) offer insight into the role of coordination in responding to the mental health needs of disaster-affected populations.[lxxxi lxxxii] Although the FEMA model is not readily transferable to resource-poor environments, it underscores the value of coordinated services provided by trained mental health practitioners and community participation. A highly coordinated approach can guarantee that action plan steps are: 1) subject to outcome evaluation; 2) integrated into and built on the pre-existing mental health services capacity so as to enhance response capacity for current and subsequent emergencies; and must 3) ensure that those who are in most need receive appropriate and effective intervention. Coordination would guarantee that the mental health benefits of the crisis are evaluated and lessons learned are utilized in future CEs.

Sufficient evidence exists on the role of mental health in CEs to argue that pre-CE planning of a mental health response can be routinely incorporated into the activities of

UN, non-governmental organizations (NGO) and donors prior to their involvement in CEs.

2) Assessment and Monitoring

A population-based assessment must be undertaken immediately of: 1) mental health problems and resources; 2) identification of vulnerable groups; and 3) availability of resources capable of providing mental health support to the community and clinical care to patients.

A major barrier to the effective implementation of an effective action plan has been the lack of guidelines linked to a formal system of assessment and monitoring.(Reference 1) The absence of criteria for evidence-based best practices for achieving mental health outcomes has lead some public health authorities to doubt the positive contribution of mental health assistance in CEs.[lxxxiii]

WHO recommendations for mental health in emergency situations (Reference 77) and the Sphere project[lxxxiv] may lead to results in this area. Until culturally validated and standardized mental health needs assessments become available for use in CEs, simple ethnographically informed quantitative measures can be generated for each CE to provide invaluable information for planning, monitoring, and evaluation that include simple measures of macro-level factors (economic opportunities, social capital, and human rights violations), mental health outcomes (symptoms and disability), and available mental health resources.

3) **Early Intervention Phase**

Early mental health interventions in CEs must focus on (Reference 77) [lxxxv]: 1) supporting public health activities aimed at reducing mortality and morbidity; 2) offering psychological "first aid"; 3) identifying and triaging seriously mentally ill persons to specialized psychiatric care[lxxxvi]; and 4) mobilizing community-based resiliency and adaptation.

To date, early CE mental health interventions have been based upon the premise that 90% of the affected-population will not develop mental illness in spite of high initial levels of emotional distress related to the crisis. (Reference 79, 85) This premise may be incorrect. Table 1 data reveal the development of chronic psychiatric disorders. The aforementioned study on Bosnian refugees shows that a higher percentage of individuals may be seriously affected by chronic mental illness than previously considered.(Reference 33) Eventually high risk individuals will be identified through early screening and will be treated. For the general population, the action plan must support the normalization of everyday life, through the reduction of medical diseases, reestablishment of normal socio-cultural and economic activities, family reunification and protection from ongoing violence. The most intensive psychological intervention at this phase is psychological "first aid" which consists of listening (not forcing talk), conveying compassion, ensuring basic needs, mobilizing support from family members or significant others and protecting the survivor from further harm. (Reference 77)

4) The De Facto Mental Health Care System

The existing mental health care system consists of local primary care practitioners (PCP), traditional healers and relief organization workers that are capable of being organized ito a culturally competent effective mental health system during CEs.

A. Primary Health Care

The role of primary health care (PHC)[lxxxvii] in the mental health care of resettled traumatized refugees has been well-documented.[lxxxviii] The integration of mental health services into PHC has been widely promoted, especially in developing countries. [lxxxix xc]

PCPs are well suited for helping traumatized patients by identifying and treating medical and psychiatric disorders during CEs.[xci] Local doctors, nurses, social workers, and occasionally psychiatrists (e.g. in Bosnia[xcii xciii]) exist within the community in crisis and can be mobilized to deal effectively with their community's mental health needs.

In CEs, PCPs have the capacity to treat the mental health problems of traumatized patients in a non-stigmatizing environment since in most societies emotionally distressed individuals avoid psychiatric treatment. With modest training, PCPs can obtain the patient's traumatic life history and identify related physical and mental health sequelae, in order to provide culturally sensitive assistance.[xciv] PCPs can also identify illnesses and disabilities resulting from human rights violations.

Randomized clinical trials (RCT) in non-traumatized populations reveal the important potential role of mental health services in PHC in CEs. PHC's efficacy has been demonstrated for the treatment of depression. [xcv xcvi] Effective interventions include use

of: 1) psychotropic drugs and 2) interpersonal therapy and cognitive-behavioral therapy (CBT). The most effective treatment for PTSD in PHC has not been substantiated. Studies mainly from small RCTs suggest that specific psychological treatments such as CBT and psychotropic drugs are effective.[xcvii] While supportive counseling is useful for practical assistance helping patients cope with the adversities of a CE, there is no evidence currently available that it prevents or ameliorates PTSD. However, there is also no evidence to date that supportive counseling is harmful. Recent studies indicate that CBT is effective for cases of PTSD that have failed to respond to supportive counseling.[xcviii xcix]

A review by Raphael and Wilson[c] provides evidence that routine debriefing should not be used by PCPs and other providers in CEs, in light of potential harm that may result. These authors state that stress debriefing is not recommended for disaster-affected populations as there is evidence that it is both ineffective and potentially associated with adverse outcomes. The effectiveness of eye movement desensitization and reprocessing (EMDR) is being studied; early data indicated that EMDR can be an effective component of treatment. However, more recent studies have not substantiated the efficacy of the technique. [ci cii ciii] Similarly drawing and art therapy, which have children relive their experience of violence while revealing no harmful effects have not been proven to be therapeutic.[civ]

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B.   Traditional Healing

A major component of the indigenous healing system that can be utilized in CEs is the traditional healing system and its practitioners.   Traditional medicine (TM) is those diverse health practices, approaches, knowledge and beliefs incorporating plant, animal and/or mineral based medicines, spiritual therapies, manual technologies and exercises applied singularly or in combination to maintain the well-being of the patient, as well as to treat, diagnose or prevent illness. TM is widely accepted and practiced as a valid form of treatment worldwide.   In industrialized countries, alternative approaches to Western medicine are developing rapidly.[cv]

A traditional healer often is a religious healer or family (or community) elder.   TM generally uses a local classification system for emotional distress consisting of folk diagnoses accepted by the community.   Patients' accessibility to TM practitioners, confidence in their abilities to manage mental health problems, reduced stigma, and potential cost-effectiveness place traditional healers in a suitable position to be supported in CEs.

Experience with traditional healing and mental health has been extensively described for the Cambodian refugee crisis of the 1990s.[cvi cvii cviii]   The evidence base for TM interventions is growing.   RCTs in non-CE situations reveal the clinical effectiveness of herbal medicines, acupuncture, and non-medication therapies in reducing depression, anxiety, insomnia, and pain.

C.   Psychosocial Approach

Mental health services provided by relief organizations have been in the form of psychosocial interventions. These interventions fall along a wide-spectrum.[cix][cx] based on a primary concern for the psychological and social well-being of the individual to the repair of damaged collective social structures. The term "psychosocial"[cxi]: " underlines the dynamic relationship between psychological effects (e.g. emotions, behaviors, memory) and social effects (e.g. altered relationships due to death, separation, family and community breakdown), each continually influencing each other. Psychosocial interventions aim to enhance the abilities of survivors of mass violence to "cope" with the demands of their social world that has been shattered by mass violence.

Psychosocial proponents uphold that CEs impact on a population's capacities is not reflected solely or primarily in terms of established psychopathology.[cxii] This approach upholds that while resources are depleted across many domains, three in particular reflect psychosocial well-being: human capacity (i.e. skills, knowledge, capabilities), social ecology (social connectedness and networks) and culture and values. Psychosocial proponents focus on bolstering resources in these domains in order to enhance the individual's and communities' psychosocial well-being.[cxiii]

Psychosocial approaches usually focus on directing their services towards vulnerable groups or those with "special needs".[cxiv]   These are individuals with specific characteristics that place them at risk for developing psychological distress and social disability and who have the potential of being neglected, abused, and stigmatized by their society, limiting their capacity to access humanitarian relief. The psychosocial emphasis

on vulnerable groups, however, should not preclude an appreciation of the mental health impact of mass violence on all members of an affected population.

Few evidence-based psychosocial studies exist demonstrating the effectiveness of specific components of this approach. A study by Mollica et al. of Cambodian refugees on the Thai-Cambodian border revealed environmental conditions (e.g. opportunity for economic productive activities) that could have been ameliorated by camp authorities, reducing psychiatric morbidity among camp residents.[cxv] In a study of psychosocial program beneficiaries in Bosnia-Herzegovina and Croatia, Agger and Mimica (Reference 8) found positive appraisals of services received, with higher rankings for the general value of group meetings and shared activities than individual therapeutic provision.

Many psychosocial project evaluations have utilized beneficiary feedback despite methodological limitations.[cxvi] A case-control study by Dybdahl revealed a reduction of intrusive memories and higher self-rating of well-being in traumatized mothers in Bosnia who participated in weekly group meetings compared to mothers who received basic package medical care. [cxvii] The initial results of the UN with emergency and peace education [cxviii] [cxix]with the objective of improving social capital is promising, yet needs further evaluation.

D. Specialized Psychiatric Services
Western-trained psychiatric practitioners in CEs can participate in trainings, provide consultation and on-site supervision within the system, conduct evaluation and evidence-based research.(Reference 86) They have an important role in providing specialized clinical care to the seriously mentally ill. Many conflict-affected countries have limited

experience with Western psychiatry (e.g. Rwanda has one psychiatrist), demanding that psychiatric practitioners maximize their impact by partnering in a culturally effective manner with the local indigenous healing system.

5) Training and Education

During the CE emergency phase, first responders who are on the frontlines in health care and humanitarian assistance should be trained in basic mental health concepts such as psychological "first-aid".(References 77, 79) Mental health practitioners must be provided with additional skills and knowledge, that will enable them to deliver culturally effective evidence-based mental health interventions since few mental health practitioners have previously encountered the high numbers of individuals emotionally affected by the violence characterized by CEs.[cxx]

A new trend is the provision of brief mental health trainings to policy-makers, doctors, teachers, and relief workers by relief organizations. Professional expertise and mental health knowledge of those being trained frequently exceeds that of the trainers. Despite their popularity, scientific evidence is lacking to substantiate positive results of these trainings.[cxxi] In contrast, recent evaluations of mental health trainings of local PCPs in Bosnia and Cambodia have revealed sustainable results.[cxxii]

While mental health training materials have been extensively produced, few curricula are available or have been evaluated for their scientific quality and cultural content. All CE training projects must be made publicly available along with lessons learned in order to avoid duplication of effort and prevent the repetition of failed approaches.

6) Cultural Competence

CEs have affected societies that have different medical worldviews from the Western medical perspective. Mental health programs in CEs must ensure the provision of culturally effective services; yet not a single scientific study on providing culturally competent health and mental health services in a CE was found by this review. This is surprising as it has been well-demonstrated that ethnicity and culture have a major impact on mental health-seeking behavior and treatment outcomes;[cxxiii][cxxiv][cxxv][cxxvi][cxxvii] and it is expected that these effects will be intensified during a CE.

Furthermore, cultural attitudes and behaviors toward mental health care may exist that need to be overcome during a CE such as: fear of the mental health care system due to its prior utilization for torture, punishment and incarceration; stigma and community rejection of vulnerable groups[cxxviii]; and avoidance of the health care system, since health facilities have been targeted for destruction.[cxxix]

Much debate has surrounded the cultural validity of the Western diagnosis of PTSD in non-Western societies.[cxxx] However, significant advances in the ethnographic study of traumatized populations have demonstrated the common symptoms of emotional distress and related folk diagnoses that can be utilized by mental health providers in caring for these populations. (Reference 88) Western psychiatric diagnoses based upon the DSM-IV and ICD-10 can be combined with specific folk diagnoses to provide maximum benefit to the patient. (Reference 106)

Cultural competence should characterize the mental health action plan's goals and procedures. It is insufficient for individual providers alone to practice cultural

competence in a CE. The California Pan-Ethnic Network and the California Healthcare Foundation compiled a list of 12 major characteristics of a culturally competent organization that can be directly applied to a CE setting (including knowledge of population served; diversity in organization, governance and decision-making; mandatory cultural competence training; promoting delivery of culturally competent health care; and measuring outcomes).[cxxxi]

7) Ethics and Community Participation

Mental health practices must be infused with the ethical diligence to "do no harm" and to ensure respect for the "freedom" and "autonomy" of patients.[cxxxii] Informed consent is the basis of all mental health interventions[cxxxiii] and without it, no mental health intervention in a CE can be morally justified. Informed consent must be articulated and communicated in a culturally appropriate manner. While difficult in a CE setting, the patient and community should be an equal partner in a shared decision-making process. Similar standards apply to psychosocial interventions whereby community input and participation are required for those interventions operating at the collective level. The Humanitarian Accountability Project[cxxxiv] is a step in ensuring this. Mental health care providers in a CE must make a special effort to guarantee informed consent, since normal standards that existed prior to the conflict are frequently either disrupted by the destruction of the healthcare system or may have never existed in the first place.

Public awareness campaigns that involve the community in all aspects of the action plan are not only ethically responsible but may also be therapeutic. Yet, it is naïve to think

that mental health care is uniformly benign in CEs and is associated with limited risks.[cxxxv] Some mental health interventions in CEs, especially when used in caring for individuals suffering from extremely traumatized life events (such as sexual violence and/or murder of a child), can be extremely intrusive and psychologically disturbing and lead to serious negative mental health outcomes. While eliciting the "trauma story" of survivors is essential to the practice of mental health care at the individual and collective level[cxxxvi] [cxxxvii] and cannot be avoided[cxxxviii], it is dangerous for the mental health practitioners to engage in an active stripping away of survivor psychological defenses (e.g. denial of recent traumas) in order to unmask the underlying trauma experience believed to be at the basis of the survivors' mental health and physical problems. Talking cures are not always benign or welcomed, especially in non-Western cultures. Scientific evidence still needs to determine the type of personal sharing of traumatic life experiences that are most beneficial to the healing process.[cxxxix]

8) Ensuring self-care: preventing and addressing "burnout" of mental health care providers

Awareness is growing of the potential negative mental health impact of CEs on relief workers. Recent years have seen a shift from initial advocacy for the psychological needs of humanitarian workers working in challenging circumstances to empirical analyses of risk and resilience factors.[cxl] It appears a 'dose-response' relationship exists between the experience of trauma events and anxiety symptoms of clinical significance, indicating the mediating role of personal coping resources. Vulnerability is greatest for those workers either on their first assignment or with a long history of serial deployments.

Of particular concern are local staff who have been traumatized by the CE. Evidence is accumulating regarding the particular vulnerabilities of such personnel.[cxli] Strategies to provide effective mental health protection, and treatment if necessary of 'front-line' personnel in the course of interventions within CEs need to be clearly identified.[cxlii]

9) Outcome Evaluation and Research

Public health experts have called for all health interventions in CEs to be evidence-based.[cxliii cxliv cxlv] (See Panel 2) Many mental health interventions utilized in CEs are not based upon sound scientific evidence (Reference 79), and a full description of the best practices for culturally effective mental health services in CEs remain to be determined. This obligation to ensure evidence-based mental health interventions during CEs was underscored at a meeting of mental health scientists assembled after the September 11th disaster, where those present acknowledged a moral obligation "to conduct scientifically valid research to improve prevention, assessment, and intervention and treatment" during CEs.

While evidence-based practices applicable to CEs can be derived from interventions investigated in natural disasters and individual traumatic events (e.g. car accidents), the relevancy of this approach to CEs is limited. For example, in a review of the scientific literature related to early clinical interventions targeted at survivors of mass violence none of 76 studies cited was conducted in a CE. (Reference 79) The greatest barrier today for the role of mental health as an essential public health activity is the lack of systematic research evaluating clinical treatments and psychosocial interventions during a CE.[cxlvi cxlvii]

Development of a culturally valid evidence-based action plan for CEs must begin with the outcome evaluation of current mental health activities. These evaluations should use standardized uniform measures that can be simply applied by relief organizations to assess results. (Reference 30, Reference 31) [cxlviii cxlix cl cli] The public reporting and discussion of these results is essential so that the experience and lessons learned from mental health programs can be used to improve ongoing activities and contribute to future CEs. For example, the outcome results of UNICEF's national training program in Rwanda and UNHCR's counseling programs in the Balkans could provide considerable benefits to future efforts. [clii]

Donors and relief organizations need to advocate for research and evaluation in mental health as a major funding priority during CEs. Some have argued that research is a wasteful utilization of limited resources and increases the likelihood that the scientific community will exploit vulnerable populations. However, the opposite is true. Careful research provides effective interventions that will maximize resource allocation. Furthermore, international covenants beginning with the United Nations Declaration of Human Rights (1948)[cliii], offer specific proscriptions against the coercion of individuals into medical and scientific experiments. Guidelines to ensure ethical behavior in research conducted during CEs can and should be established.[cliv clv clvi]

PANEL 1: MENTAL HEALTH ACTION PLAN FOR CEs

Components	Key Features
Coordination of Mental Health Care	Strong centralized coordination established at beginning of CE to organize, monitor, supervise and evaluate all mental health activities.
Assessment and Monitoring	Early rapid baseline assessment of the population's resiliency and risk factors, and vulnerable group's mental health problems and available mental health resources.
	Monitoring system established able to review changes in baseline status over time
Early Intervention Phase	Early interventions must: 1) support reduction in mortality and morbidity; 2) offer population-wide "psychological first-aid"; 3) identify and triage seriously mentally ill to psychiatric treatment; and 4) mobilize community-based resiliency and adaptation by facilitating restoration of normal community life.
De facto mental health system	Build-up and finance the *de facto* mental health system of local primary health care practitioners, traditional healers, and local/international relief workers
	Use culturally validated and scientifically established mental health interventions throughout the system.
Training and Education	Train all front-line responders in basic mental health principles such as psychological "first aid".
	Build mental health capacity in the *de facto* mental health care system through effective training that emphasizes teaching of culturally effective evidence-based interventions.
Implement, manage and monitor a culturally competent system of care	All policies, practitioners, and organizational structures must actively utilize the cultural medical worldview of the population(s) served as well as engage the local communities' participation in the action plan.
Ethics and community participation	Informed consent must be followed. Patients and communities must participate in shared decision-making processes.
	Public awareness campaigns will improve community support of plan and improve outcomes.
Prevention of negative mental health consequences among mental health providers	All mental health providers must be provided with a self-care program that includes identification of risk factors and opportunities for resiliency in order to prevent negative mental health outcomes.
	Mental health treatment must be readily available to affected relief workers in a safe, non-punitive and confidential setting.
Outcome Evaluation and Research	All mental health interventions must be evaluated as to their overall benefit to individuals and community as well as to their cost-effectiveness.
	All mental health trainings must be evaluated to determine at minimum an increase in skills and knowledge of culturally competent evidence-based practices.

Scientific investigations including population studies and RCTs are not a luxury and must be incorporated into all mental health action plans (see Panel 2)

PANEL 2: RESEARCH AGENDA FOR MENTAL HEALTH AND CEs

__Future Investigations__	__Rationale__
Adapt and develop culturally valid and reliable instruments with known psychometric properties for measuring risk and resiliency factors and mental health outcomes	Instruments such as the HTQ, HSCL-25 and GHQ can be expanded for use in current CEs by establishing their psychometric properties through a simple standardized approach.
	Simple measures that include risk and resiliency factors such as economic status and social capital do not exist for baseline mental health needs assessments. Culturally validated measurements of physical functioning and socio-economic disability are necessary for identifying those in need of mental health care without sole reliance on psychiatric symptomatology, as currently exists.
Undertake longitudinal studies that assess the impact of CEs on the health and mental health status of conflict-affected populations over time	The natural course of mental health outcomes in conflict-affected populations is unknown; cause and effect relationships are poorly described by available cross-sectional research. Studies are necessary for planning, preventing and for the timing and implementation of interventions.
Conduct evidence-based studies of the effectiveness of interventions	While scientific studies from other settings support the benefits of a number of mental health interventions, few evidence-based intervention studies such as an RCT have been conducted during a CE.
Conduct evidence-based studies of the effectiveness of mental health trainings	In spite of the increased frequency of mental health trainings in CEs, few studies have evaluated the effectiveness of trainings. Studies must focus on relative effectiveness of mental health trainings in producing sustainable results including increase in the knowledge and skills of scientific practices, and the proper use of these practices resulting in improved mental health outcomes.
Investigate the ability of public awareness campaigns to protect affected populations against the negative mental health consequences of CEs	Do public health awareness campaigns help prevent psychiatric illness as well as increase the use of services by those most in need? Do they improved shared decision-making and community participation? Are they the most culturally acceptable approach to guaranteeing community involvement? If the answers to any of these questions is no, what are more effective alternatives?
Determine the unit cost of providing culturally competent, evidence-based mental health care during CEs	This information is essential for donors and policy-makers to make informed decisions on their financial support of a mental health action plan.

***Research agenda applies to adults, children and adolescents.

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CHAPTER 4

EVIDENCE-BASED MENTAL HEALTH TREATMENTS FOR CHILDREN AND ADOLESCENTS IN THE AFTERMATH OF COMPLEX HUMANITARIAN EMERGENCIES AND MASS VIOLENCE

Victor Balaban, Ph.D.

ABSTRACT

War, complex humanitarian emergencies and other mass trauma experiences can have devastating effects on children and adolescents. Children's immature abilities to understand and process the immediate and long term effects of emergencies – their own injuries and exposure to traumatic events, traumatized or injured parents, loss of loved ones, disruptions of daily routines, frightening images in the media – make children among the most vulnerable members of affected communities. Psychological responses to trauma are normal, and it is not uncommon for traumatized children to appear stunned, numb, unresponsive, mute, hyper-vigilant or frantic in the immediate aftermath of trauma. However, the majority of children and adolescents show resilience and recovery in the face of disaster. The greatest effects on children happen when a child experiences violent harm to themselves or loved ones, is threatened with such violence, or engages in harming others. In addition, children are affected when parents are killed, harmed, terrified or unable to function. In the immediate post-disaster phase, children and families will benefit most from programs that provide psychological first aid by bolstering family and social support, providing news and information about the situation, and returning to normal roles and routines. It is extremely important to avoid separating families whenever possible. Children of all ages will experience anxiety, and in some cases panic, if separated from parents or caretakers. While there is a tremendous need for basic knowledge about appropriate treatments and interventions that support psychological and social resilience in children and families, all available data point to the importance of early intervention. For those children and adolescents whose symptoms persist, the available data suggests that early, brief, and focused cognitive behavioral treatment approaches (CBT) have the strongest empirical evidence for reducing post-traumatic symptoms.

CHILDREN'S RESPONSES TO TRAUMA

With the increasing sophistication of recent research, a body of data has emerged

showing that children and adolescents who experience catastrophic events can have a

wide range of psychosocial reactions including, but not limited to, post traumatic stress

disorder (PTSD)[10], depression, anxiety, somatic disturbances, learning problems, anxiety

and behavioural disorders. See Figure 1 for an overview of post-traumatic symptoms in

children (Mollica et al., in press; NACCT, 2003; NIMH, 2002; NPDPRCM, 2003).

Figure 1 – Traumatic Stress Reactions in Children and Adolescents

Ages	Traumatic Stress Reactions
0-5	Fears of being separated from parents, crying, whimpering, screaming, immobility and/or aimless motion, trembling, frightened facial expressions and excessive clinging. Children may also regress to behaviors exhibited at earlier ages, such as thumb-sucking, bedwetting, and fear of darkness. Younger children may also show signs of re-experiencing traumatic events in the form of play reenactment.
6-11	Withdrawal, disruptive behavior, and/or inability to pay attention. Regressive behaviors, nightmares, sleep problems, irrational fears, irritability, refusal to attend school, outbursts of anger and fighting are also common in traumatized children of this age. Also the child may complain of stomachaches or other bodily symptoms that have no medical basis. Schoolwork often suffers. Depression, anxiety, feelings of guilt and emotional numbing or "flatness" may be present as well.
12-17	Adolescents may exhibit responses similar to those of adults, including flashbacks, nightmares, emotional numbing, avoidance of any reminders of the traumatic event, depression, substance abuse, problems with peers, and anti-social behavior. Also common are withdrawal and isolation, physical complaints, suicidal thoughts, school avoidance, academic decline, sleep disturbances, and confusion. Adolescents may feel extreme guilt over failure to prevent injury or loss of life, and may harbor revenge fantasies that interfere with recovery from the trauma.

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[10] Post Traumatic Stress Disorder (PTSD) is an anxiety disorder that can occur after exposure to traumatic stress, and symptoms of PTSD are among the most common types of psychological distress observed in children after disasters. It is characterized by 1) persistent re-experiencing of the traumatic event such as recurring or intrusive thoughts or nightmares; 2) emotional numbing or avoidance of cues such as people or places associated with the trauma; and 3) persistent physiological hyper-reactivity or arousal. Signs and symptoms must be present for more than one month following the traumatic event and cause clinically significant disturbance in functioning in order to meet a diagnosis of PTSD. A child is considered to have Acute Stress Disorder (ASD) when these criteria are met during the month following a traumatic event. PTSD is further characterized as Acute when present for less than three months, Chronic when present for more than three months or Delayed Onset when symptoms develop initially six months or more after the trauma (DSM-IV-R; Pfefferbaum, 1997; Yule, 1999).

Post-traumatic symptoms can occur immediately or some time after a traumatic event, and children who have witnessed violence in their families, schools, or communities are also vulnerable to serious long-term problems.   Early and well-organized intervention is an essential component of promoting psychosocial resilience children and families after disasters, and in preventing the development of problems in the future (LaGreca et al., 2003; NACCT, 2003; NIMH, 2002; NPDPRCM, 2003; Norris et al., 2002; Pfefferbaum, 1997; Shalev et al., 2004; Yule, 2001).   Although the relationship is not simple, there is evidence that children who are in closer proximity to traumatic events and who are exposed to multiple or ongoing traumatic events, are at higher risk for PTSD symptoms (Pynoos et al., 1998; Vernberg, 2003).   Evidence suggests that the majority of children who do develop PTSD symptoms will do so in the immediate weeks and months following a disaster, while symptoms of depression may emerge months later.   There is also evidence that perception of a threat to life is associated with emergence of PTSD symptoms, whether or not anyone was actually injured or killed in the event; and that mass trauma caused by terrorism or other deliberate human intent maybe more traumatic than traumas resulting from natural disasters or industrial accidents (Norris et al., 2002; Silverman & LaGreca, 2003; Yule, 2001).

Acute stress reactions are common in the immediate aftermath of disasters and mass violence.   These reactions are not the same as PTSD, although many of the symptoms may be similar.   Responding to trauma is normal, and it is not uncommon for traumatized children to appear stunned, numb, unresponsive, mute, hyper-vigilant or frantic in the aftermath of trauma. Stress reactions can also include aggressive behaviors as well as reduced social competencies, depression, fears, anxiety, sleep disturbances,

and learning problems. Children exposed to war and mass violence may also experience intense stresses that include fear of death and fear of loss of their parent. It is not uncommon for children to experience intense rage, feelings of guilt, and a sense of responsibility for violent events to which they are exposed. It is also common for children and adolescents to report loss of trust in adults and fear of traumatic events occurring again (Groves, 1999; Mollica et al., in press; Shalev et al., 2004). Other common acute stress reactions vary according to age and are summarized in Figure 1.

Reactions to trauma may appear immediately after the traumatic event or days and even weeks later. The presence of post-traumatic symptoms is not necessarily cause for long-term follow-up because, in many cases, they will eventually remit within several weeks or months. In some cases, acute stress responses may even have an adaptive value i.e. avoiding reminders of trauma may keep survivors away from dangerous situations (Shalev et al., 2004). There is currently no data available for how long stress responses last in children, but adult survivors of traumatic events who do not manifest symptoms after approximately two months generally do not require follow-up, although they should receive follow-up if they request it (NIMH, 2002).

EARLY INTERVENTION AND PSYCHOLOGICAL FIRST AID

Because of the small number of studies that are specific to disaster interventions for children and adolescents, many of which are methodologically limited, it is necessary to extrapolate findings from the adult trauma intervention literature. In general, it has been found that the majority of adults exposed to disaster and emergencies show resilience and

do not develop trauma-related psychopathology (Shalev et al., 2004). It is likely, though not yet proven, that many children and adolescent may also display acute stress symptoms in post-emergency contexts, but that the majority will not develop psychopathology. Since acute stress reactions are very common in the immediate aftermath of disasters and mass violence, and are not predictive of later psychopathology, early psychotherapy is not considered an effective early intervention or an efficient use of resources. Some forms of early psychological interventions, such as mandatory debriefings, where survivors of a traumatic event are brought together soon after the event and asked to recall the details of the trauma and discuss their emotional reactions, may even worsen outcomes (see Shalev et al., 2004). While a minority of children and adolescents may exhibit severe reactions such as extreme dissociation, acute suicidal behaviors or homicidal rage that need immediate protection and care; care for the majority should focus on "psychological first aid".

Psychological first aid refers to pragmatic interventions designed to provide immediate needs and emotional support to victims of trauma. The goals of psychological first aid are to manage immediate crises and help children and families function as well as possible (Shalev et al., 2004; NIMH, 2002). These goals can be accomplished by activities such as establishing safe environments, providing food, rest, sleep, and medical care, providing accurate information about ongoing events, connecting children and families to available resources, and to the extent possible, returning to daily routines and reestablishing opportunities of play and go to school (NIMH, 2002; Vernberg, 2002). Whenever possible, interventions should be consistent with the UNICEF best practice recommendations that interventions with traumatized youths take place in stable and

supportive environments and be administered by caregivers who have solid and continuing relationships with the children (Machel, 1996).

Figure 2 lists some important elements of post-disaster support and psychological first aid.

Figure 2 - Important Elements of Post-Conflict Support and Psychological First Aid.

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Basic Needs
- Provide survival, and a safe and secure environment
- Provide food, shelter and rest
- Provide medical care
- Orient survivors to the availability of services and support
- Provide opportunities to communicate with family, friends, and community members

Psychological First Aid
- Protect survivors from further harm.
- Reduce stress and anxiety
- Mobilize support for those who are most distressed
- Keep families together and facilitate reunions with loved ones
- Provide information about ongoing events

Fostering Resilience and Recovery
- Foster but do not force social interactions i.e. with caretakers and with other children.
- Provide coping skills i.e. problem solving and anger management training
- Provide education on stress responses, traumatic reminders, coping, normal versus abnormal functioning, risk factors, available mental health services, etc.
- Foster natural social supports.i.e. reuniting families, resuming expected roles and routines, providing opportunities for worship, public ceremonies, memorials and rituals, etc
- Look after the bereaved i.e. provide strategies for coping with grief by identifying traumatic grief reactions and helping children to form a non-traumatic image of their loved ones
- Provide opportunities for meaningful action and activities
- Repair the organizational fabric. i.e. to the extent possible, returning to daily routines and reestablishing opportunities of play and go to school

(Sources: NIMH, 2002; Vernberg, 2002)

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Whenever possible, psychological first aid for children should focus on restoring social support for individuals, families and communities i.e. by providing opportunities to connect with family and community members, reassuring children that they are loved and

that adults will do everything possible to keep them safe, answering questions, and resuming routines and community activities. It is especially important to help parents function as well as possible and provide meaningful activities for children and adolescents. There is evidence that better psychological and emotional functioning in parents following disasters and emergencies is an important predictor of better mental health outcomes in children; and that resuming familiar roles and routines as soon as possible can help reduce the intensity and duration of post-traumatic reactions (NACCT, 2003; Prinstein et al., 1996; Vernberg, 2002). For children and adolescents this ideally includes reopening schools and other institutions as soon as possible, and providing information about events and about expected stress reactions for parents and teachers in formats children can understand. Although not yet supported by research, it has also been suggested that public ceremonies, memorials and rituals can help children and families to express grief and provide opportunities for social support (Vernberg, 2002).

In addition, it is increasingly being recognized that post-disaster child and adolescent mental health services are best provided, not only by clinicians, but also in interactions with a range of individuals and groups with whom children have contact in the aftermath of complex humanitarian emergencies and mass violence. These interactions can include law enforcement, emergency responders, community providers and local "de facto" child and family mental health systems such as primary care providers, school teachers, counselors and nurses, clergy, family members, and neighbors. It is particularly important to integrate these "de facto" child and family mental health systems into early responses and supportive care, i.e. non-traditional first responders such as members of the faith community and volunteer organizations who are often first on the scene and

resources to whom families turn to in times of difficulty as sources of emotional and spiritual support (NACCT, 2003; NPDPRCM, 2003).

SCREENING

Effective intervention following war and mass violence can be facilitated by screening and identifying children and adolescents who have persistent trauma-related symptoms. In situations involving mass violence and related threats, the mental health and psychosocial needs of children should be assessed as soon as possible, using validated behavioral and psychosocial assessment instruments, in order to identify populations of children and adolescents who may be at higher risk for developing trauma-related psychopathology, direct resources, and allow for early intervention (Cohen et al., 2000; NIMH, 2002.

Evidence suggests several important factors that should be taken into account whenever conducting post-emergency mental health needs assessments of children and adolescents events (Balaban, in preparation).

1) Necessity of assessing severity and type of trauma.

It is essential that the type, nature, and duration of trauma be assessed in children exposed to disasters and emergencies. There is evidence of relationships between the type and severity of trauma children are exposed to and the outcome in relation to PTSD, anxiety, and depression, i.e. children in war situations may have been exposed to a variety of traumas over long periods of time, while children in the aftermath of a natural disaster may be dealing with a single, relatively circumscribed event.

A screening should include basic exposure information about where the children were and what happened to them and those around them. This should be followed by specific questions about high-risk experiences for example, direct life-threat, being trapped or injured, witnessing grotesque injury, hearing screams of distress, being separated from family members or caretakers, or, injury or death of family members. Additional exposure screening questions should address the child's subjective appraisal of the event and associated emotional responses.

2) Necessity of assessing multiple disorders

Post-emergency psychological assessment should not be limited to determining the presence of any single psychological disorder. A great deal of the current knowledge of children's psychological responses to disasters is based on research on PTSD. However, PTSD is only one of a range of possible responses to trauma. Traumatized children can also exhibit trauma-based symptoms including physical symptoms such as headaches or stomachaches, anxiety, depression, and behavioral problems such as aggressive or disruptive behaviors (see Figure 1).

3) Independent Assessment of Children's Behavior

Whenever possible, assessments of children should include an assessment of the child's functioning by an adult familiar with the child's behavior such as a parent, caretaker or teacher. Assessing child mental health often requires input from several informants. Children have generally been found to be able to accurately report their own internal states, but are often not reliable observers of their own behaviors. Adults, in contrast, are

generally reliable observers of children's behaviors, but have a tendency to underestimate children's emotional distress.

4) Assessment of family members, especially mothers

If possible, assessments of children's mental health should be conducted in conjunction with an assessment of parental mental health. A variety of studies have indicated that parental adjustment, particularly mothers, is an important predictor of children's mental health outcomes. If a parent is distressed, depressed or highly anxious, he or she may need to get emotional support or counseling in order to be able to better care for and help their children.

5) Functional status

Whenever possible, screening instruments should include questions of social and behavioural functioning such as how children are behaving at home and at school. In the aftermath of emergencies, some children who report trauma symptoms in an assessment might be functioning well enough not to need immediate intervention; while the absence of reported symptoms does not necessarily mean that a child is not distressed and not functioning well.

6) Age and Developmental Differences

Although the impact of age on children's post-traumatic behavior and functioning are not yet well understood, it is critically important that any assessment instruments used in an assessment be age and developmentally appropriate and presented in language that children can understand. Instruments used in post-emergency assessment of younger

children must take into account their limited verbal skills and different ways of reacting to stress. For example, younger children may show re-experiencing symptoms of PTSD in the form of play reenactment, rather than flashbacks or intrusive thoughts.

7) Pre-Existing Risk Factors

Good practice in early intervention should take into account the special needs of those who may be vulnerable and less able to cope with unfolding situations. A variety of studies have identified risk factors which influence response to trauma and affect recovery. These include: exposure to previous traumas, pre-existing psychopathology such as depression or anxiety disorders, and social isolation. Other studies of traumatized child populations have also indicated that family displacement and loss of parents can add to the effects of the original trauma itself.

8) Cross-cultural differences

Whenever possible, assessments should be carried out using instruments that have been validated in the culture and population where they are being used, since different ethnic and cultural groups may have different categories of mental health and illness, and different culturally appropriate ways to express grief, pain and loss.   Many assessment instruments may not be appropriately sensitive to cultural and ethnic variability; and simply translating an instrument into another language does not necessarily mean that the same symptoms or the same disorders are being assessed across cultures. Even when language is not an issue, original validation studies of an instrument may not be sufficient to establish cutoff scores in a new setting or population i.e. a test validated in a middle class clinical population may need to be re-validated for use in a non-Western context.

TREATMENT

There is reliable evidence that psychotherapy can be effective in treating symptoms of PTSD, depression, anxiety and phobias in children and adolescents, either alone or in combination with medications (Cohen et al., 2000; Kazdin et al., 2003).

Medications

There has been a great deal of research on the use of psychotropic medications for adults with PTSD, including research on the formation of emotionally charged memories and medications that may help block the development of symptoms. Medications appear to be useful in reducing some adult symptoms of PTSD and accompanying conditions such as depression and panic, and improving impulse control and related behavioral problems. However, research on the use of medications to treat PTSD in children and adolescents is still in very early stages and no definitive recommendations can be made at this time (Kazdin, 2003; NIMH, 2002). Considering that medications can be expensive and considerable resources and infrastructure are needed for administration and monitoring by trained clinicians, use of psychotropic medications for children and adolescents in post-conflict settings would not be recommended.

Psychotherapy

There have been very few randomized controlled trials of psychological interventions following disasters and mass violence, and even fewer on interventions for children and adolescents. However, existing data suggests that early, brief, and focused cognitive behavioral treatment approaches (CBT) have the strongest empirical evidence for reducing post-traumatic symptoms in children and adolescents (Kazdin, 2003; NIMH,

2002). CBT is generally a short-term form of psychotherapy lasting between eight and twelve weekly sessions, although sessions can be offered more than once a week. CBT uses techniques such as teaching stress management, relaxation techniques and problem solving skills to help in overcoming anxiety or depression and modifying thoughts and behaviors such as panic at reminders of traumatic events.

At present, the only controlled studies of child treatment following mass trauma after war or in a developing nation are those of the model of brief trauma- and grief-focused psychotherapy for children developed by the UCLA Trauma Psychiatry Program (Goenjian et al.; 1997; Pynoos et al., 1998; Layne et al., 2001). The UCLA model incorporates many aspects of CBT. It is a school-based group psychotherapy program that is designed to address five therapeutic foci:

1) Traumatic experiences – assessment, restructuring and therapeutic reprocessing of traumatic event(s)

2) Trauma and loss reminders – identifying, normalizing and developing tolerance for traumatic reminders

3) Postwar stress and adversities - increasing social support and encouraging proactive measures to cope with stress and losses

4) Traumatic Bereavement - strategies for coping with grief by identifying traumatic grief reactions and helping children to form a non-traumatic image of their loved ones

5) Resuming developmental progression - identifying missed developmental opportunities and promoting appropriate developmental tasks.

Goenjian et al. (1997) administered the therapy in four school based settings to 64 Armenian adolescents (mean age 11.5) who reported symptoms of PTSD and depression 18 months after a deadly earthquake. The adolescents received four half-hour group sessions and two one-hour individual sessions over a three-week period. Youths with more severe symptoms received two additional individual treatments. The treated adolescents showed a significant decline in PTSD symptoms 18 months after the treatments, while a control group of adolescents who did not receive the treatments showed an increase in symptoms.

Layne et al. (2001) administered the therapy to 55 Bosnian adolescents (mean age 16.8) who reported symptoms of PTSD and depression fours years after the war. The adolescents received an average of 20 group psychotherapy sessions over a twelve week period. Treated adolescents showed significant reductions in PTSD, depression and grief symptoms compared to a control group of adolescents who had only received part of the therapy program.

These results, while very preliminary, are promising and are consistent with other outcome studies of treatment of children after traumas such as fires, gunshot wounds, motor vehicle accidents, sexual abuse, and community violence (e.g. March et al., 1998; Cohen & Mannarino, 1996; Saltzman et al., 2001). A great deal more research is needed, however, to establish evidence-based interventions for children and adolescents after mass violence and complex humanitarian emergencies.

It should be noted that the majority of child and adolescent psychological treatment approaches have not been evaluated. CBT is a very popular form of psychotherapy and so has been most researched, but other approaches may also prove to be effective (Kazdin, 2003). Two other forms of intervention have been evaluated and found not to be reliably effective: a) there is no evidence that early, mandatory debriefings (where survivors of a traumatic event are brought together soon after the event and asked to recall the details of the trauma and discuss their emotional reactions) reduce risks of later post-traumatic stress disorder or related adjustment difficulties; and b) there is no evidence that Eye Movement Desensitization and Reprocessing (EMDR) as an early mental health intervention following mass violence and disasters, is a treatment of choice for children and adolescents over any other approach (NIMH, 2002). Based on the current state of research, early, brief, and focused CBT would be the recommended form of therapy for children and adolescents in post-conflict settings.

CONCLUSION

Children and adolescents are among the most vulnerable members of communities affected by wars, terrorism, complex humanitarian emergencies and mass violence. The physical and emotional consequences of experiencing or witnessing violence can continue long after the initial event and affect many children who are not in the immediate vicinity at the time of the event. Ill and injured children react differently than adults to stress, and their psychological vulnerabilities in the aftermath of disasters and emergencies are still only imperfectly understood. On every level - physical, medical, psychological, emotional and social - children have unique needs and vulnerabilities that must be taken into account when designing mental health interventions in post-conflict

settings (LaGreca et al., 2003; Mollica et al., in press; NACCT, 2003; NPDPRCM, 2003; Pfefferbaum, 1997; Pynoos et al., 1998; Yule, 2001).

The best available evidence suggests that many children and adolescents may display acute stress symptoms in the immediate aftermath of disasters and emergencies, but that this does not predict the development of subsequent serious psychopathology. Resilience is facilitated by psychological first aid - meeting survival needs such as safety, food and rest, keeping families intact, good parenting, returning to daily routines and reestablishing opportunities of play and go to school. For those children and adolescents who do experience extreme or prolonged effects of trauma, the available data suggests that early, brief, and focused cognitive behavioral treatment approaches (CBT) have the strongest empirical evidence for reducing post-traumatic symptoms.

Ultimately, interventions for individual children and families are necessary but not sufficient to help restore post-conflict societies to normal functioning. A broad model of public mental health care for children and families affected by wars and mass violence is needed (Pynoos et al., 1998; Laor et al., 2003). The larger, societal stresses and difficulties that can affect communities recovering from complex humanitarian emergencies and mass violence – lack of social support, poverty, disruptions of family, education and social life, domestic violence, substance abuse, displacement, unemployment, crime and sexual exploitation - can all contribute to prolonged post-traumatic distress in children and adolescents. A further potential risk factor is the development of an intergenerational cycle of violence: studies have shown that children and adolescents who have witnessed and been victims of community and domestic

violence are more likely to become perpetrators of violence than those who were not exposed (Shakoor and Chalmers, l991). It is only through long-term community-based strategies for providing psychosocial assistance to children and families that society as a whole will ultimately be able to ensure the futures of children exposed to wars and other mass traumas.

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<center>CHAPTER 5</center>

<center>TRADITIONAL HEALING IN CONFLICT / POST-CONFLICT SOCIETIES.</center>

<center>**Seggane Musisi, MD and Pratiwi Sudarmono, MD**</center>

ABSTRACT

Approximately 50 countries in the World today are affected by massive conflict/post conflicts physical and mental health problems. Furthermore over 75% of the world's population is emotionally and culturally tied to indigenous systems of health care including mental health care (traditional healers). In the West, complimentary alternative medicine has become increasingly popular. Societal beliefs (culture) attitudes and responses influence people's health seeking behavior including mental health care. Furthermore, in most conflict/post conflict countries, there's a paucity of Western trained medical practitioners. In conflict / post-conflict societies, the mentally affected are part and parcel of their massively traumatized community together with their traditional healers and with whom they share their same environment, beliefs, fears, hopes, faiths, culture, resources and finally their destiny.

Considerable scientific evidence shows that universal physiologic processes as seen in trauma victims present with differing idiomatic, somatic and behavioral expressions of distress specific to particular cultures thus giving popularity to the term *post-traumatic culture-bound syndromes,* e.g. *Nervios* in Latin America, *Dissociation and Possession* states in Africa or *Wind Illness* in Asia. Cultural understanding of these illnesses of distress as happens in conflict/post conflict communities is crucial for their holistic management. Traditional healing has been defined as that "sum total of knowledge and practices, whether rational or not, used in the diagnosis, elimination and prevention of physical, mental or social imbalance and which relies mostly on practical experience, observation or knowledge handed down from generation to generation verbally, by apprenticeship or in writing".

This chapter presents a discussion of the cultural link between a prototypical universal illness of distress, post-traumatic stress disorder (PTSD), which is variously expressed in various cultural setting thus calling for its holistic management. This calls for culturally competent approaches to treatment alongside Western medicines especially when dealing with massively traumatised populations where issues of social, cultural, religious and family variables are concerned.

INTRODUCTION

Approximately 50 countries in the world are today affected by conflict/post-conflict

health problems: (1). Most of these are in developing countries (2). There is

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overwhelming evidence showing that mass trauma in conflict/post-conflict societies is associated with considerable mental health problems (2). Furthermore, literature shows that over ¾ of the world's population is emotionally and culturally tied to indigenous systems of health care and this also includes the care for the mentally ill (3). In Africa and Asia alone, over 80% of the mentally ill seek resort from traditional healers (3). Indeed traditional healing exists side by side with Western medicine in these countries. In the Western countries themselves alternative medicine has become increasingly popular in the last twenty years (3). It is also well established that societal beliefs (culture), attitudes and responses influence people's ideas about mental illness and their subsequent health seeking behavior. In most developing countries the psychiatrist to patient ratio is 1:1,000,000 or more and yet the traditional healer to patient ratio is 1:50,000 or less (3). Thus in terms of accessibility, traditional healers are far more prevalent and accessible to the population than Western trained medical doctors. Even when one considers all mental health professionals put together (psychiatrists, psychologists, nurses, social workers, occupational therapists, counselors etc), traditional healers are still the main source of care in 80% of cases either by people's choice, preference of by their sheer availability and accessibility (3).

Traditional healing has been defined as "The sum total of all knowledge and practices, whether rational or not used in the diagnosis, prevention and elimination of physical, mental or social imbalance, and relies mostly on practical experience, observations or knowledge handed down from generation to generation verbally, by apprenticeship or in writing" (4). In conflict/post-conflict societies, mentally affected people are part and parcel of their massively traumatized community together with their traditional healers

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who live amongst them and with whom they share their same environment, beliefs, fears, hopes, faiths, culture and any available resources including their destiny. In a primary health care approach, therefore, traditional healers must be part and parcel of the integrated approach to mental health care delivery in a very cost-effective and efficient manner.

This chapter will examine ways of how best to incorporate and utilize traditional healing systems for mental health care in the complex health emergencies of conflict/post-conflict societies and to identify research areas that need to be addressed.

SCIENTIFIC EVIDENCE FOR TRADITIONAL HEALING IN COMPLEX HUMANITARIAN EMERGENCIES

Studies done in Africa, Asia and among Native American Indians (in both South and North America) have repeatedly shown traditional healing to be effective in treating many common forms of mental illness (2,3,4). Kleiman and Sung (1979) investigated Chinese traditional healing practices in Taiwan by local shamans, *tang-ki,* and concluded that most patients (90%) presented with 'chronic-self limited illnesses and masked minor psychological disorders with 50% of the latter presenting as somatizations (5). Most reported improvement after the *tang-ki* treatment.

The major determinants of the outcome were:

(i)   Quality of therapist-client communication.

(ii)   Compliance to and satisfaction with (belief in) the treatment.

(iii) Care of the clients in their own community, culture and language.

They concluded that for healing to occur, medical care cannot be in the abstract but must be anchored in a particular social and cultural context. This provides for the balance

between "control of sickness and provision of meaning to the experience of illness." These universal therapeutic components of psychotherapy have been noted to be present and recognizably effective in both traditional and modern treatments thus favoring the argument that indigenous forms of psychotherapy treat certain psychological and physiological diseases (5). Today's evidence of the psychic ameliorative effects of meditation, yoga, biofeedback, relaxation therapy, exercise and a wide variety of behavior therapies on psychological dysfunction all favor a rendering of meaning to care as a most important aspect of well-being. Traditional forms of practice lead to 'healing' and do not just limit themselves to 'cure' of illness. This adds 'human value, cultural balance, peace and meaning to life and existence' in the care of patients. These factors are central to affecting mental health healing and stability to the massively traumatized individuals as found in the complex humanitarian emergencies of conflict/post-conflict societies.

Various studies in Thailand and Cambodia have attested to the need and use of traditional healing systems in dealing with the mental problems of massively war-traumatized populations (5,6,7). Van De Put and Eisenbruch (2000) studied Cambodian war-survivors of the Khmer Rouge 'killing fields' (6). They concluded thus: "Traditional beliefs and traditional healers of many kinds were essential in offering people at least a thread of continuous identity in the massive turmoil that threatened their existence and culture"(6). They felt that any intervention aimed at alleviating the psychological suffering of the war-traumatized peoples needed to be complimentary to or at an absolute minimum be informed about the work of the Traditional healers. Mollica et al (1994) came to the same conclusions (7).

In Africa Musisi et al (2000, 2002) also found that many war-traumatized individuals resorted to traditional and faith healing practices to deal with their massive psychological problems (13, 14). As shown in Table 1 below, more than half of the respondents in a war- traumatized population in Northern Uganda sought healing from their Traditional healers (14).

TABLE I : Health Seeking Behavior in Awer IDP Camp, Gulu, Uganda.

Service Sought	Number (N=2256)	Percentage (%)
Traditional Healer	1168	52
Faith Healer	49	2.2
Medical Clinic	425	18.8
Hospital	199	8.8
Mental Health Clinic	86	3.8
None	329	14.6

 Workers in Latin America described the beneficial role of traditional healers including the *curanderos* in helping the massively traumatized local Indigenous Indian populations e.g. during the plantation, conflict and hurricane displacements (2).

The questions that are often asked are:

(i)   Why do people prefer traditional healing even when modern care is available?

(ii)   Do traditional healing Systems really work and if they do, how?

(iii)   How could traditional healing Systems be used in the complex humanitarian emergencies of conflict/post-conflict societies?

In dealing with the above complex questions, some workers have questioned the validity of universalizing Western concepts of suffering to other cultures. Bracken (2001) argued that PTSD is a peculiar construct of life in contemporary post-modern societies of the West and denied its universal application to other non-western cultures (8). On the other hand various workers have described a core set of symptoms found in all cultures and societies as constituting the core syndrome of PTSD as described in the American Diagnostic and Statistical Manual of Mental Disorders, DSM- IV (9). Moreover numerous historical reviews have always referred PTSD but by various names e.g. shell shock, soldiers heart etc. O'brien (1998) has claimed that, "PTSD is merely the renaming or synthesis of an age old condition." Whatever the arguments, all agree on the varied expression of psychological distress in different cultural settings thus giving rise to the notion of 'Post-traumatic culture-bound syndromes' (10)

The central themes in all these various cultural healing systems in the face of mass trauma was:

(i)   respect for human life

(ii)   recognition of what constitutes a good and meaningful life

(iii)   the notion of personal dignity.

Mass trauma denigrates all the above 3 concepts. Yet, for any healing to take place in conflict/post-conflict communities, one must pay respect to the specific cultural meanings of those three notions hence the importance and centrality of traditional healing

systems in war trauma. It is through cultural traditions that man values human life, constructs the meaning of life and respects personal and others' dignity.

HARMONISING SCIENCE AND CULTURAL EXPERIENCES IN TRAUMATISED INDIVIDUALS

There has been considerable work geared to harmonizing the vast scientific evidence pointing to the universal physiologic processes seen in trauma victims and yet presenting with differing idiomatic expressions of distress specific to particular cultures as the so called *post-traumatic culture-bound syndromes* (10).

This often causes confusion, when the affected victims migrate out of their homelands to especially Western Industrialized societies, e.g. the *ataques de nervios* of Latin Americans in USA and Canada (2). Boehnlein (2001) describes the 'cultural interpretations of physiological processes in PTSD and panic disorders' (11). He argues that "listening simultaneously to the literal (spoken) language, knowing cultural metaphors and observing somatic (body) language leads to a more comprehensive understanding of human suffering in the psychiatric care of the traumatized. Thus ethnographic observations, consultation with traditional healers when integrated with modern clinical skills produced a better understanding and care of the traumatized patients. Thus, in Cambodia, *kyol goeu,* or wind illness becomes a prototype PTSD in traumatized victims. In Africa, Van Duyl (12) and Musisi et al. (13) observed various somatoform disorders, dissociation, hysteria and possession states in traumatized internally displaced persons (IDPs) refugee camps in Uganda in what would otherwise be classic PTSD syndromes. This cultural link between a prototypical illness which is variously expressed and the physiologic experience which is universal argues well for a better understanding of PTSD in the massively traumatized in different cultural settings

and points to a need to develop culturally competent approaches to treatment of victims of complex humanitarian emergencies in different cultural settings. Such understanding calls for the inclusion of traditional healing alongside Western medicine when dealing with traumatized populations especially where issues of social, cultural, religious and family variables are concerned. Thus in summary, culture influences not only the patient him/herself, but also the patient's family, social environment and his/her intimate sensations and interpretations of physical bodily functions and experiences during times of great psychological distress as is commonly seen in the massively traumatized. This also applies to the experience of the effects of drugs and their side effects.

METHODS OF WORKING OF TRADITIONAL HEALERS

WHO has characterised traditional medicine as "those diverse health practices, approaches, knowledge and beliefs incorporating plant, animal and /or mineral based medicines, spiritual therapies, manual techniques and exercises applied singularly or in combination to maintain the well-being of the patient as well as to diagnose, treat or prevent illness" (3). Traditional healers, therefore, use all kinds of techniques to effect healing. Abbo (2003) in Uganda classified these into 4 as follows:

(i)   Phytotherapy and other medicaments (Herbal/plant, organic-animal and non-organic remedies: taken orally, smoked, inhaled or applied topically)

(ii)   Talking Therapies (Psychotherapies and Counseling)

(iii)   Behavioral modification therapies (symbolisms, rituals, drama: song, drum & dance, and interactive group therapies)

(iv)   Spiritual (faith) healing (including spirit consultations, prayer & possession states and/or carrying/wearing protective artifacts).

In conflict/post-conflict communities traditional healers have been found useful in the following:

(i)   To mobilize the people into or for particular actions;

(ii)   To provide meaning to the experiences of traumatized victims, e.g. dissociation & possession states in Africa or *ataques de nervios* in Latin America, or *Kyul-goeu* in Cambodia, etc.;

(iii)   To treat common psychological discomforts e.g. anxiety, panic, depression or demoralization;

(iv)   Case identification, management and referral of more complex cases;

(v)   To resolve interpersonal conflicts especially in traumatized families;

(vi)   To instill values, norms and morality where there have been destroyed by the traumatic social disintegration of war or conflict, e.g., destroyed neighborhoods, wayward teenagers in IDP camps, rampart sexual abuse of women in war- torn areas etc.;

(vii)   To restore a sense of identity and cultural continuity where these have been broken by conflict e.g. broken families, orphaned children, the widowed etc;

(viii)   To create a sense of hope and faith as is in spiritual (faith) healing in   seemingly hopeless situations;

(ix)   To restore dignity to the wronged, pay respect to the dead, implore justice for all and cleanse desecrations;

(x)   To enhance tolerance, understanding and patience and to avoid the vicious cycles of trans-generational traumatizations and hatreds. For example, traditional rulers using Traditional Healers have waged or stopped waging wars in so called

culturally justified wars, e.g. the Mau Mau and Maji-Maji armed rebellions in East Africa against colonialists;

METHODS OF INCORPORATING TRADITIONAL HEALING SYSTEMS IN THE MENTAL HEALTH CARE OF CONFLICT/POST-CONFLICT COMMUNITIES

Up-to now there is no universally agreed upon method of incorporating traditional healing systems in complex humanitarian emergencies although their importance is universally acknowledged. This is an area in need of much systematic scientific research. Nevertheless, the following principles need to be observed:

(i)   The cultures and beliefs of the traumatized peoples must be respected;

(ii)   Existing knowledge of healing must be acknowledged, respected and incorporated as appropriate;

(iii)   Universal respect to human life, values and dignity must be observed;

(iv)   There must be adherence to the principle of universal human rights and respect for all irrespective of gender, race, ethnicity or religion;

(v)   Practices that are traditionally discriminative must be discouraged e.g. class, caste, racial, gender, tribal or religious prejudices;

(vi)   The medical, social , security, food, housing and spiritual needs of the traumatized community must be catered for in a culturally accepted way;

(vii)   Traditional healing systems need to be incorporated early and at primary health care level alongside other treatments and with no associated stigmatizing labels.

In order to successfully incorporate traditional healing systems in the complex humanitarian emergencies of conflict/post-conflict communities, baseline surveys to establish and address the following need to be done:

(i)   The cultural practices and beliefs of the affected society

(ii)   The nature of the problems involved

(iii)   The magnitude if the problems

(iv)   The traditional knowledge and mechanisms of dealing with the problems

(v)   The resources available in terms of personnel, knowledge, expertise and materials

(vi)   The useful and beneficial traditional practices to be incorporated

(vii)   Possible harmful practices to either modify them to usefulness or discourage them

(viii) Innocent /neutral practices to be left done

(ix)   Identification of culturally competent (modern) clinical practitioners to work with the traditional healers

The following figure summarizes the vicious cycles operative in conflict/post-conflict societies, the recommended action plan passed on the current scientific knowledge and the top research areas that need to be explored in regard to the role of traditional healing in complex humanitarian emergencies.

Fig. 1: The vicious cycles of events affecting mental health in conflict/post-conflict society

NORMAL PEACEFUL SOCIETY

- Socio-economic Activity
- Intact Traditions & Healing Practices
- Social Capital

CONFLICT SOCIETY
- Mass trauma
- No/ or erratic systems of health care
- Chaos (public disorder)

SOCIETY IN RECOVERY

- Active Mental Health Policy & Programs
- Recovered Mental and Public Health
- Social order
- Traditional practices alongside modern

Positive Cycle

Negative Cycle

Recovery Cycle

MENTAL DISABILITY

- Mental Health Impairments
- Trans-generational effects
- Public Health breakdown
- Capital flight

ACTION PLAN & RESEARCH
-Research in Traditional systems
- Mental Health Policy / care
- Best practices, Peace and
- Conflict resolution

In a normal peaceful society, there are intact healing systems and traditions as well as public order and respect for human rights and good economic activities. Mass trauma destroys all that and creates a situation of chaos, public disorder, absence of governance and destroyed health care systems with no respect to human rights or life. The result is a negative cycle of massive mental health and social impairments as well as Public health breakdown and capital flight. Such a situation perpetuates trans-generational effects of trauma including poverty, disease and future mass trauma. To change this, a recovery cycle needs to be activated and this needs a recovery *Action Plan of Best Practices* to include the restoration of healing systems that take into consideration local circumstances, culture, knowledge and practices. This calls for the incorporation of traditional healers into the planned interventions, which must be formulated into the new post-conflict health policy to be followed by appropriate legislation. How best to incorporate traditional healers into the newly planned post-conflict mental and public heath system should be based on country specific research taking into account the current practice and the social-cultural realities of that particular society (Please see section on future research below). The recovery action plan then should translate into a society in recovery with social order, revived integrated health care (including mental health care) systems, good governance and respect for human rights. These then drive society into a positive cycle with intact traditions and health practices, revived economic activities and a return of social capital and social order with good governance and respect of human rights.

FUTURE RESEARCH

Traditional healing systems (THS) have been marginalized in many countries of the world today. However they persist side by side with modern Western medicine. There is need to incorporate THS in modern health care. Currently there are three systems of Health Care approaches in use in the world today (15).

These are:

(i) **The Integrative System**: Here traditional medicine is fully recognized and incorporated in the national health care system

(ii) **The Inclusive System**: Here traditional medicine is recognized but not incorporated in the national health care system.

(iii) **The Tolerant System**: Here national health care system is entirely allopathic but some traditional health care is allowed though not officially recognized.

In this chapter, the Integrative System is the ideal one we recommend. However, most countries practice the Tolerant System. In order to achieve the ideal Integrative System, the following research areas need to be undertaken:

(i) Research into Herbal Medicines (Phytotherapy) and other traditional remedies e.g. minerals, oils, etc. This should address the following:

(a) The efficacy

(b) The appropriate dose regimen and duration of treatment

(c) Their toxicity (phytoxicity)

(d) When and how to "pick" them and apply them e.g. flowers, leaves, roots or stems; and their applications, e.g. as steams, inhalation or liquids for bathing/drinking etc.

(ii)   Research into the "Healing aspect", that is, relief of suffering and cure, of traditional medicine e.g. mysticism, spiritualism, belief/faith, rituals, drama, observations, taboos, behaviors etc.

(iii)   Research into the:

(a) Beneficial practices and how to enhance them.

(b) Harmful practices and how to stop these.

(c) Innocent practices and how to leave them alone. Often these are part of cultural symbols e.g. certain forms of dress, amulets, music etc.

(iv)   Research in ways of how to incorporate THS into modern mental health care as part of primary health care and achieve an integrative health care system. This has to be done specific to each particular country/society as it is bound to differ from country to country.

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CHAPTER 6

SCIENCE-BASED MENTAL HEALTH SERVICES: PSYCHOSOCIAL PROGRAMS

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ABSTRACT

Mental health issues should be understood within the broader context of the psychosocial well-being of post-conflict societies. Such well-being is influenced by many factors. A framework developed by the Psychosocial Working Group suggests that resources available in three key domains significantly impact the psychosocial well-being of communities. These domains of human capacity, social ecology and culture and values are outlined. Conflict degrades the resources available to communities in each of these domains, and intervention is appropriately targeted at assisting engagement with difficulties by increasing such resources. The basis of 'best practice' interventions is outlined, with key principles for effective intervention identified. Key actions for promoting psychosocial well-being are identified, as well as key research areas for developing the evidence-base for such interventions.

THE RELATIONSHIP BETWEEN MENTAL HEALTH AND BROADER PSYCHOSOCIAL WELL-BEING

The increased involvement of civilians in war is evident from our television screens, newspapers and first hand experience. In the last decade civil conflicts in Rwanda, the former Yugoslavia, East Timor, Liberia, Israel and the Palestinian Territories, the hidden wars in Uganda and Sudan, as well as the televised wars in Afghanistan and Iraq, have increasingly been brought to the attention of the general public through images of brutality and suffering. The International Committee for the Red Cross (ICRC) now estimate that 10 civilians die for every soldier or fighter killed in battle (2001).

Following the Indochinese war, and the subsequent refugee exodus, researchers investigated the psychiatric and social needs of refugees while in camps and later in their countries of resettlement. In the early 1990s, many of these researchers led the

exploration of the diagnosis post-traumatic stress disorder (PTSD) as a framework for the conceptualisation of the experiences of refugees. Little research was conducted in countries in the midst of conflict because of the difficulty accessing the affected population and associated ethical considerations. This situation changed with the conflict in the former Yugoslavia. Local mental health workers were caught up in the midst of the conflict and from situations of siege and assistance were able to research and document the conflict 'first hand' (Ajdukovic & Ajdukovic, 1993). Predominantly, this research continued to focus on the symptoms of psychological distress resulting from the distress and traumatic experiences of war. However, a critique was starting to develop that questioned whether PTSD and its related symptom otology was an adequate account for the personal and social experience of misery, humiliation, sorrow and social uprooting that characterized such wars as the Balkan conflict. This has led to an increasing emphasis on the importance of such a clinical conceptualisation as PTSD (or, indeed, any other psychiatric condition) being seen in the much broader context of communities within which the social and cultural fabric – as well as the individual psyche - has been disrupted.

The close inter-dependence of mental health issues with the wider personal, social and cultural circumstances of communities recovering from conflict is now widely accepted. Mental health interventions may thus be appropriately framed within the broader context of 'psychosocial' programs. Alternatively, community-based psychosocial programs may be encouraged to address local mental health issues. Either way, there is no clear dividing line between mental health interventions and those addressing the broader psychosocial well-being of communities.

Psychosocial interventions can be defined as actions that seek to address the interplay of social conditions and psychological well-being. With such a broad definition, a very diverse range of interventions is delivered under the 'psychosocial' banner. This, in itself, is a confusing state of affairs. Most significantly, however, such diversity presents difficulties for the development of a firm evidence-based for such interventions. If there is a lack of consensus on the goals of psychosocial interventions, there is little hope for the development of a consensual evidence-base to guide best practice.

For this reason, the Psychosocial Working Group (PWG) was established in 2000, comprising five major humanitarian agencies and five leading academic groups involved in the planning, delivery and evaluation of psychosocial interventions in situations of conflict and post conflict. Representing something of the diversity of programming approaches in the field, the group was charged with developing a conceptual framework for psychosocial intervention with respect to which an evidence-base for best practice could be established (Ager, 2003; PWG, 2003).

A CONCEPTUAL FRAMEWORK FOR PSYCHOSOCIAL INTERVENTION
The Impact of Events and Conditions
The proposed framework begins with the assumption that in post-conflict settings the needs of individuals are appropriately conceptualized within the context of a family or household which, in turn, is located within an 'affected community'. The 'events' experienced by the community may include direct exposure to military conflict, disruption of livelihoods, population displacement etc. The nature of these events is very diverse, and they often contribute to broader conditions that continue to impact the

community over many years. The common feature of such events and conditions is that they challenge the community and its members by disrupting or diminishing the resources of that community. Such challenges typically involve physical, material and economic losses. They also potentially erode psychosocial well-being.

Psychosocial Well-Being

The term psychosocial well-being has come to be preferred to narrower concepts such as mental health by humanitarian agencies to the extent that it points explicitly to social and cultural (as well as psychological) influences on well-being. The psychosocial well-being of an individual is here defined with respect to three core domains: *human capacity*, *social ecology* and *culture & values*. These domains consider respectively the human, social and cultural capital available to people responding to the challenges of prevailing events and conditions. *Human capacity* is fundamentally constituted by the health (physical and mental) and knowledge and skills of an individual. In these terms, improving physical and mental health, or education and training in support of increased knowledge, enhances human capacity and thus psychosocial well-being. While the importance of mental health and, particularly in work with children and adolescents, development of skills are widely accepted as a contribution to psychosocial well-being, social connection and support has increasingly been seen as an important complementary dimension of experience. There is strong empirical evidence linking mental health outcomes to the presence of effective social engagement, but wider cultural and programmatic concerns also justify the specification of *social ecology* as a discrete domain underpinning psychosocial well-being. Thirdly, the *culture and values* of a

community – traditions, practices, bases of local identity and belonging – also represent key resources underpinning psychosocial well-being.

Challenges to Psychosocial Wellbeing

Depression, social withdrawal, physical disability, and loss of skilled labor all serve to degrade available human capacity, as do less tangible impacts such as a reduced sense of control over events and circumstances. Events and conditions also frequently lead to wide disruption of the social ecology of a community, involving social relations within families, peer groups, religious and cultural institutions, links with civic and political authorities etc. Targeted disruption of such structures and networks is often the central focus of contemporary political and military conflict. Impacts on the social ecology of an affected community frequently include changes in power relations between ethnic groups and shifts in gender relations. Events and conditions may also disrupt the culture and values of a community, challenging human rights, cultural values and mores etc. Conflict can threaten cultural traditions of meaning that have served to unite and give identity to a community. Conflict can also serve to reinforce hardened images of other political or ethnic groups, encouraging escalation of violence and hatred.

Psychosocial well-being – of both individuals and of the communities of which they are members – is thus seen to be dependent upon the capacity to deploy resources from these three core domains in response to the challenge of experienced events and conditions. While psychosocial well-being is appropriately defined with respect to these three core domains, other issues clearly have a significant influence on such well-being. The loss of physical and economic resources available to households, disruption to community and

regional infrastructure, and degradation of the natural environment all plausibly have impact on the psychosocial well-being of communities. Such issues define the broader context within which individuals, families and communities seek to protect psychosocial well-being.

Available Resources

As noted, the resources of each of these three domains can be seen to be eroded by the experience of conflict. Importantly, however, each domain also represents a pool of resources that can be mobilized to respond to the demands of the post-conflict setting. All affected communities respond to and engage with the disruption caused by conflict. In terms of this conceptual model, this engagement involves interaction between the various domains highlighted. Social networks are utilized to protect significant cultural activities. Human capacity is invested in restoring social linkage. Culture and values are drawn upon to bolster human capacity and well-being. The effectiveness of this engagement and the utilization of resources within the community may be seen to be a measure of the 'resilience' of that community.

It is tempting to think of this process of engagement as one with the goal of 'restoration' of the situation existing before the impact of events, a perspective emphasized by a number of authors. However, experience in such settings as Rwanda and East Timor, where elements of a pre-conflict situation have contributed directly to the onset of violence, suggest that it in some circumstances it may be more appropriate to recognize this process as one of 'transformation', involving development of new relationships between the capacities, linkages, values and resources of a community. Such

transformation is a process rather than a single event. Adjustments in human capacity, social ecology, and values may shift over many, many years.

Whenever external resources are considered necessary to support the engagement of an affected community with the challenges it faces, the framework identifies programmatic intervention developing in response to the interaction of that community and an 'external community' of governmental and non-governmental agencies. Effective programmatic response is heavily reliant upon the effectiveness of this interaction between the affected and 'external' communities. Events and conditions also impact the functions of this external community (e.g. security situation influencing program implementation) as well as the 'affected' community. While this external community offers potential support through the deployment of additional human capacity (and, generally, physical resources), its operation is also influenced by its own (often complex) social ecology, and by the culture and values of its agencies. The domains of human capacity, social ecology and culture & values are thus helpful for understanding the process of engagement of the external community with the affected community, as well as of the affected community with prevailing events and conditions.

DEFINING PSYCHOSOCIAL INTERVENTIONS

The framework suggests that post-conflict psychosocial interventions can be defined as actions that support the engagement of individuals, families and communities with the demands of post-conflict settings by strengthening the human, social and cultural capital available to them. In practical terms, the PWG sees psychosocial interventions as actions that typically:

- alleviate human suffering by mitigating the effects of violence on human development and capacity,

- provide protection to those especially vulnerable to the impacts of conflict, and/or

- promote community healing and reconciliation (reducing conflict and increasing economic and social development).

Developing Best Practice for Psychosocial Intervention

What is best practice for such interventions? The framework suggests a number of domains within the affected community with respect to which interventions might be targeted (e.g. human rights initiatives with respect to the domain of culture and values; mental health programs targeting enhancement of health and well-being within the domain of human capacity; restoration of social linkage to support the socialization of children). These suggest a number of alternative routes to impacting the psychosocial well-being of a community and its members. Research on the concept of resilience (e.g. Haggerty et al. 1994) has, until recently, provided the major evidence-base for such interventions. Resilience refers to the capability of individuals or communities to withstand demanding circumstances. Broadly, the research literature on resilience points to the resources – which, in terms of the framework, can be grouped in terms of human capacity, social ecology and culture and values – that help mitigate against the impact of conflict, stress and loss.

Best practice in interventions that develop such resources – and those promote resilience – is very much centered around the process of identifying needs, and supporting local processes of engagement, rather than producing resources that are not relevant to local

coping strategies. Analysis of case studies (PWG, 2003) very much indicates that ineffective interventions tend to be those where what is provided is not sufficiently related to local agendas, capacities and strategies. The PWG has thus identified ten programming considerations that define best practice in psychosocial intervention. These are: (1) effective preparations; (2) adoption of a critical perspective on potential impact; (3) valid assessment; (4) active local participation; (5) commitment to capacity building; (6) an orientation to peace-building and social justice; (7) prioritization of human rights and protection issues; (8) evaluation and knowledge improvement; (9) training; and (10) sensitivity to the linkages between individual, household and community across different cultural settings (see PWG, 2004 for full details).

The Emerging Evidence-Base for Psychosocial Intervention

Such best practice is increasingly being informed by focused research effort related to the PWG framework. The PWG has defined a research agenda, which sees the key tasks for developing the evidence-based for psychosocial intervention as the following:

- documenting (with respect to the proposed framework) the emphases of current psychosocial programming;

- identifying appropriate assessment measures of need in each of the domains identified;

- evaluating outcomes of particular intervention approaches (on non-targeted as well as targeted domains);

- examining the utilization of relevant knowledge by agencies in framing interventions; and

- considering the experience of program beneficiaries with respect to the core domains charted by the framework.

There are now a number of studies which have addressed – or are addressing – elements of this agenda, including a series of collaborative studies commissioned by the PWG.

ACTION PLAN

With the current state of conceptual understanding and evidence-base within the psychosocial field, the following are key actions that should be considered for implementation in addressing the needs of post-conflict populations.

Key Potential Actions
1. Restore public, civic and religious institutions that provide social order and meaning to affected populations. This will include support for re-establishment of schooling, public markets and civic routines, as well as fostering the reformation of local religious and other associations. **2. Promote active engagement and participation in activities by all sectors of the community** This may involve special provision for groups (e.g. youth, women, persons with disabilities, those in extreme poverty) who may otherwise be unable or ill-equipped to actively engage in community processes of recovery. Activities need not necessarily be directed at mental health and psychosocial needs. Often, practical concerns can more valuably bring people together, and help build confidence and hope. **3. Assess resources of impacted communities alongside assessment of needs** Too often needs are assessed, without an awareness of the strengths and capacities of affected populations. This sets intervention off 'on the wrong foot', not taking into consideration the current ways that people are using to deal with their difficulties (and seeking to bolster these). Assessment should thus address existing coping mechanisms and strategies, and how these may be supported. This will include resources drawn upon from the informal and popular sectors, such as religious ceremonies and

traditional healers.

4. Ensure that mental health promotion activities utilize and strengthen community linkages

Mental health should not be seen as an individual issue, but once understood – and addressed – at the community level. Active use should be made of existing social groups and networks to identify mental health needs, and mobilize response to them. These might be women's groups, sports clubs, religious associations, social clubs – any social group can serve as a basis for effective mental health promotion.

5. Link mental health promotion activities to work on peace-building and human rights

In many post-conflict settings, human rights protection and peace-building activities will usefully serve to promote mental health. Connections between such activities should be actively encouraged.

6. Make training and capacity development key programming activities.

This will include support for means of addressing mental health needs at the community level, facilitation and participatory skills, psycho-educational inputs and, where appropriate, knowledge of paths for advice and referral.

7. Commit resources to the evaluation of programs and services.

This will involve equipping people with the skills to learn from experience of what approaches are most effective in a given cultural context. Participatory evaluation methods should be used alongside any more quantitative evaluation measure.

PRIORITY RESEARCH AREAS

A research agenda for developing the evidence-base for psychosocial intervention was identified earlier. With respect to this agenda, key issues in post-conflict settings are those indicated below.

Priority Research Areas

1. What measures of well-being are suitable and valid for local use in diverse cultural settings and for contribution to the development of a global evidence-base?

Measures are required that are valid for use within a particular locality for the purposes of identifying needs (and resources) and evaluating outcomes. This can be difficult when the understanding of well-being so reflects cultural variation. However, in addition, to lessons from one setting need to be related to the experience of others if an effective evidence-base guiding action is to be developed. Measures need to reflect issues relating to the 'culture and values' and 'social ecology' of a community, in addition to narrower measure of individual mental health and other human capacity.

2. What methods are most effective for promoting psychosocial well-being?

Evidence is emerging regarding effectiveness (see above) but the evidence –base needs to be significantly strengthened.

3. How can psychosocial programs make best use of the available evidence-base?

This involves considering how evidence is abstracted to define 'best practice', and how such statements of 'best practice' are then effectively translated into program and service activity. A particularly neglected issue is that of fieldworker supervision – how are those delivering interventions supervised and supported in delivering targeted interventions?

4. How do beneficiaries experience psychosocial programs?

Current evidence suggests that those involved in receiving psychosocial services greatly appreciate them. However, in circumstances of significant loss and deprivation, any form of intervention is likely to be appreciated. More focused work needs to be done, indicating what aspects of programs – e.g. their technical components, the relationships established with fieldworkers, their participatory focus etc.- are seen as the most crucial from the perspective of beneficiaries.

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CHAPTER 7

CONSIDERATIONS IN PLANNING MENTAL HEALTH SERVICES IN CONFLICT-AFFECTED COUNTRIES IN THE DEVELOPING WORLD

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ABSTRACT

Mental disorders are a source of substantial disability worldwide and this burden is likely to be greater in countries affected by mass conflict. Resources and skills in those environments are limited, so that careful consideration needs to be given in determining service priorities. It is important to recognize that direct clinical services can only reach a small percentage of the population. Fortunately, most persons recover from common stress reactions with effective repair of wider social systems. A minority with severe mental illnesses and those with disabling traumatic stress reactions require direct clinical care. Community-based mental health services can provide accessible, equitable and effective care at low cost, thereby avoiding the harm created by institutionalising patients in large mental hospitals. In creating services, attention needs to be given to training; mentoring and supervision; to the integration of mental health within the broader primary health care system; and to coordinating activities across all relevant government and non-government services. The balance between specialist and primary care-based mental health services requires careful consideration in each context.

INTRODUCTION

Mental disorders generate substantial disability worldwide with post-conflict countries in the developing world often bearing a disproportionate proportion of the burden because of the additional stresses associated with violence and poverty and the absence or destruction of services for those in need.

In planning services, it is useful to consider two broad categories of mental disorder, the low prevalence, severe neuropsychiatric disorders and the higher prevalence emotional disorders such as the more common forms of depression, anxiety and posttraumatic stress disorder. It should be noted, however, that there is substantial overlap between these two broad groupings. For example, although severe (melancholic and psychotic) depression

falls into the first category, with more moderate forms of depression falling into the second, the distinction between the two types of depression often is blurred with stress and trauma playing a role in the onset of both forms.

Although severe neuropsychiatric disorders such as psychosis, manic depression, acute brain syndromes and epilepsy have a relatively low prevalence in all communities (combined point prevalence of roughly 2-3%), if untreated, they can lead to severe disability, premature death and disruption to the lives of sufferers, their families and the wider community. The incidence of these disorders may be higher in countries experiencing mass conflict because of the increased rates of brain injury, psychological trauma, dispersal of families, disruption of social support networks, unemployment, and poverty. In addition, poorly developed or disrupted services and the flight of mental health professionals may lead to the neglect of existing patients. Social chaos and population displacement may result in the abandonment, exploitation and abuse of the severely mentally ill, and families and other careers may be dispersed, killed or incapacitated.

Mass exposure to violence, conflict and displacement also greatly increase risk to the higher prevalence disorders such as posttraumatic stress disorder (PTSD), and the more common forms of depression and anxiety. As will be discussed, these disorders are particularly prevalent in the early phase of humanitarian emergencies and their immediate aftermath. Social stresses (living in refugee camps, being in detention centers) can lead to persistence of these reactions. Careful consideration needs to be

given, therefore, to how services should be provided to this larger group of stressed persons, particularly in settings where resources and skills are limited.

SOCIAL RECOVERY

This chapter focuses primarily on issues relating to the development of mental health services in conflict-affected countries. Nevertheless, it is critical to recognize that for populations affected by the stress of war, the key to psychosocial stabilization for most persons is the re-establishment of security and the capacity of communities to recover socially, culturally and economically. Given the high rates of acute stress reactions amongst such populations (up to 40%), it is neither feasible nor desirable to offer individual mental health services such as counseling to all persons in distress. Fortunately, there is mounting evidence that most persons with acute stress reactions recover if attention is given to repairing the social environment, the central task of humanitarian relief efforts working in partnership with emerging local authorities particularly Ministries of Health.

In the early, emergency phase, the overriding humanitarian objective is to minimize harm, that is, to provide protection with dignity for the affected population. Security is not only important to physical safety but also to psychological well-being. I have proposed an ADAPT model (Adaptation and Development after Persecution and Trauma) that identifies five domains of social recovery that, if well attended to, encourage natural psychosocial recovery. These domains relate to broad psychosocial areas that go beyond providing food, water, shelter and basic health care. The identified domains include the provision of: (1) security, both physical and psychological; (2) attention to interpersonal

bonds including reunion of families and the promotion of kinship networks and community cohesion; (3) creating systems of justice that promote dignity, trust, and a sense of faith that grievances will be addressed effectively; (4) establishing a framework for survivors to pursue existing and new roles and identities (family roles, study, work, social leadership); and (5) re-creating systems of meaning that allow pursuit of political, social, cultural and spiritual aspirations.

All sectors of government have a role to play in reconstructing these social systems. For example, in relation to the second domain (repairing ruptured bonds and relationships), international agencies such as the Red Cross can assist in re-uniting families and communities; efforts can be made to re-establish cultural and religious processes to facilitate grieving and remembrance for those lost; widows' groups can be formed to provide self-help, emotional and vocational support systems; truth and reconciliation processes can identify perpetrators and the fate of the deceased; and mental health services can provide counseling, but only for the minority who are disabled by persisting and complicated grief reactions. The key issue is that the more effective the reconstruction effort is in supporting the five adaptive domains at a community-wide level, the fewer will be those in need of direct mental health services. Put another way, mental health services should focus only on those persons (the minority) whose grief reactions persist and are disabling in spite of ongoing repair of these larger social systems.

CLINICAL SERVICES

Table 1 outlines some key issues in developing mental health services.

Needs Assessment

Planning in mental health needs to be context-specific but there are some general steps that need to be taken in all settings. These include: (1) a rough estimate of the prevalence of mental disorders in each context, information that is obtained by matching data from international sources with rapid local assessments using qualitative, purposive, sampling methods, that is, by interviewing key informants; (2) obtaining information about the availability of community resources and indigenous healing mechanisms; (3) evaluating existing local professional resources and skills in mental health, the capacity to dedicate human resources to this area, and the potential for recruiting strategic assistance from international sources; (4) logistic and material needs (transport, availability of clinics, drug procurement and distribution); (5) potential interactions with other areas in health especially in public health, health promotions and maternal-child health; (6) existing or planned activities of NGOs and other relevant sectors (social services, education, correctional services, rehabilitation, etc); and (6) levels of awareness and stigma about mental health throughout the various strata of the society (community, leaders, health professionals, planners and administrators, international agencies).

Principles of Planning

Key guiding principles in planning services include: (1) Awareness that interventions need to be affordable, feasible and have clear priorities; (2) Involving communities in the design and delivery of services; (3) Focusing on human rights issues, the reduction of stigma and marginalization, and prevention of unnecessary hospitalization or imprisonment; (4) Encouraging input from those who have good local understandings of traditional beliefs about mental illness and its management so that, as far as possible,

imported international methods are integrated into these existing healing systems; (5) Drawing on existing community strengths including the capacity of the family, community leaders and traditional healers to provide support and care; (6) Designing interventions to maximize social and work functioning in the mentally ill and the promotion of strategies that, as far as possible, integrate the person back into society; and (6) Ensuring that the service has immediate, measurable benefits while at the same time building a model that is sustainable and ultimately integrated within broader primary health service.

Three key areas will be identified for further discussion: (1) the service model, (2) the scope and focus of interventions, and (3) structural relationships within the health service and across government and non-government services.

A Community-based service model – preserving the family as the unit of care:

There is an international consensus that mental health services should be located in the communities they serve. The established principles are that the service needs to be a) accessible (close to where people live); b) equitable (allowing access by all those in need irrespective of wealth, influence or location of residence); c) acceptable (the community must feel that the service is welcoming, culturally sensitive, responsive and interacts with them in a respectful and dignified way); d) safety conscious, evidence based and offering good quality care; e) cost-effective; f) logistically practical (that is, issues of transport, availability of medications and other aspects of infrastructure support can be provided); and g) accountable in its activities to the local community and to the health authority.

Involving staff, local leaders, family of the mentally ill and other interested groups in designing and shaping the service promotes community awareness and a sense of local ownership. Active community involvement in turn helps to reduce fear, stigma and a sense of mystery about mental illness and also ensures that services are responsive and accountable.

Priority emphasis should be given to treating patients in their home environments wherever possible, thereby avoiding their dislocation of transferring them to distant mental hospitals. A key principle in developing countries is that the family is the greatest asset in caring for the mentally ill. Unlike in many technologically developed societies where mentally disturbed persons often are rejected by the family, traditional families tend to be more accepting and responsible for their ill family members. It is critical that mental health services support and promote this sense of responsibility. Once the culture is changed so that there is an expectation that services will take the mentally ill away, the principal of communal and family-based care is eroded, and the cost to Ministries of Health and the government as a whole of taking over the complete care of the mentally ill becomes unsustainable. The mistakes made by developed countries in that regard need to be considered very carefully by post-conflict societies in the developing world as they plan new mental health services.

Mental health promotion activities should include educating the family and wider community about mental disorders with the aim of destigmatizing sufferers, normalizing the experience of receiving treatment, giving families a sense of confidence in caring for

patients and re-integrating affected persons into the community by facilitating their return to active roles (work, school, child-rearing, etc.).

Community-based mental health services are relatively inexpensive to establish. Although access to some laboratory investigations is desirable, such facilities are not essential to assessing and treating most patients, which, unlike in other areas in medicine, is essentially based on engaging patients and their families, applying sound interviewing and history-taking skills, detecting behavioural signs and symptoms and forming a collaborative management plan. The main financial costs incurred are for the wages of personnel, medications, training and supervision, transport and basic office resources.

The community-based model avoids the tendency, still strong in some countries, to institutionalize the mentally ill. Large mental hospitals are expensive to establish, manage and staff, patients are dislocated from their communities, and there is the ever-present risk of neglect and abuse in such institutions, particularly in times of armed conflict or in the unstable post-conflict period. As indicated, if custodial institutions are created, this removes the responsibility from families for caring for the mentally ill, patients often are forgotten about or abandoned by families (they become the state's problem), hospitalization increases dependency and passivity in patients (institutionalization), and inmates become difficult to reintegrate into the community.

At the same time, there are social costs involved in instituting a wholly community-based model. Community services can find it difficult to deal with a small percentage of mental health emergencies, such as those few patients who are severely aggressive or

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highly chaotic in their behaviour. A problematic issue for a community-based services, therefore, is how to deal with the minority of persons that requires short-term custodial care: whether this should be in collaboration with the criminal-justice system (small, dedicated forensic units in jails) or within the health system (small, secure, short-term inpatient units or safe houses with sufficient security). The level of development of the health system will determine which of these options is most feasible: where there are few general hospital beds and low levels of staffing, dangerous patients need to be held for short periods in humanely ran forensic units alongside prisons. If that model is pursued, prison staff will need adequate support from community mental health personnel who will assist in rehabilitating patients with the aim of returning them to the community as soon as possible.

Scope and focus of post-conflict services: who should get priority treatment?

It is important to define the population that most urgently requires clinical services because limitations in resources and skills in all conflict-affected countries means that only a small portion of the community can be provided with direct, individual treatment – in most post-conflict societies, the numbers receiving direct treatment can rarely exceed 1% of the total population per year. (Commonly the treated numbers are smaller than this.)

Several factors determine the urgency of need for mental health attention: the nature of the illness; its severity; the degree of disability; the level of behavioural disturbance especially violence and suicidality; the availability and effectiveness of family support; and the overall social context. Severe mental illnesses include acute or unremitting

psychosis (schizophrenia and related disorders), severe mood disorders (manic depression, severe melancholic or psychotic depression), especially where risk of suicide or aggression is present, and the more disabling forms of anxiety such as acute posttraumatic stress disorder and panic disorder. The severely mentally ill come to attention usually do so because of severe and unremitting distress, bizarre and socially disruptive behaviour (wandering away, shouting at neighbours, throwing stones), loss of capacity to care for themselves or those for whom they are responsible, especially children, and suicidal or aggressive behaviour.

It should be noted that there are more persons in the community with these severe disorders who do not need urgent attention for several reasons: their conditions may be stable or in remission; they may have good social supports; they or their families may not want treatment; they may be receiving treatment from traditional healers; and/or their social behaviour may not be problematic. The subgroup presenting at services are more likely to be in situations where the family already is under duress, for example, where members have been killed, injured or are sick and where the unit as a whole is struggling to survive economically.

Some psychotic persons are so disturbed that they are chained to trees for their own protection and the safety of the family. Often, especially when countries have experienced long-term conflict, there has been an accumulation of untreated cases of severe mental illness over time, so that there is an early referral "bulge" when clinics are re-established. In addition, in many settings, persons with epilepsy are brought to clinics because communities regard epilepsy as a form of mental illness and there may be no

other specialists or facilities to treat this disorder at least in the immediate post-conflict setting.

Most developing countries can only afford the psychiatric drugs that were introduced over forty years ago ("first generation drugs") such as the antipsychotic agents, chorpromazine and haloperidol, the tricyclic antidepressants (imipramine, amitriptyline), sedatives such as diazepam, and mood stabilizers/anticonvulsants such as sodium valproate and carbamazepine (these drugs also are used for epilepsy). Although replaced by more expensive second-generation medications in developed countries (antidepressants such as fluoxetine, antipsychotics such as risperadone), the older drugs remain effective and reasonably safe in low dosage although use in persons with physical illnesses, in children, and in the aged needs to be undertaken with caution and most of these drugs are dangerous in overdose. Treatment needs to commence at low dosage and patients monitored closely for side-effects and possible adverse effects. Family education and counselling should include information about what is known about the illness, as well as how medications should be used and their side effects. In many settings, patients are not used to taking medications regularly over long periods of time and families need to be advised that the psychiatric response will be gradual, often taking weeks or months to achieve a full effect.

Counselling also should focus on strategies the family might use to resolve conflict with patients, how to deal with bizarre or inappropriate behaviour, ways to encourage better functioning without being punitive, and detection of signs of early relapse. Community leaders may be included in discussing how to ensure safety if a patient is suicidal (the

extended family and/or neighbours may be helpful taking turns in a "suicide watch" until the person recovers) or where the person becomes threatening. Community leaders can also be helpful in advising neighbours and villagers in general about the nature of the problem so that they do not laugh at the patient, tease him or her, or retaliate if the ill person is aggressive. Referral to other agencies (medical services, local and international NGOs) may be needed for general medical care, support for food and housing, and attendance at rehabilitation services for education or work training. Religious leaders and/or traditional healers may be helpful in providing a spiritual understanding of the person's suffering and by offering rituals or religious practices that assist in giving meaning to the person's experiences.

As indicated earlier, there is no absolute distinction between severe mental illness and the more prevalent stress-related psychological disorders found in post-conflict settings. Depression in particular crosses the divide with some cases having characteristics of severe mental illness (especially the melancholic and psychotic forms) and others, the more moderate types, often being more clearly a response to stress. Nevertheless, because stress-related reactions are so common, and if they persist, they can become disabling, they present a challenge to health services since not all these reactions can (or should) be treated especially when resources are scarce.

Epidemiological studies undertaken across diverse post-conflict settings have revealed a substantial prevalence of these stress reactions, sometimes as high as 30-40%. Evidence suggests, however, that direct clinical interventions may only be needed for a minority of these persons. Most of the early psychological responses to trauma (hypervigilance,

arousal, avoidance of threats, traumatic memories) can be seen as normative, meaning that they are expectable acute reactions to life threatening experiences and many of these reactions will settle down if social stability is achieved (see the principles of the ADAPT model).

There are certain patterns that are likely to be more disabling, for example, where the reaction is in response to very severe trauma such as witnessing the brutal death of family members, being held in concentration or re-education camps or being subjected to torture and sexual abuse. Where posttraumatic stress symptoms are complicated by depression (that is, where there is comorbidity), disability is likely to be more severe. If populations remain displaced, or are kept for long periods in refugee camps, detention centres or other places where they feel unsafe and uncertain about their futures, then these reactions are also more likely to become chronic. On the other hand, if well applied in social reconstruction programs according to the principles of the ADAPT model, community resiliency and natural recovery will be promoted so that the number who experience chronic stress symptoms is likely to be smaller. Put simply, for most people, the best "treatment" is good policy that promotes social and economic stability, an important principle that should encourage a "whole of government" effort to achieving these objectives.

Relevant to this issue, is that there is strong evidence that early mass psychological debriefing (counselling for all persons exposed to trauma) is not warranted, nor is it feasible or affordable in most developing countries. Some acute stress reactions need emergency attention, however, because the level of distress or behavioural disturbance is

so severe that the sufferer or the family cannot cope with the immediate situation. A crisis intervention approach using a combination of interventions can be very successful. This includes a full psychosocial assessment offering culturally appropriate emotional support, encouraging problem solving, providing family counselling, mobilizing community supports and NGO assistance, and judiciously using medication when indicated. Traditional healers, cultural mourning practices and other social mechanisms may assist those with severe traumatic reactions, although, as yet, no systematic evidence has been gathered to show the effectiveness of these interventions.

Nevertheless, a minority of persons continue to suffer chronic and severe posttraumatic stress reactions, depression and anxiety even after peace has been established. These patients may use alcohol and/or drugs to gain relief from their symptoms and they may become withdrawn or aggressive. An increasing number of these persons may begin to attend clinics once the community has developed trust in the service (torture and rape survivors may be particularly reluctant at first to attend). Hence service providers need to be aware of the likely changes in service demands in clinics over time: in the early phase of establishing clinics, the majority of patients are likely to have severe mental disorders (psychosis, epilepsy, severe depression, brain syndromes) and acute stress reactions, whereas as time passes, there will be an increase in persons with chronic and unremitting traumatic stress reactions.

For the common trauma and stress-related problems, multi-modal treatments are needed in which all or some of the following elements are used: collaboration with traditional heelers where possible; practical counselling focusing on family and social problems and

how to solve them; stress management techniques (relaxation, breathing exercises, dealing with negative attitudes about symptoms, gradual exposure to phobic situations that create fear), family support and education; medication in selective cases; liaising with community supports and medical services; and work retraining and occupational assistance. Some but not all patients find that talking about their traumatic histories to a sympathetic counsellor gives them a sense of relief. The timing of such discussions varies across patients with some wanting to speak early in counselling about the trauma they have suffered and others only feeling comfortable to talk once they get to know the counsellor well. Some patients benefit from antidepressant agents and, in selective cases, from the addition of mood stabilizers.

Although there are no treatment outcome studies specific to post-conflict countries, clinical observations suggest that most patients (whether with severe mental illness or stress reactions) and their families are assisted by interventions. In many instances, the outcomes can be dramatic, with psychotic patients tied to trees or locked in rooms for their own safety being released from their chains once appropriate treatment is given. Persons with more moderate, acute forms of anxiety, depression and posttraumatic stress usually respond well. On the other hand, there is a range of therapeutic responses, with some chronically mentally ill persons only achieving moderate but nevertheless significant benefits from treatment, and some severely traumatized persons only making gradual progress. Overall, the social, cultural and economic advantages of access to mental health services usually are evident: no longer does the community have to fear mental illness or feel helpless in dealing with it, and affected families are assisted in the burden of caring for a previously dysfunctional member, allowing healthy members to

devote more of their energies to survival and adaptation in the demanding post-conflict environment.

Structural and Developmental Considerations: How to Start

It is common, particularly in the midst of an acute humanitarian crisis, for substantial numbers of international NGOs to enter conflict-affected areas and to initiate psychosocial programs focusing on the communal effects of trauma and abuse or on the psychosocial needs of vulnerable groupings (rape survivors, single mothers, child soldiers, unaccompanied minors, torture survivors, amongst others). This influx creates many challenges including the tendency to compete for donor funding, lack of coordination, and risk of duplication of interventions. Other limitations include the short-term (and hence unsustainable) nature of many projects, and uncertainties about how such projects "fit in" with emerging national policies in health, social services, education and other broad government services. A particular concern is the confusion created between psychosocial programs and mental health services with the two sectors often seen as overlapping and sometimes competing with each other. The area of traumatic stress is a key example where confusion can occur: whether the focus should be on broad-based population-wide prevention programs or on clinically-focused treatment approaches.

The difficulty is that in the period of conflict or early post-conflict, there may not be a strong enough health authority to insist on coordination of agencies or to adherence to an interim strategic plan that details the roles and responsibilities of each group. Creating such a platform for coordination and ensuring adherence to it should be a critical criterion

that donors, UN agencies and international NGOs are required to adopt with an explicit commitment to supporting emerging Ministries of Health to assume responsibility and authority as soon as is feasible.

Integrating mental health into the general primary care system is desirable for many reasons: it is cost-effective, it avoids stand-alone vertical programs in each medical speciality; it destigmatizes mental disorder by aligning services with general health; it ensures a stake for mental health in the core package of services; and it facilitates accessibility by having all services "under one roof". Nevertheless, *developmental* factors need to be taken into account in devising the optimal model for establishing mental health services in each context. In countries with an established cadre of mental health professionals (such as was the case in the Former Yugoslavia), the focus of development should be on enhancing the capacity of that group and drawing it closer to the primary care setting.

In very poor, post-conflict countries where there has been no previous mental health services or relevant professionals, as was the case in East Timor, there can be serious constraints in implementing a generic, primary care model for mental health immediately following the period of mass conflict. In such settings, rebuilding functional primary care services can be slow and primary care workers (usually nurses) are faced with a wide array of problems for which they need specific skills (maternal-infant and child health, physical trauma, communicable diseases and a wide range of severe and untreated physical illnesses). Adding the full array of mental health problems to the list of generic

activities for which primary care nurses are responsible in the *early reconstruction phase* may extend primary care workers beyond their capacity.

If mental health is simply "added" to the list and the training provided is brief and superficial, the area is likely to be neglected or dealt with in a cursory manner. Because of time constraints and low levels of skills, inadequate attention is given to assessing cases from a full biological, psychological, social and cultural perspective and wrong diagnoses can be made. Wanting to help, nurses may dispense diazepam (a sedative) for all types of mental disturbance instead of prescribing accurately for conditions such as depression and psychosis. Inappropriate use of these and other medications can lead to drug dependency, side effects (such as drowsiness) that actually decrease functioning, serious adverse effects, including suicide, and frustration amongst inadequately treated patients and families. These outcomes are more likely if, under pressure of time-limited donor funding, program developers institute rapid training (and train-the-trainer models) for primary care nurses that may be appropriate for some other medical fields but which generally are not effective for developing and sustaining mental health skills.

Genuine skills in mental health can only be gained gradually, with substantial input in mentoring, supervision, feedback and experience. As in other areas of health, skills include technical capacities in diagnosis and treatment but if this knowledge is to be applied appropriately, a deeper understanding is needed of a range of inter-related areas, for example, in the spheres of professionalism, ethics, leadership, community development and relationships, liaison, advocacy and training. Much is demanded of mental health workers who often function for long periods of time in settings of

professional isolation. They need to learn comprehensive assessment and diagnostic skills and gain knowledge about psychotropic medications; how to respond to the social, familial and interpersonal aspects of mental disorder within a specific cultural context; deal with the challenges of matching imported "international" techniques with indigenous healing approaches; pay attention to issues of safety and suicidality; work to reduce stigma and to advocate for patients; liaise with NGOs in relation to accommodation, livelihoods and rehabilitation; coordinate with social services, for example, in relation to the care and protection of children placed at risk by mental illness in a parent; collaborate with the police in situations of crisis where there is a risk of violence; interact with the general health system in relation to comorbidity (co-existence of physical and mental disorder); and undertake broader roles of community education, negotiation, planning and policy development.

Transitional Model

For these reasons, a case can be made that in some settings, for a *transitional model* to be adopted as a developmental strategy, especially where community health services are at a low point of functioning. In those contexts, it may be more appropriate to develop a small specialist mental health team with members placed strategically across districts. The team will require intensive training and ongoing supervision from expatriate professionals for a period of time while the workers develop close relationships with primary care teams to gradually build the overall capacity of the workforce in mental health. In the first instance, existing specialists, whether expatriate or local, provide mental health workers with in-depth experience and knowledge by in-service training and supervision in a manner that, as time passes, allows the specialist worker to transmit their

knowledge using a train-the-trainer approach to the primary health care workers as the capacity of the whole system increases. Gradually, the specialist mental health worker can pass on cases to generic workers, providing them with in-service training, support and consultancy so that the primary care system can assume a growing responsibility for mental health. In general, even where small specialist teams are created, costs can still be contained, especially as mental health requires virtually no technology or special investigations to be able to function effectively. In most countries, the specialist group are mainly drawn from the nursing profession with local or expatriate psychiatrists providing leadership, consultancy, training and support.

Having a core specialist team also is important as a visible vanguard that ensures mental health overcomes its stigmatized image and remains high on the Ministry of Health agenda and more generally within society. In many settings, scepticism about mental health persists, with persons from all walks of life wanting to avoid the issue and tending to question whether interventions are necessary or effective. Worldwide, knowledge about mental health and the need for services remains at a low base and the mentally ill find it difficult to advocate for themselves. It is common for voices amongst the public to demand that mentally ill are taken away and hospitalized to "clean up the streets". Following that path leads to human rights abuses so that the attempted institutional "remedy" turns out to be worse than the original problem. Hence, advocacy and education of politicians, planners and administrators about these critical issues remains an important initial and ongoing task. The role of the specialist team can evolve over time, with members either increasingly assuming leadership or consultancy positions

within mental health or they may return to generic roles but with mental health as a key focus.

CONCLUSIONS

In summary, for mental health services to be successful in post-conflict countries in the developing world, several essential elements are needed. These include (1) early advocacy for the field since the mentally ill can rarely advocate for themselves; (2) an approach that is consistent with the broad humanitarian mission of promoting survival and adaptation, in this case, for a vulnerable subgroup, the mentally ill; (3) a community-based model that reverses the usual injustices and neglect caused by institutionalisation and which draws on the assets of the family and community to normalize the experience of mental disorder and maximize the functional capacity of affected persons; (4) a step-wise capacity-building approach that recognizes the need for some specialization but which builds the capacity of primary care at a pace that general community services can absorb; (5) a focus on sustainability, cost-effectiveness, and measurable outcomes; (6) a strong ongoing focus on raising awareness at all levels (community, political leaders, Ministry of Health staff) in order to promote the field, build bridges with the community and relevant supporting agencies, and ensure that the Ministry gives priority to mental health as an integral and essential component of the primary care community health system.

FUTURE DIRECTIONS AND THE NEED FOR RESEARCH

As in other areas of health service development in post-conflict developing countries, mental health has been poorly researched. To create a scientific foundation for practice

in the field, there is a pressing need for donors and Ministries of Health to support high quality research and evaluation activities documenting the process and outcomes of service development (including mental health prevention and promotion programs). Ultimately, rigorous research and evaluation activities will be cost-saving, since it will obviate the need to "reinvent the wheel" after each humanitarian emergency.

Some key topics for research include:

1. What are the conditions that are required to develop a sustainable and effective mental health workforce at the primary care level in post-conflict countries?

    - What models of training, mentoring and supervision are effective in training primary care nurses in the field?

    - What should be the content, style and mode of delivery of training programs and how do contextual and cultural factors influence how training is best undertaken?

    - Which areas do primary care workers find most difficult to absorb and implement in mental health (for example, particular diagnostic groups, areas of assessment, areas of treatment)?

    - What is the minimal level of "specialist" support needed to maintain moral, professionalism and effectiveness of primary care workers in mental health?

2. What is the course of treated mental disorders in post-conflict countries and what components of intervention are most helpful for particular conditions?

    - Which disorders respond well to treatment and which do not?

- What are the social factors (family, community) that assist recovery and functioning?

- To what extent do traditional healing methods assist in recovery and for what categories of disorder?

3. How do attitudes change in relation to mental illness with the introduction of mental health services and what factors lead to positive change?

    - Amongst high level planners, policy makers, politicians

    - Amongst general health staff

    - Amongst the community at large

4. What are the real costs of using "older" compared to newer drugs in relation to effectiveness, side effects, adverse effects and long-term functioning of patients?

Table 1

Issue	In humanitarian phase	Towards future
Service model	Depends on existing resources and expertise: if mental health personnel available, build their expertise and use crisis to assist in reform (eg move to primary care model); if no facilities or skilled staff available, develop a community-based crisis approach with capacity building and planning elements	Focus should always be on community-based approach integrated or closely aligned with primary care
Transcultural Diagnosis	Use international system but with flexibility if no indigenous system immediately available	Gradually establish indigenous concepts and develop local classification
Traditional healers	Investigate capacity early and attempt to	Coordinate and define roles as far as

	coordinate but should not hold up interventions for severely disturbed	possible but standards important
Approach to doctor-patient interactions	Often top-down (authoritarian) to begin with	Gradual shift towards a collaborative approach but culture will determine the pace
Family/village involvement versus confidentiality, professional boundary concerns	Difficult to insist on confidentiality in traditional environments	This and other ethical issues to be discussed and debated with workers to reach a local consensus
Managing violence arising from mental disturbance	Early protocols must give high priority to safety for patient, family, community and health worker	Gradual development of memoranda of understanding and later, legislation, dealing with violence (mental health, police, criminal-justice system). Aim towards least restrictive option

		consistent with safety
Coordination with NGOs and other contributors	**Can be a challenge in early phase**	**Aim towards the Ministry having a coordinating role with interagency process defining roles, responsibilities and referrals**
Training	**Rapid training without further supervision is dangerous**	**Training must lead to sustainable professional change: incremental development requiring longer term plan of mentoring, supervision, in-service training**
Credentialing	**Difficult to predict whether local workers recruited early in post-conflict phase will be eligible for future MOH positions**	**Commence as early as possible discussions with MOH about credentialing of training and workers as well as delegations (who can prescribe**

		medication)
Training of psychiatrists	Local doctors often scarce in post-conflict settings and needed for primary care	If psychiatrist(s) trained, critical that appropriate training is given: focusing on leadership in a community-based public mental health system not solely on treating individual patients.
Service focus	Persons and their families who are at high survival and adaptational risk because of mental disturbance of any kind	Severe mental illness and neuropsychiatric disorders likely to predominate early, with chronic cases of severe trauma-related stress and depression emerging more gradually over time

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CHAPTER 8

BURNOUT AMONG HUMANITARIAN AID WORKERS AND HUMAN SERVICE PROVIDERS IN POST-CONFLICT SOCIETIES

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ABSTRACT

Humanitarian aid workers and human service providers, in post-conflict societies are exposed to stress from a variety of source that may result in burnout and stress-induced illnesses. Burnout is a syndrome associated with job-related stress; other reactions to stress that occur in people working under stressful conditions include PTSD, depression, anxiety symptoms, and risk-taking behavior. Initial research shows that burnout and other stress-related illness may be substantial among human service providers and aid workers. A number of known risk factors may contribute to burnout; however, there also are a number of mitigating factors, which may lessen the risk for stress-related illness. The ability to cope with stressful situations depends upon a person's individual psychological strengths, as well as on external factors. Support strategies for aid works may include family and social networks, preventive measures of self-care, and organizational support systems. To date, there is a lack of science-based knowledge about the psychological health of staff or the impact of stress-related illness in post-conflict settings. There also is a lack of studies about the consequences of extremes stress on aid workers and about what agencies can do to appropriately manage and support staff and improve worker productivity. Are of future research should include longitudinal studies to establish predictive relationships between the personal, organizational, and duty-related stressors, and mental health and organizational productivity. Evaluation of organization programs designed to promote psychological well-being of staff can determine the effectiveness of such interventions. Other areas of research should address the selection of aid workers and investigate psychological support frameworks.

INTRODUCTION

Humanitarian aid workers and human service providers in post-conflict societies are exposed to stress from a variety of sources that may result in burnout and stress-induced illnesses. Human service providers include physicians, social workers, health and mental health care workers. Aid workers are those who work for humanitarian relief and aid

agencies. Even in stable environments, human service providers, workers are exposed to numerous factors that may lead to burnout or vicarious traumatization. Burnout is defined as "exhaustion of physical or emotional strength and motivation usually as a result of prolonged stress or frustration" (Merriam-Webster dictionary). Burnout is a syndrome associated with job-related stress and is reportedly common among humanitarian aid workers and human service providers.

In the early phases after the end of a conflict, health and mental health care services often are partially provided with the assistance of the international humanitarian community. International humanitarian aid workers, staff who are working in a country other than their native country, as well as national aid workers may be at risk for high occupational stress levels, burnout, and other adverse effects such as vicarious traumatization, depression, and posttraumatic stress disorder. It is well known that human service providers worldwide are at risk for these effects; however, national staff working in post-conflict societies face additional stressors because they may have previously experienced traumatic events related to the conflict in their country. Over the last decade the environment in post-conflict countries has become more unpredictable and has resulted in aid workers being targeted by warring parties,[2] intensifying the level of stress, trauma, and mental illness of aid workers.

National staff described in this chapter, includes all workers in post conflict nations but may also include staff employed by international organizations. National staff generally make up the majority of workers in international aid organizations.

Although all staff in post-conflict societies are exposed to stressors and are at risk for burnout, all are not affected in the same way. There are risk or protective factors, which may mitigate the effect of stressors on an individual worker. In this chapter, intervention and prevention strategies will be described for individuals as well as organizations.

Finally, we will outline future research directions and describe strategies that will shed some light on remaining questions.

STRESSORS

Humanitarian aid workers and human service providers in conflict and post-conflict settings are exposed to a number of stressors and traumatic events that may result in stress-related illness. Over the last 10 to 15 years, the environment in which humanitarian assistance has been implemented has changed resulting in workers increasingly being targeted by violence. During the last decade, intentional violence has become the leading cause of death 67.4 %, (n=253), among aid workers in complex emergencies, and death due to motor vehicle accidents 17% (n=64) was a distant second,[2] other causes including disease and natural causes was 8% (n=31). The murders of aid workers that took place over the last five years, in East Timor, Central Africa, Chechnya, Afghanistan, and Iraq illustrate the dangers of violent physical assault in conflict and post-conflict nations. The increased risk for assault and death is one example of psychologically traumatic events confronting aid workers today.[2]

Staff also suffer more mundane stressors related to difficult situations in post-conflict societies.[3, 4] Living conditions are often poor, with a lack of privacy, a lack of separation

between work and living space, and intermittent or non-existent running water and electricity. The job may require traveling on hazardous roads with unreliable means of transportation. Access to medical care often is limited, and evacuation in case of personal illness or injury may be difficult. In addition to these difficult working conditions, international aid workers are separated from by their usual social support network. Separation from family and friends for extended periods of time may be a stressor in itself. Furthermore, communication with the outside world may be limited due to a lack of access to phone lines, e-mail, and international newspapers or television.

PHYSICAL ILLNESS

Physical illnesses experienced by humanitarian staff can have serious consequences in countries where the availability of health services may be limited. Preventable infectious diseases, such as malaria, as well as accidents have been reported as the main medical problems and account for the majority of medical evacuations among international staff.[5] Peytremann et al. (2001) included national staff in their study sample and they found that fatalities related to infectious disease, particularly HIV, were noticeable, reflecting the burden of disease in these parts of the world.[6]

The stressors for national staff are compounded with previous traumatic experiences. For example, in June 2000, a study conducted by the Centers for Disease Control and Prevention (CDC) in Kosovo among 410 international and 429 Kosovar Albanian aid workers from 22 humanitarian organizations, found that national staff had higher rates of posttraumatic stress disorder (PTSD) than their international counterpart.[7] This is understandable because these workers had been exposed for 10 years to an environment of oppression, persecution, ethnic killings, and hatred. Shortly after the end of the war in

1999, the remaining mental health care workers in Kosovo started a center for rehabilitation of trauma and torture victims, and mental health staff were providing care to the victims of the conflict. Most of the national staff themselves had suffered the consequences of the conflict.

STRESS REACTIONS

Burnout is a syndrome associated with job-related stress, and the term describes the effects of stress on all types of workers. Burnout differs from depression in that burnout only involves a person's relationship to his or her work, whereas depression globally affects a person's life. Lay people first described the syndrome of burnout, and social scientists and psychologists have developed the concept further. Burnout is a prolonged response to chronic emotional and interpersonal stressors on the job, and is defined by three components: exhaustion, depersonalization (a change in an individuals self-awareness, such that they feel detached from their own experiences, with the self, the body and mind seeming alien or distant), and diminished feelings of accomplishment or reduced efficacy.[8] Burnout usually has negative consequences on job performance and may lead to reduced efficacy and lower productivity.[9]

In the past 10 years, the emotional impact of working with trauma survivors has been examined under several concepts other than burnout, including secondary traumatic stress[10], vicarious trauma[11], and compassion fatigue.[10] These concepts are related but not identical to burnout. A full discussion of these concepts is outside the scope of this article. Health and mental health workers in post-conflict settings may suffer primary traumatization by direct exposure to severe traumatic events, such as assaults and sniper fire. Mental health workers in particular may be exposed to additional distress and

secondary traumatization because of this potential indirect exposure in their role as therapists.[12] This phenomenon also has been termed "vicarious traumatization" and originally was introduced by McCann and Pearlman in 1990.[11] The concept of compassion fatigue was described in 1992 when Joinson used the term to investigate the nature of burnout in nurses.[13] According to Figley, compassion fatigue is a more user friendly term for secondary traumatic stress disorder, which is almost identical to PSTD, except that it affects persons who are emotionally affected by the trauma of another (usually a client or a family member).[10]

Other reactions to stress that occur in people working under stressful conditions include PTSD, depression, anxiety symptoms, and risk-taking behavior (e.g. alcohol abuse).

MAGNITUDE OF THE PROBLEM

Burnout and other stress-related illness, e.g., depression and other mental morbidity, may be substantial among human service providers, such as physicians, social workers, aid workers, and other care-givers. Caplan reported that stress, anxiety, and depression were more common among general practitioners working in a major hospital in the United Kingdom, than among managers.[14] In Finland, burnout is reported to be more common among psychiatrists than physicians in other specialties.[15] Another study in the United States found that a history of depression was significantly more common among psychiatrists than among other physicians or the general population.[16] In the scientific literature, evidence regarding stress and burnout is mostly derived from studies of small and localized samples that were conducted in stable societies.[17]

Burnout and vicarious traumatization, have rarely been studied in aid workers and mental health care workers in post-conflict societies. In June 2000, the International Emergency and Refugee Health Branch of CDC/National Center for Environmental Health conducted a mental health survey of aid workers employed by international humanitarian organizations in Kosovo. This survey showed that event-related stressors were common in both international and Kosovar Albanian aid workers. Symptoms of depression among all aid workers were higher than among the general population in stable communities.[7]

A cross-sectional survey of leading international organizations described the selection, training, and psychological support of aid workers in 1997 and found that procedures for recruitment, selection, training field support, and follow-up varied widely.[18] Preventive mental health measures for aid workers received little attention by management of humanitarian aid organizations. In 1998, another cross-sectional survey was conducted by the WHO and the International Center for Migration on the occupational health of field personnel in complex emergencies.[19] Although this survey did not specifically measure burnout, general fatigue, headaches, irritability, and sleeping difficulties were found to be common. In 2001, a study among 915 returned staff from five humanitarian aid agencies showed high rates of direct or indirect exposure to life-threatening events. Approximately 30% of respondents showed significant symptoms of PTSD.[20]

RISK AND MITIGATING FACTORS

A number of known risk factors may contribute to burnout; these include excessive demands from self, others, and the situation; lack of resources, personnel, and time to complete a job; excessive time in the same job; repetitive tasks; lack of control over the

job situation, unrealistic expectations; and lack of acceptance, acknowledgement, and recognition.[21] However, there also are a number of mitigating factors which may lessen the risk for stress-related illness such as burnout.

Individual Factors

The ability to cope with stressful situations depends upon a person's individual psychological strengths, as well as on external factors. These factors can be viewed in terms of personal (internal) and external resources. Personal resources include the characteristics that constitute *resiliency*. Some factors that have been associated with resiliency to stress in different contexts include: resourcefulness, flexibility in emotional experience, intellectual mastery, the desire and ability to help others, and a vision of moral order.[22] Other factors include self-esteem, hardiness, and a strong physical and psychological constitution.

Studies among war veterans have attempted to identify personality risk factors for stress-related illnesses, adverse life events prior to the trauma, and previous psychiatric illness.[23]However, personality characteristics of veterans alone cannot account for the high prevalence of mental illness among them.   Clearly, external environment plays a major role in the etiology of stress-related illness.   Several studies have found a correlation between the cumulative number of traumatic events and prevalence of PTSD.[21] A relationship between trauma events and depression also has been observed. Moreover, personality risk factors appear to become less relevant as the intensity of the traumatic experience increases.

External Factors

Support strategies for aid workers include family and social networks, preventive measures of self-care, which consists of teaching the individual how to manage stress on his or her own, and organizational support systems, or the systems put into place by an organization, including stress management training before departure, psychological support while working in the field, and after completing the assignment. Social support networks and family can be particularly important assets to offset stressors encountered by aid workers. International staff often is separated temporarily from family and friends back home. Access to communication with family and friends at home appear to be particularly important for international staff.[7, 24] Usually this is not the case for national staff. On the other hand, national staff may have to deal with additional stressors e.g. loss of family members; these workers often are selected from the same population that the humanitarian agency serves and may have suffered traumatic events directly related to the events that precipitated the humanitarian intervention. National staff generally cannot go home to a safe place and stable environment after the assignment is over, in contrast to international staff.

ACTION PLAN-EVIDENCE BASED STRATEGIES AND INTERVENTIONS FOR PREVENTION OF BURNOUT

Stress / Support Balance

The stress and support balance depicted in figure 1 shows the equilibrium between the factors that place stress on the individual and those that lessen the stress, also known as mitigating factors. Job-related and other stressors may results in burnout among aid workers and human service providers if no adequate and effective mitigating factors are

in place, e.g. organizational support, supervision, self-care resources, adequate training and education, to counterbalance these stressors. On the one hand every effort should be made to try to minimize stressors, and on the other hand mitigating factors should be instituted to decrease the risk for burnout.

Strategies for the Individual

Education and training for health staff working in post conflict settings may provide additional personal tools for managing stress, known as coping skills. Various intervention strategies have been recommended for workers in stable communities. These include teaching workers how to relax; how to interact with their co-workers, and how to manage competing work demands for their limited available time. Most of these will also be helpful for workers in post-conflict societies.[25, 26]

Clinical supervision is an important mechanism for those human service providers who work with victims of trauma. Individual or group supervision can provide emotional support and provide an intellectual perspective for dealing with the effects of vicarious traumatization. Supervision also provides a teaching element about ways that vicarious trauma may affect mental health workers and other caretakers.

Organizational Policies

A focus on sound organizational policies of humanitarian organizations is essential for the prevention of stress in the human services professions and aid organizations working in post-conflict environments. At present these policies tend to be non-existent or incomplete and vary significantly from one organization to the next.[18] Within the

framework of institutional policies, mechanisms to support staff need more detailed elaboration.

In general, an organizational culture that is designed to be supportive of its staff and has clear management structures, with a well-defined decision-making process, is less likely to cause preventable organizational stressors. Contracts with poor conditions for workers, unclear terms of reference, and salaries, which are not paid in a timely fashion or are inadequate, may be major sources of stress. Although many humanitarian aid organizations, including the United Nations and non-governmental organizations, employ larger numbers of national staff than international staff, organizational policies for national staff, such as selection and recruitment, remuneration, insurance, and psychological support, are rarely fully developed. National staff generally receives less organizational support and lower salaries from international aid organizations than their international counterparts.

A formal mentoring system for new personnel or the designation of a particular worker chosen by his or her peers in the field to act as the support person for that particular area are two examples of good current practice. Ad hoc peer support networks often exist but should be formalized in organizational policies.

Work overload is common among staff working is post-conflict settings. The needs are usually enormous and resources are limited. Organizations must guard against excessive workloads by employing sufficient staff. Paid vacation time and mandatory rest and relaxation policies (R & R) can help alleviate the effects of unavoidable work overload.

Health and mental health care workers in post-conflict countries often lack the specific education, clinical training, and experience to deal with survivors of war and conflict. Health care workers in post-conflict settings often lack up-to-date books, and access to medical journals and other training resources. International organizations and academic institutions may help provide additional training and materials to colleagues in post-conflict countries.

FUTURE RESEARCH DIRECTIONS

Although there is a substantial body of research concerning psychological morbidity in health care and mental health care workers in stable societies, less is known about the psychological health of staff or the impact of stress-related illness in post-conflict settings. To date, there also is a lack of studies about the consequences of extreme stress on aid workers and about what agencies can do to appropriately manage and support staff and improve worker productivity.[18]

Cross-sectional Surveys:

The cross-sectional surveys mentioned previously have identified many areas of research that need elaboration. For example, it is possible that results from the CDC survey in Kosovo cannot be generalized to aid workers operating in more acute emergencies or in more stable, post-emergency situations.[7] Further cross-sectional studies among staff in post-conflict nations would contribute to our understanding of psychological morbidity and provide data of the prevalence of stress-related illness and post-traumatic responses in human service providers.

Cross-sectional surveys provide us with a snapshot of the risk and mitigating factors and psychological morbidity at a given point in time. However, no causal inference can be drawn from such studies. In cross-sectional surveys, no adequate baseline information is available on the mental health status of relief workers prior to deployment. Moreover, it is not possible to know whether aid workers had symptoms of poor mental health before the assignment or whether the nature of the work contributed to the development of symptoms. Although complex and logistically difficult, a long-term prospective study is required to answer some of these questions definitively.

Longitudinal and Prospective Studies

Only a longitudinal approach can establish predictive relationships between the personal, organizational, and duty-related stressors, and mental health and organizational productivity. Such a study could provide scientific evidence regarding mental health outcomes and organizational effectiveness among staff working in conditions of stress and hardship. Specific objectives include the following:

1. To identify aspects of work associated with elevated risk of poor mental health and burnout in staff.

2. To identify the risk and resilience factors moderating the impact of such stressors on mental health and organizational outcomes.

3. To provide recommendations for selection, training, and management of staff, and effective intervention for stressed individuals.

Evaluation Studies

There are indications that good staff management and psychosocial support to aid workers may prevent stress-related mental illness to some extent and improve the overall

quality and efficiency of humanitarian aid. For example, in the survey conducted by the CDC in Kosovo, international aid workers who reported poor organizational support were significantly more likely to be depressed and had higher non-specific psychiatric morbidity scores than those reporting excellent support.[7,26] Evaluation of organizational programs designed to promote psychological well-being of staff can determine the effectiveness of such interventions.

OTHER AREAS OF FUTURE RESEARCH

Selection of Aid Workers

Screening and selection procedures for aid workers by humanitarian agencies often are not well defined, and it is uncertain which characteristics and qualities are likely to be the most desirable in terms of prevention of psychological morbidity. The selection process of aid workers varies widely between organizations. This may be partly due to a lack of a sensitive interviewing instrument for predicting whether potential workers are more likely to be successful in the field and less likely to develop stress-related mental illness. The personality factors that play a role in defining successful outcomes of international workers may be different to some degree for national staff in post conflict societies. It would be important to conduct further studies to determine which personality factors are the most likely to result in positive outcomes in terms of work performance and resilience to developing mental illness. Adverse life events prior to the experience of working in post-conflict societies and previous psychiatric illness may be important factors as well. It will be necessary to develop and validate instruments to predict resiliency, assess the

impact of trauma, and predict the development of PTSD and burnout. Prospective studies will be needed to identify the most desirable psychological profile.

Psychological Support Framework

Little research has been done to investigate which psychological support framework or which services provided by humanitarian aid agencies are the most effective in preventing adverse mental health outcomes among their staff. Peer-support networks, either organized by the organization or informally arranged by returning aid workers may be beneficial. Some organizations provide access to psychological care on an "as needed" basis. A general supportive organizational environment may be important, as may clear organizational structures.

Further research with an interdisciplinary approach is necessary to shed more light on these questions. Research that helps to clarify the relationship between vicarious trauma, compassion fatigue, and burnout also would be useful in providing a clearer theoretical framework.

Figure 1. Balance of Stressors and Mitigating Factors of Humanitarian Aid Workers and Human Service Providers

Mental Health

Organizational support
Training
Group support
Supervision
Reasonable workload
Self-care
Adequate resources

MITIGATING
FACTORS

Violence
Accidents
Illness
Living conditions
Separation

STRESSORS

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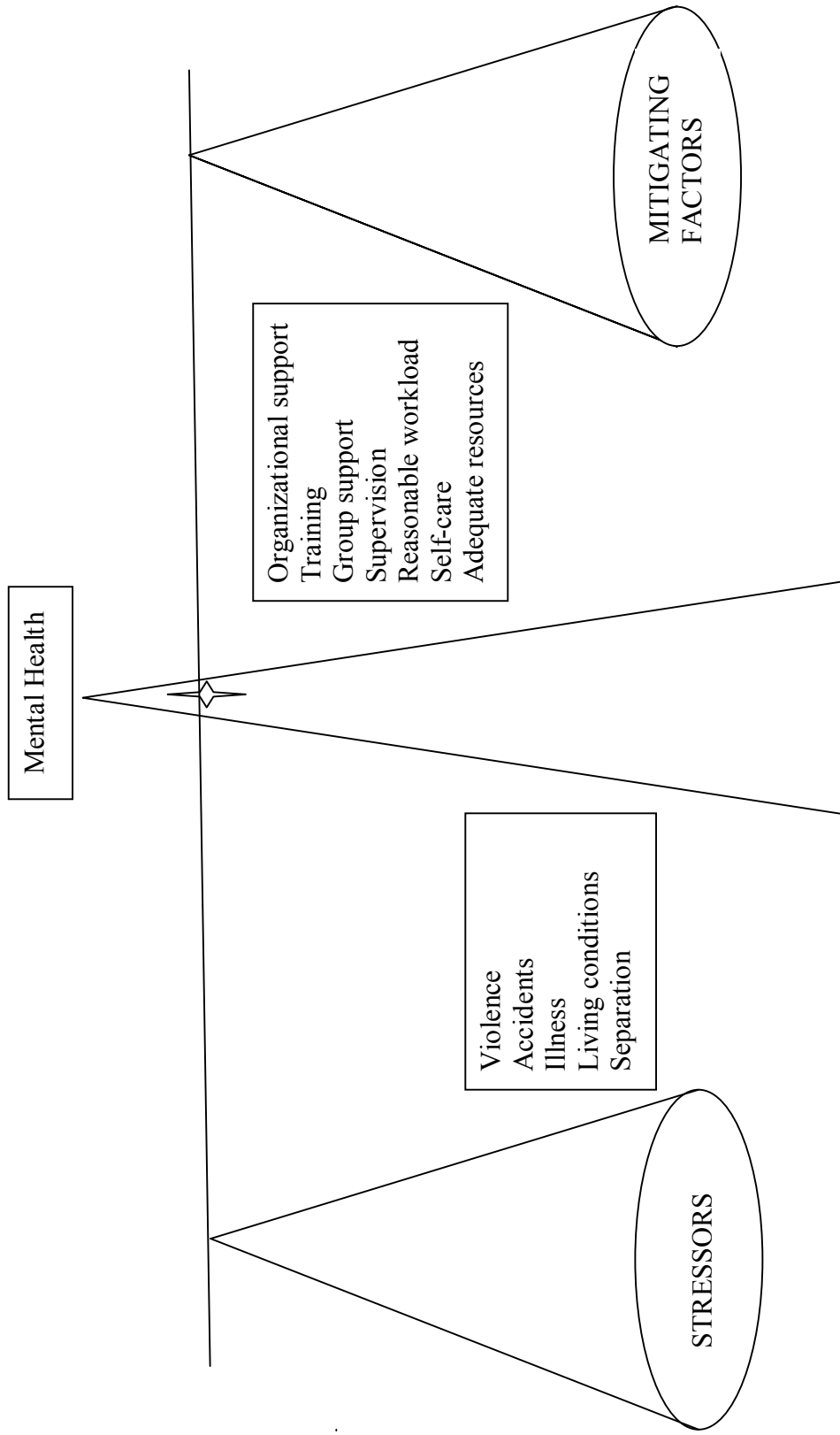
Figure 2. Priority Research Directions

Future Investigations	Rationale
Cross-sectional surveys to establish a database of burnout among health care providers in post conflict countries.	To contribute to our understanding of the magnitude of burnout and other psychological problems among staff.
Prospective study to identify personality factors among staff in post conflict settings.	To help identify the most desirable psychological profile of staff.
Longitudinal studies to establish predictive relationships between personal, organizational and duty-related stressors, and mental health and organizational productivity.	To provide scientific evidence regarding mental health outcomes and organizational effectiveness among staff working in conditions of stress and hardship.
Outcome evaluation of psychosocial support programs	To evaluate organizational programs designed to promote psychological well-being of staff to determine the effectiveness of such interventions.
Development of a psychosocial support framework	To investigate which psychological support framework or which services provided by the humanitarian agency are the most effective in preventing adverse mental health outcomes among staff.

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CHAPTER 9

CONTINUING MEDICAL EDCUCATION AS A MODEL FOR MENTAL HEALTH TRAINING FOR POST-CONFLICT COUNTRIES

Aida Kapetanovic, M.D.

ABSTRACT

Continuing Medical Education (CME) is essential to mental health recovery in post-conflict countries, and can be derived from CME programs in developed countries. The significance of well-organized, state regulated, contextually and culturally customized system of CME in the process of mental health care will be highlighted. Different formats of CME are described and a comprehensive model of CME that reflects the relationship of mental health care to context, content and outcomes are presented. Five trainings, conducted by the Harvard Program in Refugee Trauma (HPRT), for primary health care professionals are briefly described as an example of best practices. A future research agenda for CME in post-conflict environments is suggested.

INTRODUCTION

"Collective violence, in its multiple forms, receives a high degree of public attention...The world is still learning how to respond best to the various forms of collective violence, but it is now clear that public health has an important part to play." (WHO, Report 2002). Health professionals in post-conflict society, dealing with human beings on daily basis, are faced with increased health and mental health needs of population. In order to be able to respond to new reality in an effective way they need new knowledge and new skills.

The most effective way to disseminate new knowledge and new skills to medical professionals is through a system of continuing medical education, commonly referred to as CME. An effective CME system is institutionalized, highly supported by a Ministry of Health, and regulated by law.

The Harvard Program in Refugee Trauma (HPRT) has been working for more than 25 years in the field of mental health in post-conflict societies (i.e., Cambodia, Bosnia and Herzegovina, East Timor, Rwanda). During that period HPRT developed wide scope of curricula for different forms of CME education.

CME – DEFINITION, IMPORTANCE AND ORGANIZATION

CME is being defined in different ways. The American Medical Association defines CME as:

> *Educational activities designed to maintain, develop and increase knowledge, skills and professional performance, as well as relationships and links that a physician utilizes in order to satisfy patients' needs, or those of the population or the profession" (American Medical Association). CME system includes the following core elements: (1) updated knowledge and excellence, i.e. "...a commitment to life-long learning", (2) technical aspects, i.e. organization, legislation, financing, formats (3) professional ethics, i.e. full commitment to the patient, altruism, duty, honor and integrity, respect for others.*

CME of particular country has to be integrated in all levels of health care delivery system with its reflection on health policies, programs, structures, services and attitudes. However, most of post-conflict countries have never established CME as a system.

While this definition has been developed for American medical practitioners, primarily physicians and nurses, it can be applied to the mental health practitioners of all types including medical doctors, nurses, mental health practitioners, including psychologists and social workers, community workers and humanitarian relief workers. The core elements can be contextualized to all mental health activities in a post-conflict society.

The key difference of a mental health CME program in a post-conflict environment from one in a non-traumatized setting is that the CME is first used to build capacity (i.e. knowledge, skills, behaviours) in all mental health practitioners, and then it is used to sustain this capacity over time through an ongoing process of CME linked to on-site supervision and technical assistance. Without the latter process, the initial capacity building investment will collapse or greatly diminish over time. All mental health practitioners will need this process of ongoing support and supervision overtime in a post-conflict society.

In regard to the other core elements of traditional CME, the following needs to be considered. Knowledge, one of the key elements offered to medical professionals through CME, should address medical and mental health needs of population, i.e. scientific content of CME must be based on needs assessment with two major components: assessment of patients' needs, and assessment of health professionals' needs. Basic content should reflect biological, psychological, social and spiritual needs of individuals and affected societies.

CME have to be adjusted to context of particular country. The social, economic, cultural and political context of particular country determines not only content, but also set of outcomes and organization of CME as a system (regulation, formats, way of delivery, etc.).

As mentioned above, most of post-conflict countries have never had a CME system. some of At the same time post-conflict societies are characterized by the increase in both health and mental health needs of population, significant shortage of health professionals, insufficient health services by scope and number, destroyed and seriously damaged health infrastructure, poverty, and broken traditional social structure. Health professionals in post-conflict environment have found themselves in a situation they had never been before; with lack of professional knowledge and skills to face the consequences of human cruelty and violence. They do not know how to categorize, and heal immeasurable grief and pain of population that was exposed to tremendous losses, torture and humiliation. They are frustrated as professionals and human beings, but on the other side these circumstances additionally oblige them to act according to the highest standards of their professional ethics.

CME can offer a scientifically based plan of mental health care that includes the most up-to-date knowledge on identification, treatment and evaluation of outcomes. The crucial role of CME in post-conflict society is to translate updated and evidence based knowledge into effective practices in the health sector that will resulted in improvement of patient and public health outcomes, and contribute to healing and reconciliation of the society as a whole. Successful transformation from knowledge to effective praxis is by itself a demanding process, with a number of challenges to be solved, in particular in chaotic post-conflict environment.

As any other educational system, CME has to be culturally competent, which means "… integration and transformation of knowledge and data from and about individuals and

groups of people into specific clinical standards, skills, service approaches, and attitudes that mach the individual's culture and increased both the quality and appropriateness of health care outcomes." (Davis King,1997). Besides cultural competence and cultural sensitivity the experiences from post-conflict societies highlight some other factors with strong influence on CME capacity to produce positive changes in health care practicing. Patient and health professional might belong to different ethnic groups, which may have been in conflict, and establishing of therapeutic relation between patient and healer becomes more difficult. In such situation medical professional has a responsibility to recognise and confront his/her own religious or ethnical prejudices. CME strengthens health workers' professional identity, and increase their capacity to perform with a respect to the principles of ethical neutrality. The traumatic experiences of patients are very often associated with strong feeling of stigma and shame. For example, in many cultures raped women are blamed and rejected by their own society. Victims will confess painful and usually humiliated experience to a doctor, only if the relation of trust and mutual respect and understanding is developed. Consequently, doctor-patient relation becomes a central part of healing process. Inequality in the access to services (remote rural areas, not existing health care insurance system) can also be a serious obstacle in providing for health care. Health professionals, physicians and nurses, in post-conflict societies, are usually in position to act as managers. Being faced with a lack of human and other resources s/he should be both effective and efficient, with available resources. On one side shortage of human and other resources and, on the other side, increased exposure to stressful situations urge them to develop their team-leading skills.

CME outcomes are generated within the realities of the country's political, economical, and health care system. Due to physical damage and loss of life caused by violence, CME in post-conflict countries involve a wider scope of outcomes. Since mental health outcomes can influence the economic recovery and reconciliation process. Economic development and reconciliation are of special importance in any post-conflict society.

Tentative relationships between context, content and outcomes of CME in post-conflict society are presented in Figure 1. The basic elements of Figure 1 reveal a mental health CME in a post-conflict setting.

Figure 1: Mental Health CME In Post –Conflict Societies

CME MODEL

- Scientifically Based Best Practices
- Cultural Validity / Appropriateness
- Evaluation of Outcomes
- Ongoing Training, Supervision and Technical Assistance

OUTCOMES

- Patient Changes in Symptoms / Disability
- Economic Productivity
- Reconciliation
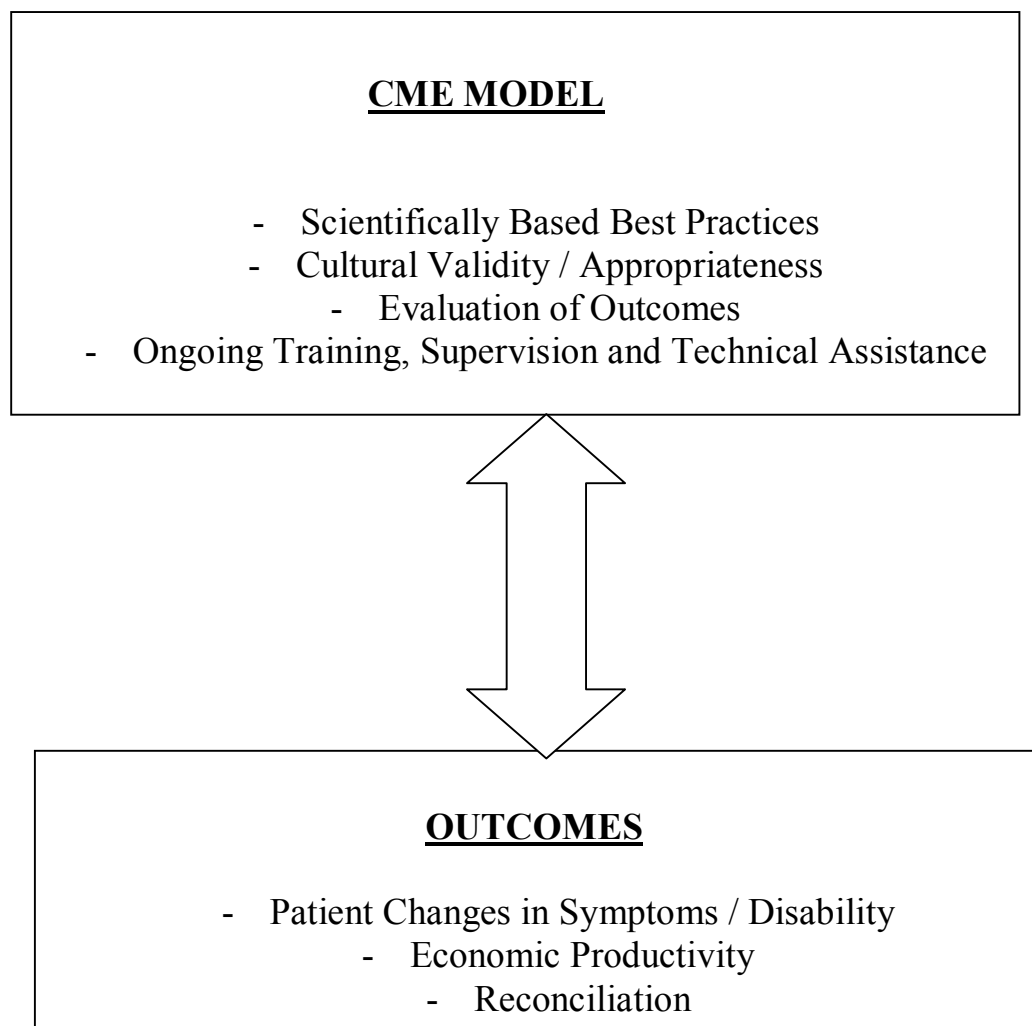
CME in the field of mental health in post-conflict societies has to be an organized and planned activity, aimed at achieving and promoting healing process of individuals and societies affected by mass violence. As such it should be directed to broad spectrum of healing professionals, not just health professionals. Teachers, social workers, traditional healers, clerics, society elders and the whole community could and should be mobilized and included in the healing process.

Basic planning, administration, content, organizing and financing of CME system has to be managed in a proper way with high influence of government and health authorities. Managing of CME system could be done in different ways, which is not a topic of this paper. Regardless of how CME system is organized, a type of regulatory body as a pivotal actor of CME system, should be established. This body should deal, on one side, with administration, planning and financing CME activities, and, on the other side, with content and forms of CME establishing CME education as a system. Complexity of context in post-conflict societies imposes need for national curricula recommendation.

Taking into consideration that health systems of post-conflict societies are usually in process of reform and transition, CME need be integrated into the health reform as its driving force. One of the roles of CME in the process of health reforms is maintaining the achieved reform goals sustainable.

A well-established CME system, up-dated and scientifically based, can transform mental health practices and result in positive healing outcomes of individuals and societies affected by mass-violence.

TYPES OF CME COURSES

CME is a very complex body of knowledge that can be disseminated in a number of different formats (see figure 2). CME includes (1) postgraduate studies; (2) medical school courses and (3) specialist courses. These formalized educational formats are integrated into official educational system. Postgraduate study is an integral part of development of knowledge that includes set of courses in a specific field. By completing postgraduate study participants receive academic degree such as a Master's degree or Ph.D.. Medical school courses are part of an official curricula offered to medical practitioners in training. Specialist courses are offered to graduate professionals or specialists who are already in clinical practice.

Mental health CME can also be offered in more flexible formats such as (4) short trainings, (5) small lecture series, (6) Internet based CME courses. CME courses (1) to (3) can lead to degrees; (4) to (6) should result in academic credits and training certificates.

Figure 2: Delivery formats in CME system
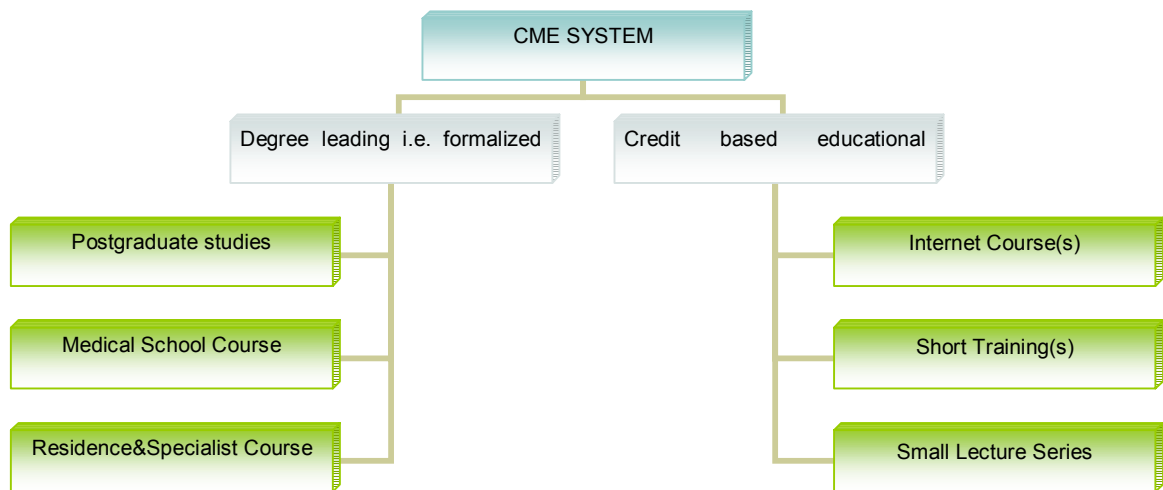
Mental Health CME Content

Generally, it is possible to make distinction between courses with standardized curricula and information-based trainings, based primarily on lectures, presentations and other forms of information sharing.

Training with Standardized Curriculum

Training based on state-of-the-art scientific knowledge with stated specific science-based curriculum and objectives.   Trainings are usually built into courses that teach using lectures, case presentations, and workshops, and are given over a three to six month period, or longer.   The courses usually include systematic evaluation of training

outcomes offering academic credit and/or degree from an affiliated university/government. This would includes format (1), (2) and (3).

Information Based Training

Short training that attempts to disseminate new skills, knowledge and attitudes by primarily relying on lectures, case presentations by international and local experts, workshops, use of films and videos. Training is not part of a course and usually lasts for three to five days. Evaluations of these types of trainings usually do not include assessment of knowledge transfer. These trainings, especially if conducted by a university will offer a certificate indicating successful completion of the training.

Trainings with standardized curriculum are more appropriate for a post-conflict society. Standards-based curriculum includes not only goals, objectives, and standards, but everything that is done to enable attainment of those outcomes and, at the same time, foster reflection and revision of the curriculum to ensure students' continued growth.

Integrating standards into curriculum is a very demanding process which basically includes four processes: (1) developing curriculum framework, (2) selecting curriculum, (3) choose the most appropriate education format (4) monitoring, reflection upon and evaluation the curriculum implementation. In fact, all type of training regardless of length can be based on standardized curriculum. In other words, standardization of

curriculum does not depend on training length. It depends on fulfillment of set of content and performance standards.

Box 1
Although more than a billion of people are affected by consequences of mass violence, most of Medical Schools curricula all over the world consider violence and psychological trauma as caused by violence only under DSM IV- PTSD category. There are still a lot of discussions among scientists about PTSD diagnose being culturally appropriate and valid. These discussions are beyond the scope of this article, but mental health consequences of mass violence are much broader than they can be comprised within a PTSD diagnose. Medical workers, physicians and nurses in spite of all recent knowledge describing wide range of psychological and physical consequences, symptoms and complains of emotional suffering caused by mass violence usually complete their formal education largely with no knowledge and skills sufficient to deal with violence consequences.

Unfortunately, there are not many trainings with standardized curricula in the field of mental health in post-conflict societies. Even university course curricula in the field of mental health are not updated according to recent scientific achievements and knowledge about impact of mass violence to physical and mental health (Box 1), i.e. these courses do not match all criteria for courses based on standardized curricula.

In post-conflict societies numerous NGOs are involved in delivering different trainings and courses in the field of psychosocial and mental health issues. Most of these courses are information-based trainings with content and outcomes that are not adjusted to specific environment of particular post-conflict country. At the same time these NGOs organize and finance CME in post-conflict society aiming at dominating over the content and administration of CME activities. High degree of coordination of these activities undertaken by NGOs should be obtained through proactive role of CME regulatory body and Ministry of Health.

HPRT'S CURRICULA FOR CME IN POST-CONFLICT SOCIETIES

HPRT fully developed several curricula that can be successfully adapted and applied in different post-conflict settings. They were originally developed and implemented for training of primary care providers, mostly medical doctors, but some of these curricula have been successfully used for training other healing professionals, i.e. sociologist, social workers, priests. Each curriculum can be customized for primary care (PC) settings that have special patient population or clinical needs and modified in a way to be maximally cultural sensitive and clinical effective, i.e. updated and properly culturally customized HPRT curricula could be world-widely used. HPRT developed the following training curricula:

1. Medical School Curriculum - *Pedagogy of Trauma*

2. Curriculum for Internet based CME

3. Harvard Training for Primary Physicians in the Kingdom of Cambodia

4. Harvard Training for Primary Care Providers in Bosnia-Herzegovina

5. Toolkit for healing victims of mass-violence

Brief description and development process of these five HPRT training curricula are presented in the text bellow.

Medical School Curriculum - Pedagogy Of Trauma

Pedagogy of Trauma is a university curriculum for professionals who work with traumatized persons, i.e. training with standardized curricula. It is primarily designed for

family medicine residents. The curriculum was developed in collaboration with University of Sarajevo, Bosnian and Herzegovina, sponsored by Soros Foundation. It was published by HPRT in January 2000. It is a teacher-student guide; an innovative and radical course in its approach to healing victims of mass violence. The patient-doctor partnership is considered central to the healing process, whereby the traumatized person becomes a teacher and a physician become a student.

The course provides a theoretical framework, pedagogical method for training, and reveals gaps in knowledge and practices within a single historical period. The course objective is to provide for all medical doctors - as the most important healing profession in Bosnia and Herzegovina - the understanding, appreciation, recognition, and use of healing resources in additional to biomedical treatment.

The curriculum was implemented at the University of Sarajevo and University of Tuzla. Initially, the course participants were family medicine residence at the Medical School in Sarajevo and Tuzla, graduate level social workers at the University of Sarajevo Department of Social Work, graduate level psychologist at Psychology School, and graduate level Franciscan Theology School in Sarajevo.

The training process lasted for 16 weeks, or one semester. It consisted of lectures, small and large group discussion, and practical work with traumatized person as a teacher. The training took place at the five different sites mentioned above. More than 50 patients as

teachers,100 students, 50 faculty members, 9 course leaders, and 14 facilitations took part in this extraordinary training.

In conditions of mass traumatization, the healing professions are always concern with issues related to the best methods of treatment of trauma survivors. Usual psychotherapeutic methods are not appropriate due to the huge number of affected persons. Pedagogy of Trauma offers innovative method and model for the care of trauma victims in the primary healthcare setting of post-conflict societies.

One-third of the participants considered Pedagogy of Trauma as the most exciting and innovative learning experience they ever had. But at the some time one third of course participant found course emotionally to be very demanding. Course participants were received a certificate of participation, but more important, the course opened new avenues in approach to healing of trauma survivors, in post-conflict society. Lack of financial resources did nor allowed he course evaluation for the patients' outcome.

Curriculum For Internet Based CME

This web-available course (http://cmeonline.med.harvard.edu) provides a series of multiple-choice questions based on common clinical cases seen in primary health care clinics caring for highly traumatized patients from culturally diverse communities. For example, one case deals with a Cambodian woman who was tortured under the Khmer Rouge and is then re-traumatized by life events as a refugee in the United States, including the terrorist attacks of September 11, 2001. Primary care physicians, as well as psychiatric practitioners including psychiatrists, nurses, and social workers, are the target

audience for this course. This includes health care practitioners in America, as well as other parts of the world exposed to extreme violence. The participants will have an opportunity to learn the diagnosis and treatment of the mental health sequelae of terrorism and other forms of extreme violence in culturally diverse populations. The course participants will also be able to advance their skills in mental health care of all general medical patients who have had violent life experiences and are suffering from common mental health disorders such as depression and posttraumatic stress disorder.

Overall Learning Objectives:

1. Clinical knowledge of the Harvard Program in Refugee Trauma (HPRT)'s 11-point system for the mental health care of survivors of extreme violence.

2. Case-based clinical problem solving (a multiple-choice question based format will be used for the cases).

Clinical Learning Objectives:

1. Develop the skills to elicit the patient's trauma story.

2. Identify the major mental health effects of extreme violence.

3. Diagnose and treat acute stress disorder, major depression, posttraumatic stress disorder (PTSD), and chronic insomnia.

4. Increase skills related to the use of simple screens for depression and PTSD.

5. Enhance patients' coping and resiliency.

6. Appreciate the proper use of psychotropic drugs in culturally diverse patients.

7. Describe the key measures for preventing practitioner "burnout."

Research has shown that CME programs provided via Internet are as effective in transferring knowledge as traditional forms of CME. Course completion provides credits and Harvard Medical School CME certificate.

Harvard Training For Primary Physicians In The Kingdom Of Cambodia (1997-1998)

The Harvard Program in Refugee Trauma (HPRT) was invited to train 104 primary care physicians (PCP) in mental health knowledge, skills and attitudes by the Cambodian Minister of Health representing all 21 provinces in the country. The Harvard Training Program in Cambodia (HTPC) was established in 1994 in Siem Reap as a "center of excellence" with three PCPs and eight family-child mental health workers, working in collaboration with HPRT.

The training focused on the identification and treatment of both trauma-related illness and serious mental illness in primary care using both Western and folk diagnosis. Two or three PCPs from each of the 21 provinces were recruited to participate in a year-long training which consisted of seven on-week sessions. Many traveled two days by motorbike and boat to reach the training and compliance was near 100% in both years (50 PCPs in 1997 and 55 in 1998, with one person not completing the training). The training philosophy was a result of twenty years of experience working with Cambodians both in the U.S. and border camps. (Lavelle et al.,1996).

The training methods included a variety of activities including lectures, case group discussions, homework, examinations and self-care techniques. The training content was focused on basic concepts such as the history of present illness, interviewing skills and case review, counseling and approaches to treatment, psychopharmacology, and mental status examination. DSM-IV diagnosis and Cambodian Community diagnosis, i.e. local folk diagnosis which HPRT calls Categories of Emotional Distress (CED), were presented together as a major innovation of the course. (Mollica et al., 1998) Also, PCPs were taught how to use screening instruments for depression, anxiety and trauma-related illness (Harvard Trauma Questionnaire and Hopkins Symptom Checklist-25) both validated in Cambodian language. (Mollica et al., 1992; Mollica et al., 1997).

Finally, all 104 PCPs upon successful completion of the course and final examination were awarded a certification of participation from the Harvard School of Public Health and the Cambodian Ministry of Health. All PCP participants were evaluated regarding their confidence levels before, after and a two-year follow-up; there was a significant improvement in PCP confidence in all confidence areas of medical and psychiatric procedures (counselling, medical evaluation, prescribing medications, psychiatric diagnosis, assessing risk for violent, traditional treatments and treating trauma victims (Henderson et al., 2004).

Harvard Training For Primary Care Providers In Bosnia-Herzegovina (2000-2001)

In 1999, HPRT was funded by the World Bank Post-Conflict Unit to build upon the Bank's WVR (War victim rehabilitation) project in BiH to further the development of mental health care to the general population through primary health care services. This

project was piloted in one country region (Central Bosnia Canton) to serve as a model for other cantons in BiH and throughout the country, and to guide the Bank's strategies on the implementation of this model in societies devastated by mass violence.

Health authorities in BiH for a long time, did not recognize primary health care practitioners as mental health providers. Although most BiH patients were seeking help for their emotional and mental complains in primary care. Primary health workers themselves were significantly exposed to emotional and mental problems imposed by the war. Hodgetts et al. (2002) found that 18% of the candidates for specialization studies in family medicine met criteria for PTSD.

HPRT's survey (2000) of 116 PCPs, almost all of whom were primary health care physicians (general practitioners, pediatricians, occupational medicine specialist, gynecologists) practicing in the area revealed their inability to identify, treat and refer the patients with mental health disorders. HPRT's provider survey revealed the following:

- 65% of the PCPs were not able to make DSM-IV (ICD-10);

- PCPs reported very low confidence in treatment of mental health crises (suicidal patients, patient threatening themselves or others);

- PCPs reported almost no or very low confidence in treatment of different groups of traumatized patients (e.g. sexually violated patients);

- 33% of PCPs did not have any information about new mental health services which government built to decrease the mental health consequences of mass violence;

After the needs assessment was completed, HPRT designed a culturally sensitive training curriculum that included majority of physicians in primary health care in selected area (Central Bosnia Canton). Training was undertaken with a special focus on medical interviews, recognition and treatment of major depression, trauma-related mental health problems and symptoms, specific vulnerable groups and case management.

During the training, the physicians were exposed to measuring instruments for mental health, primary care mental health diagnostic criteria, detailed information for administration of psychotropic drugs, counseling methods, and referral guidelines. The training was organized mostly in the form of lectures and workshops. A post-training evaluation demonstrated the efficacy of training in increasing participants' self-confidence in identifying and treating mental health problems. This study revealed that primary health care physicians could be successfully trained to be able to identify, treat and refer most frequent mental health and trauma related problems. All participants received a certification from HPRT and Ministry of health of Federation of BiH. The course, by its' content and format, served as an example of CME education in post-conflict society.

Toolkit For Healing Victims Of Mass-Violence

Toolkit for healing victims of mass-violence is a package of comprehensive training materials for primary health care providers in which basic principles for care victims of mass violence are provided and described.

Toolkit consists of:

- pocket card with 11 steps for clinical care

- short brochure in which these 11 steps are described in more detailed way

- instruments for simple screen for the pressure and PTSD

- brochure with 29 articles relevant for trauma assessment treatment and management

- CD Rom.

Simple and detailed guideline for use of drugs in treatment of depression, PTSD, general anxiety, insomnia is provided. Special attention is given to assessment and treatment of certain types of traumatic experiences, like torture head injury, rape, sexual violence, and loss of child, spouses, or close relatives that may have potentially negative and prolonged impact.

The toolkit was developed after the September 11 2002, terrorist attack of the USA, to prepare local PCPs (primary care physicians) to deal with the acute and long-term mental health effects of terrorism. It can be customized for uses in different types of mental health environments characterised by extreme violence. This tool kit is a reliable clinical tool with precise treatment instructions including all steps from history taking to closing of treatment and patient's discharge. Toolkit is self-teaching material primarily addressed to health care professionals in primary care setting.

MAJOR OUTCOMES AND INDICATORS

Review of the scientific literature on the training outcomes reveal that most evaluations are focused on measuring satisfaction and conviction of training participants. Evaluation of HPRT training experiences in Cambodia and BiH were similarly focused on measuring participants' satisfaction and increased self-confidence in patient treatment. A post-training evaluation demonstrated the effectiveness of training in increasing participants' self-confidence in identifying and treating mental health problems. Similar to other scientific results HPRT evaluation studies revealed that primary health care physicians could be successfully trained to identify, treat and refer most frequent mental health and trauma related problems. The significant increase in physicians' self-confidence was achieved in all the training areas. But like most CME training throughout the world, HPRT did not directly measure patient outcomes. In the case of HPRT, lack of funding resources was a major barrier for measuring patient outcomes. However, in the first year after the training in BiH, the number of patients with mental health disorders who were referred by the primary health care physicians in the region increased three times.

The influence of HPRT trainings in Cambodia and BiH that can be emphasized is their positive impact on health reforms in these countries. In Cambodia, the Ministry of Health placed psychotropic drugs on their essential drug list, and five years later continued to supply psychotropic drugs to HPRT's trained PCP's in each province. In B-H during the training a forum for dialogue between the health care staff and decision makers in the existing health policy was established. The dialogue was focused on all aspects of health reform, including mental health care. The HPRT project went further in helping to

overcome problems associated with the health reform process, and has served to demonstrate how an expanded role for health care professionals at the primary level can contribute to health care and the health care system in general.

The magnitude of the health, social, economic and political consequences of mass violence in a global community demands the economic and practical justification of all training efforts. Measuring of economic and reconciliation indices are complicated and expensive. The use of randomized clinical trials (RCTs) in evaluation of training of mental health in post-conflict societies would be ideal. However, measuring economic and reconciliation outcomes, is even more complicated and more expensive. There is considerable room for scientific research in the field of CME training outcomes in the mental health field.

The model of CME presented in figures 1 and 2, show that three major outcomes in post-conflict societies can be identified: (1) patient outcomes, i.e. improved health status of patients as result of better treatment (better treatment as result of increased knowledge and skills of professionals obtained through CME trainings), (2) economic outcomes, i.e. increased involvement of successfully treated patients in real economic life, (3) reconciliation outcome, i.e. increased social cohesion and participation of patients in civic activities. Public indicators for the levels of mental illness are not well established. Even when available, mental health statistics based on prevalence of particular disorders' and suicide rates in general population, cannot provide the right insight into mental

health situation. Further research will be necessary to establish reliable indicators for mental health that can be used to show the relationship between treatment outcomes and mental health indicators. The relationship between mental health indices and economic and reconciliation outcomes are not established. Areas in which outcome measures to evaluate the efficacy of mental health treatment and CME trainings are summarized in Table 1.

Table 1: CME – outcomes and indicators

Outcomes	Indicators (How do you measure…)
Patient	Number of patients referred to psychiatric services Number of patients treated Increase of number of successfully cured patients Decrease of number of suicides (ratio/ patients as population) Decrease of number of drug addicts (ratio/ patients as population) Decrease of number of alcohol addicts (ratio/ patients as population)
Economic	Increase in patients' employment Increase of patient salaries - average (for officially employed patients) Increase of patient income generated activities Increase of patients as entrepreneurs Type of jobs patients performed
Reconciliation	Increase number of returned families to pre-war destinations Degree of participations of returned people in society (all aspects) Increase delivery of health services to minorities Decrease number of interpersonal conflicts with ethnic background

FUTURE RESEARCH AGENDA

Research on CME education in post-conflict societies is mostly focused on measuring impact of different CME presentation formats on training participants' satisfaction and conviction. This is still the most superficial level of measuring training outcomes. It is obvious that the most important aspects of CME education are not covered by current research. Against this background, the future research in CME should be directed to the following areas:

- Need assessment of relevant subjects for national curricula recommendations

- Standardization of curricula for different formats of CME

- Randomized clinical trails - CME impact on patient outcome

- CME impact on decrease of high-risk behavior

- CME impact on health care costs

- CME impact on quality of mental health services

- CME impact on increase of patient economical status

- CME impact on employment rate

CONCLUSION

Millions of people throughout the world suffer from collective violence. It is the reason why "…collective violence, in its multiple forms, receives a high degree of public attention." (WHO, Report 2002).

One possible way to respond to the problem of mass violence is dissemination and implementation of new knowledge about negative health and mental health impact of mass violence on individuals and societies. Well-organized, state regulated, contextually and culturally customized system of CME can contribute to better outcomes of patients' healing in post-conflict countries.

It seems reasonable that CMEs through good health outcomes can have positive impact on economic recovery and reconciliation process. Future research should be focused both on improvement of quality of CME and its' influence on economic recovery and reconciliation of affected society.

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CHAPTER 10

ROLE OF THE WORLD HEALTH ORGANIZATION IN MENTAL HEALTH POST-CONFLICT RECOVERY: ASSISTING GOVERNMENTS TO DEVELOP OR RECONSTRUCT MENTAL HEALTH SERVICES

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ABSTRACT

In this chapter, the authors describe the role of the World Health Organization (WHO) in mental health post-conflict recovery. The chapter covers the mandate and structure of WHO, mental health activities by the WHO Department of Mental Health and Substance Abuse, WHO-supported principles and strategies in mental health post-conflict recovery, and available WHO technical assistance. The chapter outlines a public mental health approach to make very basic mental health services broadly available in post-conflict countries.

INTRODUCTION

The mental health of populations who have survived conflict is increasingly seen as an important area requiring intervention. Attention to post-conflict mental health may be explained by a combination of co-occurring factors. Over the last 25 years, mental health professionals have become enormously interested in psychological trauma. This interest has led to numerous research programs, including the generation of converging evidence that exposure to highly stressful events and loss are sizeable risk factors for many mental problems, including various mood and anxiety disorders, in post-conflict countries (de Jong et al, 2003). At the same time it has become well-known that mental disorder throughout the world tends to generate an enormous burden on individuals, families, and communities not only in terms of mental suffering but also in terms of

disability and associated financial costs (World Health Organization [WHO], 2001a). Furthermore, it is now established that mental disorders - more often than not - can be treated effectively if appropriate services are made available (WHO, 2001a). In short, the increase in attention to post-conflict mental health may be explained by increased awareness of the potential impact of conflict on mental health and by increased awareness of the burden and treatment possibilities for mental disorder.

The growing interest to address mental health in post-conflict situations should be seen in context of a range of challenges. Only sparse human and financial resources are directed to mental health care by most national governments (WHO, 2001b). Governments in middle and low income countries frequently allocate the bulk of their very limited financial mental health resources to maintaining, renovating, or building custodial mental hospitals, where long-term treatment tends to be ineffective, or, worse, harmful and in violation of human rights. There are no formal (conventional/ modern/ allopathic) mental health services in most communities in resource-poor countries. International aid directed towards post-conflict mental health recovery is typically too short-term and too superficial to have a long-term meaningful impact. The bulk of aid is only directed to those countries that are, at least temporarily, in the media spotlight.

The focus of mental health humanitarian aid immediate after conflict is all too often exclusively on (short-term) emergency relief, rather than on (re)construction (medium and long-term development). An exclusive focus on relief in emergencies may make sense for some sectors but such exclusive focus may not be appropriate for the mental health sector. Mental health problems, when serious, are often chronic in nature.

Although natural recovery occurs for a sizeable group, people who develop chronic common mental disorders (i.e., mood and anxiety disorders) as a result of the conflict need ongoing access to community mental health services. Pre-existing mental health services, when destroyed by the conflict, need to be reconstructed, which can take a number of years. The interest in mental health and the availability of external financial resources for mental health care is for most post-conflict countries a unique and unprecedented possibility to develop a community mental health system to ensure enduring access to care for all people with serious mental health problems. Some early interventions (see below) are commendable but the bulk of increase in resources for mental health care in post-conflict countries may be best directed towards (re)construction of community mental health services.

In this chapter, we will focus on the role, tools and recommendations of the World Health Organization (WHO) to assist countries in mental health post-conflict recovery. We start with describing WHO's structure and mandate. This section is followed by a description of mental health activities by WHO, with a focus on activities by the Department of Mental Health and Substance Abuse. The next section describes WHO's recommendations in terms of principles and strategies for intervention in post-conflict countries. Finally, we describe WHO technical assistance available to post-conflict countries.

WHO: STRUCTURE AND MANDATE

WHO is the United Nations specialized agency for health. The WHO Secretariat consists of Headquarters in Geneva; six Regional Offices (in the Africa Region, the

Americas Region, the Eastern Mediterranean Region, the Europe Region, the South-East Asia Region, and the Western Pacific Region); and more than 140 Country and Liaison Offices throughout the world. The WHO Secretariat has six core functions:[1]

- Articulating consistent, ethical and evidence-based policy and advocacy positions

- Managing information by assessing trends and comparing performance; setting the agenda for and stimulating research and development

- Catalyzing change through technical and policy support, in ways that stimulate cooperation and action and help to build sustainable national and inter-country capacity

- Negotiating and sustaining national and global partnerships

- Setting, validating, monitoring and pursuing the proper implementation of norms and standards

- Stimulating the development and testing of new technologies, tools and guidelines for disease control, risk reduction, health care management, and service delivery.

These core functions reflect WHO's role as a technical agency with primarily normative functions. WHO is neither- an implementing agency (e.g., running health services) nor a financing agency.

At the global level, WHO is governed by representatives of Ministries of Health; while at the country level, WHO serves Ministries of Health. WHO is governed by 192 Member States through the World Health Assembly. The World Health Assembly is composed of

Ministers of Health from the 192 countries. At the national level, WHO Country Offices tend to work in very close collaboration with countries' Ministries of Health. WHO's strong relationships with Ministries of Health is essential to understand the agency's comparative advantage when providing assistance to governments. Another WHO comparative advantage is that multilateral aid - compared to bilateral aid - is less likely to introduce a biased agenda when assisting countries in key areas such as national policy, legislation, and national-level planning. The raison d'être of United Nations agencies is to represent a vision supported by a range of countries.

Mental Health at WHO

Mental health activities are organized by the WHO Secretariat through (a) professionals at the Department of Mental Health and Substance Abuse at WHO Headquarters in Geneva, (b) Regional Mental Health Advisers in each of the six Regional Offices, and (c) selected Country and Liaison Offices. Mental health activities by Country Offices are under the responsibility of the senior WHO officer in the country (i.e., the WHO Representative). A few WHO field offices (e.g., Albania, FYR Macedonia, Liberia, Mexico, Panama, West Bank and Gaza, among others) employ, ad hoc, mental health staff.

The Department of Mental Health and Substance Abuse aims to provide leadership and guidance for the achievement of two broad objectives, namely: (a) closing the gap between what is needed and what is currently available to reduce the burden of mental disorders worldwide and (b) promoting mental health. Mental health has emerged as an issue of major international public health interest over the last several years. WHO has

played an important role in the development of this interest in particular through the 2001 World Health Day, the 2001 World Health Assembly and the World Health Report 2001 (WHO, 2001a), which all focused on mental health. The Mental Health Global Action Programme - which was endorsed by the World Health Assembly in 2002 and which is led by the Department - is the culmination of this high-profile campaign. The program employs four strategies: information, policy and service development, advocacy, and research. These four strategies are fundamentally related to one another. Information concerning a country's mental health resources to address mental health problems leads to enhanced awareness and facilitates advocacy against stigma and discrimination. Moreover, information and advocacy are prerequisites for the formulation and implementation of integrated policy, plans and services. Countries' research capacity drives the generation of relevant evidence to inform the development of services.

At Headquarters, activities related to mental health and conflict are led by the Department of Mental Health and Substance Abuse in close collaboration with Regional Mental Health Advisors and with the Department of Health Action in Crises. The latter is the WHO Department with overall responsibility for health activities whenever disaster-affected systems become unable to respond to people's most basic needs. The sub-regional office of WHO/PAHO in Panama specializes in disaster mental health preparation.

WHO-Supported Mental Health Principles And Intervention Strategies During And After Emergencies

The Department of Mental Health and Substance Abuse recently summarized its position with respect to principles and intervention strategies during and after emergencies (WHO, 2003a). The selection of principles and strategies was informed by a range of existing consensus statements and guidelines by a variety of international organizations and by a postal survey of expert opinion (van Ommeren et al, in press; Weiss et al, 2003). The eight principles that are recommended by the Department are: contingency planning before the acute emergency; assessment before intervention; use of a long-term development perspective; collaboration with other agencies; provision of treatment in primary health care (PHC) settings; access to services for all; ensuring training and supervision; and monitoring indicators (Table 1) (WHO, 2003a).

Strategies during the acute emergency phase (when mortality rates are substantially elevated due to the conflict) and the post-emergency phase (when mortality rates are more or less under control) are briefly discussed here. With respect to the acute emergency phase, recommended early social interventions focus on access to information, family reunification, maintenance or restoration of normal activities, and active participation (WHO, 2003a). Recommended early mental health interventions focus on (a) psychological first aid for those with acute mental distress in the community (National Institute for Mental Health [NIMH], 2002), (b) care for urgent psychiatric complaints at PHC settings, and (c) ongoing care and protection for those with pre-existing disorders, including people in custodial hospitals who tend to be forgotten (van Ommeren et al, 2003). Popular interventions such as one-off (single-session) psychological debriefing and prescription of benzodiazepines are not recommended for

the routine management of traumatic stress, because their indiscriminate application may be harmful (NIMH, 2002). The above early intervention strategies have recently been included as a Mental and Social Aspects of Health Standard in the recently revised Sphere Handbook on minimum standards in disaster response (Sphere Project, 2004).

After the acute emergency, social interventions should continue, including the promotion of functional, cultural coping mechanisms (Ager, 2002; Sphere Project, 2004; WHO, 2003a). Moreover, efforts should be directed towards establishing a more comprehensive range of community-based mental health interventions. This would involve work towards:

a. Ensuring that people with severe mental disorders (e.g. psychosis, severe depression) - whether or not they are traumatized - can receive effective acute and follow- up care in the community. Services may be organized through community mental health teams working from general hospitals or from community mental health centers.

b. Ensuring that mental health care is available at PHC settings. This may involve teaching PHC staff in identifying disorders, treating common mental disorders, and referring and following-up on severe mental disorders.

c. Creating linkages outside the formal health sector by, for example, training and supervising social services workers, teachers, community leaders, and, when feasible, traditional healers in: identifying mental health problems, basic problem-solving counseling, facilitating self-help groups, and referral to formal mental health care.

A fundamental public mental health strategy in developing community mental health services is organizing services on the basis of defined catchment areas. A catchment area is a geographic area served by the mental health system and delineated on the basis of various factors, such as population size, existing administrative or natural geographic boundaries, and transportation accessibility. By definition, all residents of the area should be able to meet their need for basic services within their catchment area. Organizing services based on the delineation of catchment areas is key to ensuring wide access to basic services and is strongly preferable to organizing based on disease categories (or based on specific vulnerabilities), which tends to lead to fragmented, vertical services. Indeed, the development of a multitude of specialized trauma-focused services should be avoided without first having a basic, functioning mental health system in place. Trauma-focused care is important but is best integrated into existing systems, most notably general mental health services.

Another fundamental public health strategy in developing community mental health services is a focus on deinstitutionalization, because custodial hospitals tend to consume enormous resources and typically involve ineffective, harmful care. This means downsizing and eventually closing custodial hospitals by moving resources and patients to community mental health services in a responsible manner so that patients become part of society and at the same time start to receive appropriate social and medical community-based care.

In terms of intervention strategies at general health services (including PHC services), both medical mental health interventions (e.g., psychotropic medication) and non-

medical (psychosocial) mental health interventions should be made available. Rationally prescribed psychotropic medication is an effective intervention for many people with clear and present mental disorder. For that reason, generic psychotropic medication (based on the country's essential drug list) should be made available at health services that have appropriately trained staff. To avoid misapplication of the medical model, it is important that staff receive supervision in (a) assessment, (b) rational prescription, and (c) non-medical mental health intervention, such as emotional support, basic problem-solving counseling, organization of practical help, and referral to formal or informal social services. Ministries of Health are strongly encouraged to partner with competent non-governmental organizations to improve the quality of mental health care within general health services.

WHO COUNTRY ASSISTANCE

WHO has the staff, consultants, partner organizations, tools and experience to assist post-conflict countries to reach the above goals. WHO mental health staff assist countries upon their request with needs assessments, policy development, planning, proposal writing, as well as project monitoring and evaluation. Moreover, WHO is able to advise on interventions, assist in developing indicators for surveillance, and refer to competent organizations and consultants.

A key WHO role is assisting governments in the coordination of mental health initiatives (whether by bilateral programs, universities, or NGOs) that may flood countries after conflict ends. Key issues in the coordination of a multitude of initiatives are: avoiding

duplication of services, avoiding vertical services, organizing basic services across different catchment areas, and identifying and stopping harmful or ineffective care.

In terms of tools, the World Health Report 2001 (WHO, 2001a) provides science-based advocacy to decision makers on the need and rational for building community-based mental health systems and services. This document has been followed by an operational Mental Health Policy and Services Guidance Package (WHO, 2003b), consisting of interrelated, systematic modules to guide policy makers and planners: (a) to develop mental health policy, plans and programs; (b) to organize the structure of mental health services; (c) to determine the physical and human resource requirements and budget for a service; (d) to organize mental health financing; (e) to improve the quality of services; (f) to draft, adopt and implement mental health legislation; (g) to stimulate mental health advocacy to promote the human rights of people with disorder and to reduce stigma and discrimination; and (h) to improve access and use of psychotropic medicines.

Major further progress is being made through the WHO project on Assessing and Improving Mental health Systems (WHO-AIMS) (WHO, in press). As part of WHO-AIMS, the Department has recently developed an instrument to assess core aspects of mental health systems (WHO, in press). The WHO-AIMS tool has been pilot tested in 13 countries (Albania, Barbados, Ecuador, India, Kenya, Latvia, Moldova, Pakistan, Senegal, Sri Lanka, Tunisia and Vietnam) in 2004 and will be tested in a further 12 countries in 2005. The tool records baseline information necessary to develop national mental health plans with context-specific, realistic aims (targets), as is currently taken place in Albania and Viet Nam. Progress towards achieving targets can periodically be

monitored by the tool. Both WHO-AIMS and the aforementioned Mental Health Policy and Services Guidance Package (WHO, 2003b) are applicable in middle and low-income countries, whether or not they have been affected by conflict. For assistance in applying any of these tools in post-conflict countries, please contact the authors. For a full list of WHO's many tools in the area of mental health, please see

http://www.who.int/mental_health/resources/publications/en/.

Providing technical assistance to individual countries has become a priority for the Department of Mental Health and Substance Abuse. The Department presently helps a range of countries (WHO, 2004). With respect to countries affected by conflict, the Department has recently completed a project involving two years of intense technical assistance to the Palestinian Ministry of Health in the West Bank and Gaza in developing a plan to re-organize its mental health services, which are highly fragmented and partly institution-based. The WHO Office in Jerusalem currently provides continuation by assisting the Palestinian Ministry of Health in implementing the plan. Moreover, the Department recently assisted the Government of Sri Lanka by writing a 5-year mental health plan for North and East Sri Lanka, an area affected by more than 20 years of conflict (WHO, 2004).

The Department of Mental Health and Substance Abuse is available for advice to investigators on research in post-conflict-countries. The Department strongly argues that research should be directed to bring about meaningful change in services in low and middle-income countries (Saxena et al, in press), rather then for basic knowledge or mere

publications. A possible research agenda for post-conflict countries is suggested in Table 2.

CONCLUSION

Conflict may cause pre-existing formal or informal care systems to break down and is a risk factor for a range of mental health problems, including mood and anxiety disorders. After conflict some countries become recipients of substantial aid. Although funding for mental health is crucial, a sudden surge of foreign funds for mental health can raise issues regarding the most efficient use of resources. Numerous uncoordinated activities are problematic, especially so in resource-poor environments if local professionals leave core government mental health services and join different, often competing, international groups. WHO's role is to assist countries to avoid low quality, fragmented care through assisting in planning and coordination of services, including monitoring the quality of outside technical assistance. The opportunities to assist post-conflict countries are enormous.

Table 1: Basic Principles

Principle	Explanation
1 Contingency planning	Before the emergency, national-level contingency planning should include (a) developing interagency coordination systems, (b) designing detailed plans for a mental health response and (c) training primary health care personnel in basic, general mental health care and in psychological first aid.
2 Assessment	Assessment should cover the socio-cultural context (setting, culture, history and nature of problems, local perceptions of illness, ways of coping), available services, resources, and needs. With respect to assessing individuals, a focus on assessing disability or daily functioning is recommended.
3 Long-term perspective	Even though impetus for mental health programs is highest during or immediate after acute emergencies, the population is best helped by a focus on the medium and long-term development of community services.
4 Collaboration	Strong collaboration with other agencies will avoid wastage of resources. Continuous involvement of the government, local universities or established local organizations is essential for sustainability.
5 Integration into primary health care	Led by the health sector, mental health treatment should be made available within primary health care to ensure low-barrier (e.g., low-stigma) access to services for all.
6 Access to service for all	Setting up separate, vertical mental health services for special populations is discouraged. Nevertheless, outreach and awareness programmes are important to ensure the treatment of vulnerable groups within community services.

7	Thorough training and supervision	Training and supervision should be by mental health specialists - or under their guidance - for a substantial amount of time to ensure lasting effects of training and responsible care.
8	Monitoring indicators	Activities should be monitored and evaluated through key indicators that need to be determined, if possible, before starting the activity. Indicators should focus on inputs (available resources, including pre-existing services), processes (aspects of programme implementation), and outcomes (e.g., daily functioning of beneficiaries).

Table 2: Suggested Research Agenda for Post-Conflict Countries

Type of research	Example
1. Mental health services research	Effects of mental health care of trauma survivors in general health services
2. Treatment effectiveness research	Effects of specific mental health interventions in people with common mental disorders
3. Qualitative social science	Effects of specific social interventions (cf. Batniji, van Ommeren & Saraceno, submitted)
4. Cultural epidemiology	Identification of barriers to available care (cf. van Ommeren, in press)
5. Epidemiology of disablement	Effects of trauma exposure on daily functioning

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<center>**CHAPTER 11**</center>

<center>**WORKING WITH THE WORLD BANK AND OTHER DEVELOPMENT AGENCIES ON MENTAL HEALTH IN CONFLICT AND POST-CONFLICT ENVIRONMENTS**</center>

<center>**Florence Baingana, MD and Betty Hanan**</center>

ABSTRACT

Mental disorders as sequelae of conflicts are becoming increasingly evident as more epidemiological studies are carried out in conflict-affected countries. Depression, anxiety and Post Traumatic Stress Disorder are among the most frequent mental disorders that occur. This chapter uses the example of the World Bank, as a prototype of an International Development Agency, to describe post conflict mental health activities.

The work of the World Bank and other multilateral, bilateral and UN Agencies is guided by the Millennium Development Goals. All eight goals have a linkage to conflicts and six of the eight have a linkage to mental health. Addressing the mental health consequences of conflicts would thus go a long way to ensuring the achievement of the Goals. The chapter provides summaries of Bank funded conflict and post-conflict interventions in the sectors of Legal and Judiciary Reform, Health, Early Child Development, as well as Conflicts and Emergencies, encompassing analytic, knowledge products and operational activities. It provides a framework for linking mental health to economic development. The chapter concludes with recommendations for further research in this evolving field.

INTRODUCTION

According to the Global Burden of Disease (GBD) Study, mental disorders make up 13%[11] of the global burden of disease, second only to infectious disorders (23%). Mental disorders are a burden greater than either cancer or heart disease and greater than AIDS, tuberculosis and malaria combined (10%). These three disorders have focused world attention to reduce the 11.4% of disease burden they cause. By comparison mental disorders are often neglected. The 2001 WHO Atlas of Mental Health Resources indicates that although 70% of the countries of the world have mental health programs,

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[11] WHO: The World Health Report, 2002

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62% of the low income countries spend less than 1% of the country's health budget on mental health.

While in every population, 1-3% have a psychiatric disorder, the number increases where conflict is present due to post traumatic stress disorder (PTSD), alcoholism, drug abuse, and depression arising from conflict-related stress. A further group, maybe 30-40% of the population, may experience symptoms such as sleeplessness, irritability, hopelessness and hyper vigilance symptoms, which if it persists and becomes more severe, interferes with the normal functioning of individuals. This group is not classified as having a psychiatric disorder, but rather a psychosocial disorder, manifested as domestic violence, criminal activities, school dropouts, and other anti-social behavior. Lastly, following a traumatic event a large part of the population may suffer nightmares, anxiety and other symptoms of stress. These symptoms are often transient and will decrease in intensity and frequency over time. At the core of every conflict is insecurity. This insecurity fractures social ties, breaks up families and communities, and displaces populations. Further, insecurity and displacement causes the breakdown of social services such as health and education.

Although conflict is associated with an increase in the prevalence of mental disorders, there are few population-based studies carried out among adults in conflict-affected areas and low-income countries[12]. Among refugees, it is estimated that acute clinical depression and PTSD range between 40-70%. Epidemiological studies among IDPs and refugees on the Thai-Cambodian border, in Algeria, Ethiopia, Gaza, and Uganda indicate

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[12]   The Bank is currently analyzing the prevalence of depression among the adult population in post-conflict Bosnia and Herzegovina and explore the impact of mental health and labor market productivity and use of health care services. The Bank has just produced a discussion paper on Mental Health and Socio-economic Outcomes in Burundi, based on data from 12 psychological questions integrated into the Living Standards Survey.

that 15 to 53% suffer from PTSD as a consequence of conflict. In Uganda, 71% reported major depressive disorder, and in Algeria, Cambodia, Ethiopia, and Gaza, psychopathology prevalence was 17% among non-traumatized, against 44% for those who experienced violence. These estimates compare with less than 10% in non-conflict countries. Children are the most vulnerable group in conflict settings. They are more susceptible to shocks to their development process. These shocks may include violent and traumatic events due to conflict or more indirect effects such as malnutrition leading to stunting and cognitive impairments. In conflict situations, mothers may be depressed or suffering from PTSD, thus unable to provide proper care or stimulus to their children.

THE WORLD BANK MISSION

The vision of the Bank is a world free of poverty. The Bank's mission is to promote social and economic development and to reduce poverty. The World Bank, formally known as the International Bank for Reconstruction and Development (IBRD) was first conceived in July 1944 at the United Nations Monetary and Financial Conference in Bretton Woods in New Hampshire, USA. The World Bank (Bank) opened for business on June 25, 1946. The principle on which the Bank was founded was that many countries would be short of foreign exchange for reconstruction and development, but would be insufficiently creditworthy to meet all their needs by borrowing commercially. The first loans approved by the Bank helped finance the reconstruction of the war-ravaged economies of Western Europe. Initial Bank investments were in infrastructure, agriculture, energy, and other forms of physical capital. Today, the Bank lends to the developing countries of Africa, Asia, Latin America and the Caribbean, the Middle East, and Europe and Central Asia. In the past decade, the Bank has expanded considerably its financial support towards investments in human capital, mainly

education and health and in the area of social capital. Most recently, the Bank has also focused its activities on conflict and post-conflict-affected populations. The Post Conflict Unit of the Bank was established in 1996 to provide grant funding to support countries affected by conflicts in their recovery.

Although this chapter addresses the role of the Bank and other development agencies, the focus is on the work of the Bank, in the hope that it will provide an example of how other development partners could be engaged in this work. The work of the Bank and other development and UN agencies as well as member countries they serve, are guided by the Millenium Development Goals (MDGs), formulated in September 2000 at the Millenium Summit. All the eight goals have a linkage to conflicts. Addressing the mental health consequences of conflicts would go a long way to ensuring the achievement of the goals. The MDG goals are:

    1.1.1   Eradicate extreme poverty

    1.1.2   Achieve universal primary education

    1.1.3   Promote gender equality and empower women

    1.1.4   Reduce child mortality

    1.1.5   Improve maternal health

    1.1.6   Combat HIV/AIDS, malaria and other diseases

    1.1.7   Ensure environmental sustainability

    1.1.8   Develop a global partnership for development

MENTAL HEALTH AND THE WORLD BANK

A major economic factor affecting the development of conflict/post conflict societies and post-natural disaster societies is the mental health of its citizens. In 1990, the Bank/WHO Global

Burden of Disease Study (GBD) revealed for the first time in developing nations the importance of depression. The GBD found in its original survey that depressions was the fourth leading cause of disability as compared to all other health conditions. The GBD predicted that in 2020, depression would be the 2nd leading cause of disability in the world. The GBD, however, focused primarily on non-traumatized developing nations. Recent large scale epidemiological surveys have shown that in traumatized populations, depression can be up to seven-fold baseline level of non-traumatized societies, while PSTD can be up to ten-fold baseline. High rates of disability and premature death associated with chronic medical illnesses such as cardiovascular disease are associated with psychiatric morbidity in traumatized populations.

The Bank recognizes that economic and social stability, and human security are pre-conditions for sustainable development. Conflict, within or between countries, results in loss of life and destruction of assets. It contributes to social and economic disintegration and reverses the gains of development, thereby adversely affecting the Bank's core mission of poverty reduction. Among the many adverse effects of conflict is the impact on the mental and psychosocial well-being of large parts of the population in communities affected by conflict. These effects are often referred to as the "silent wounds" of conflict because they frequently remain hidden, un- or under-reported in post-conflict needs assessments, and consequently are not addressed in most post-conflict reconstruction programs.

The Bank has gradually recognized that addressing mental health is an important development issue, especially in the case of conflict-affected societies. It recognizes that a major economic factor affecting the development of conflict/post-conflict societies and post-natural disaster societies is the mental health of its citizens.

The Bank has supported mental health activities since 1994 within nutrition, post conflict, public health, early child development (ECD), and health systems development projects. In March 1999, the Bank established a Position of Mental Health Specialist. The four key objectives of the position are to:

- Generate and/or compile knowledge on mental health through analytic work,

- Disseminate this knowledge within the Bank and to the Bank's clients,

- Provide policy and technical advice and preparation of tools that facilitate the integration of mental health components into Country Assistance Strategies, Poverty Reduction Strategy Papers, and projects as well as other Bank lending and non lending instruments, and

- Partnership activities with WHO, UNIFEM and other UN and bilateral agencies as well as global mental health NGOs.

SUMMARY OF BANK-FUNDED CONFLICT AND POST-CONFLICT INTERVENTIONS

Several activities supporting mental health have been undertaken by the Bank in the past several years in the context of direct lending and through analytical work. The first such activity was in 1994 through a project in Argentina with a mental and social development component within the Early Child Development Project. Since then, mental health activities have been supported in different sectors -- legal and judiciary reform, health, ECD, conflict and emergencies, and social protection. More recently, the Bank has been working on a Toolkit which provides directions for incorporating mental health and psychosocial interventions into lending and non-lending activities for populations affected by conflict. Illustrations of mental health interventions by the Bank are included below. More detailed analysis of the more comprehensive activities supported by the Bank follow.

Legal and Judiciary

- Technical support to the legal and judiciary reform project of Sierra Leone to take into account mental health disorders.

Health

- Activities related to de-institutionalization of people with mental illness in Albania, Lithuania and Romania under various health sector reform projects.

- Support to Lithuania, Zambia and Trinidad Tobago to reform mental health services.

- Support to the Ministry of Health in Thailand for mental health reform.

- Technical support to the Afghanistan Health Project.

- Technical support to Lesotho in mental health policy development, community health assessment and the place of mental health within the District Health Package.

Early Child Development

- Cognitive development component in the Burundi Social Action Project.

Conflict and Emergencies

- Integration of mental health into primary health care in Bosnia and Herzegovina by training primary care physicians in the management of common mental disorders.

- Integration of mental health into primary health care in the West Bank and Gaza by streamlining referral mechanisms, addressing children's mental health, and developing an in-patient care master plan and a mental health information system.

- Mental Health component in the Turkey Marmara Emergency Earthquake Reconstruction Project (MEER) through the development of a National Mental Health Policy and the training of primary health care personnel.

Analytical Work

- The Burundi Living Standards Survey included questions on psychological well-being. The data has been analyzed and indicates a prevalence rate of 36% for "*Distress*" and 25% for "*Pessimism*". Key findings were that poor mental health was more prevalent in the regions that had been most affected by the conflict, there is an association between poor mental health of the head of the household and school enrolment for children in that household, as well as an association between poor mental health with unemployment and increased morbidity[13].

- In Burundi, In 2001-02, another survey, the Core Welfare Indicators Survey, was carried out that contained a module that included the GHQ 12 and the Alcohol Use Disorders Test. In 2004, a Risks and Vulnerability Assessment was carried out, which included the 12 Psychological Questions from the 1998 Survey.

- In Bosnia and Herzegovina, the Harvard Trauma Questionnaire and Beck Depression Inventory were integrated as a module in the LSMS.

Knowledge Management Publications

11. A range of products has been and will continue to be prepared. Examples include:

- Defining the scope for public sector involvement in mental health,

- The mental health economics paper for the WHO Commission on Macroeconomics and Health

- The interrelationship of social capital and mental health,

- The Mental Health fact sheet,

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[13] Baingana, F Dabalen A, Menye E, Prywes M, Rosholm M, 2004 Mental Health and Socio-economic Outcomes in Burundi. (Draft) HNP Discussion Paper, The World Bank.

- A social development note – Mental Health and Conflict,

- A chapter on children and conflicts in "Trauma Interventions in War and Peace, Prevention, Practice, Policy", and

- A chapter on mental health in the disease control priorities in developing countries.

WORLD BANK-FINANCED ACTIVITIES IN POST-CONFLICT ENVIRONMENTS

The Bank-supported mental health activities in **Bosnia and Herzegovina** (BIH) through the Bank Post-conflict Unit to pilot a culturally appropriate mental health program within the primary health care (PHC) system of one canton of BIH, namely Travnik Canton. The specific objectives of the three-year project which was successfully implemented included, inter alia: (i) training and technical assistance to primary care providers (PCPs) so they can identify and treat psychiatric disorders and physical disabilities resulting from the war trauma; (ii) establishment of a network of PCPs skilled in mental health care and supporting each other in the treatment of persons with trauma-related and other mental health disorders; (iii) development with the cantonal Ministry of Health an approach to the provision of mental health services integrated into all levels of the PHC system; (iv) produce sustainable results by integrating this project into the BIH health care reform, including BIH's continuing medical education activities; and (v) evaluate the achievement of objectives so that lessons learned can be disseminated to other cantons and other countries in the region.

The Bank-supported Burundi Social Action Project included a community-driven ECD component, covering cognitive development, health, nutrition and psychosocial elements. Local psychologists assessed the knowledge and literacy of mothers in participating villages and on this basis developed a training package, including a training-of-trainers manual, teacher

handbook and educational aids. Following discussion and consultations with the Ministry of Education and key NGOs, the training package was piloted in several areas. An evaluation was carried out three years after the project began implementation and the cognitive component was found to have been extremely successful. Children who had been through the Early Child Centers were found to perform extremely well in the first year of school. The Government of Burundi has promulgated a declaration making it a requirement for all children to attend Early Child Centers supported by the Community.

A six Country cost-effectiveness study of mental health and psychosocial interventions was supported by the Bank. Preliminary results coming indicate that there is a return of US$40 for every US$6 spent on interventions.

Mental Health operational activities in Rwanda, Burundi, Sierra Leone, the West Bank and Gaza, Bosnia, and Afghanistan have contributed to drawing lessons on what can be done in the area of mental health and psychosocial issues for conflicts-affected populations. The following presents a summary of the lessons learnt from the activities. A full discussion can be found in the *Mental Health and Conflicts Discussion Paper* as well as the *Mental Health and Conflicts Toolkit*.

LINKING MENTAL HEALTH TO ECONOMIC DEVELOPMENT

Framework for Mental Health and Psychosocial Interventions

Taking into account the multi factorial nature of mental and psycho-social disorders, interventions have to be developed with the collaboration and coordination of different sectors. These include, health, education, social welfare, welfare of refugees and displaced persons

administration, and legal and judiciary sectors. There are also different levels of care -- primary level, secondary level, and tertiary levels. A third dimension is the different stakeholders that have roles to play in the planning and implementation of mental health and psycho-social interventions. These include governments, NGOs (not for profit), private providers, and UN agencies.

In the majority of conflict-affected countries, services are focused on institutional care, with public funds spent on tertiary hospital care with virtually nothing at the secondary level and minimal amounts at the PHC level. This seems to indicate an inverted pyramid for funding levels, opposite to that where the majority of people with the need for services are. The aim would thus be to try to change the allocation of resources to better match the disorders burden as is illustrated in the diagram below:

Diagram 1: Present Resource allocation, Disorders Burden, Ideal Resource Allocation
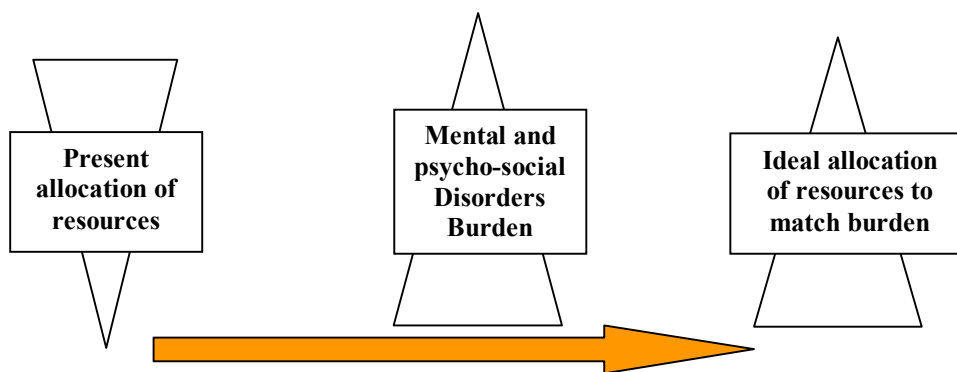
Source: Mental Health and Conflicts Discussion Paper, The World Bank, in print

To achieve the re allocation of resources illustrated in Diagram 1, there would have to be a strengthening of the integration of mental health into primary health care. This can be envisioned as being on three dimensions. The first dimension is for the program components, including coordination, standards and guidelines, monitoring and evaluation. The second represents the three levels of PHC, primary, secondary and tertiary, and the third the three

main sectors providing care -- the Government, UN Agencies, and NGOs. Implementation is not carried out by donor agencies, such as the Bank or bilateral development agencies. In most country situations, these three dimensions are going to be relevant to the programming of mental health and psychosocial interventions.

A dimension that is not included in this diagram is that of the multi-sectorality of mental health and psychosocial interventions. There are often interventions in the educational sector, within schools, to train teachers to recognize children that may be distressed, to provide initial interventions, and to refer those that may require specialized attention. Teachers may also need training on how to handle children that may have participated in conflicts, such as child soldiers, since they would react differently to authority. Schools are also an excellent opportunity for breaking the cycle of violence by integrating peace and reconciliation in the curricula.

Another sector that has a vital role to play in the mental health and psycho-social programming is that of Social Affairs. Often, women's issues and children's issues are addressed in this sector. This may include special programs that target victims of sexual violence, which is often frequent in war affected populations, as happened in Sierra Leone14 or for situations where women are severely discriminated against, such as in Afghanistan15. The social affairs sector often has the role of planning and programming for orphans and vulnerable children. This may include tracing and resettlement, which often involves a psychosocial component. This may be done in collaboration with NGOs and local governments. For each of these sectors, the three dimensions mentioned above would have to be taken into account.

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[14] Physicians for Human Rights, W*ar related violence in Sierra Leone*, 2002
[15] Physicians for Human Rights, Women's Health and Human Rights, a population based assessment, 2001

Another dimension is that of donors and the role they play in determining where resources are allocated. In most post-conflict countries, bilateral and multilateral agencies play a significant role in determining what programs should be funded and at what levels the implementation will take place. For many post-conflict countries, the initial focus may be on infrastructural rehabilitation. This may not take into account what the long-term plans are for the institution or within the sector. This often contributes to a reinforcement of funding to tertiary levels and minimal amounts to the PHC level.

In many of the conflict/post-conflict countries, the psychiatric institutions are often dilapidated. Rather than investing in their rehabilitation, it would be best for the country to determine what direction the whole sector and the mental health services in particular should be taken.

Diagram provides a framework for the three levels of care for both mental health and psychosocial services. There is a need to have complimentarity in the provision of these services as well as referral both up and down the system. It may not be as effective to establish a mental health program without the availability of psychosocial services and vice versa. Each of the levels of care is crucial to successful implementation of these interventions.

Although there are no studies that assess effectiveness of psycho-social interventions and few for mental health care in the developing world, and less for populations affected by conflict, the diagram provides the current best practice as determined by NGOs and agencies working in the psycho-social and mental health fields in relation to populations affected by conflict. The need for cost effectiveness studies for such interventions is increasingly becoming apparent and some agencies have begun to do this work. The Bank's Post Conflict Unit is

supporting a study on 'Cost –effective Interventions for populations affected by conflict in six countries'. Preliminary results are promising. It is estimated that the cost of care is about US$8 per patient and the return on this investment is estimated to be US$40. Further work is being done to refine this data.

Diagram 2: Relationship Between Mental Health Care and Psycho-Social Services

Mental Health Care   **Psycho-Social Care**

Hospital based care with specialized personnel, diagnostic and treatment facilities. This may be the Regional Hospitals and the National Referral Hospital

Residential facilities such as transition and rehabilitation centers for war trauma survivors. Specialized and multi sectoral interventions such as group therapy, intensive individual therapy etc

Provincial and district hospitals that provide more specialized care as well as out reach and support to the PHC centers and workers.

Play therapy, expressive art therapy, drama and counseling support provided in a more structured environment usually by NGOs. Interventions may be integrated into school programs

School based mental health care
Community based mental health programs.
Training PHC workers so they are able to recognize, provide early intervention and refer patients with mental disorders.

Listening and helping, provided by members of the family and the community. The community's own resource persons (CORP) may be trained to provide early recognition and referral.

Source: Mental health and Conflicts Discussion paper, The World Bank. In print.

Children and Conflicts

Children are the most vulnerable among populations affected by conflict. Children make up 50% of the populations in the developing world where the majority of conflicts are situated. Conflicts disrupt education systems limiting access to education for the future leaders and contributors to development. One example is that of the "Lost Generation of Youth" in Sierra Leone. Children, due to their sensitive neurological system, are more susceptible to shocks in their

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developmental process. These shocks may include direct traumatic events, or more subtle shocks such as chronic severe malnutrition leading to stunting and cognitive impairments.

USAID has gone a long way in defining who the vulnerable children are. This has been integrated into the work of the Orphans and Vulnerable children (OVC) work of the Bank. A framework adapted from that proposed by Anne Kielland is presented at the end of this chapter.

Integrating Mental Health Into Primary Health Care

The integration of mental health care into general health services, particularly at the PHC level was acknowledged by WHO in its 2000 World Health Report as having several advantages. These include: (i) less stigmatization of patients and staff, as mental and behavioral disorders are being seen and managed alongside physical health problems; (ii) cost-efficiency savings; (iii) efficient use of community resources which can partly offset the limited availability of mental personnel; (iv) improved screening and treatment, in particular improved detection rates for patients presenting with vague somatic complaints related to mental and behavioral disorders; (v) potential for improved treatment of the physical problems of those suffering from mental illnesses, and vice versa; and (vi) better treatment of mental aspects associated with "physical" problems.

Integration requires a careful analysis of what is and what is not possible for the treatment and care of problems at different levels of care. For example, WHO acknowledges that early

intervention strategies for alcohol are more effectively implemented at the PHC level, but acute psychosis might be better managed at a high level to benefit from the availability of greater expertise, investigatory facilities and specialized drugs. Patients should then be referred back to the PHC level for ongoing management, as PHC workers are best placed to provide continuous support to patients and their families. PHC personnel need to be trained in the essential skills of mental health care to be able to provide these services. Mental health training to physicians and nurses at health centers is essential to enable treatment of common mental health and behavioral disorders at the PHC level. There is a need also to integrate mental health and counseling into PHC to enable the largest number of people to get easier and faster access to mental health services. The training of PHC personnel must equip the personnel with disease-related skills to assess and be able to diagnose mental problems as well as psychosocial skills like interpersonal skills, including simple counseling techniques and listening skills. The Bank has been active in several countries to support the integration of mental health into PHC and specifically to support the training of PHC personnel. As noted earlier in the chapter, the Bank has provided financial support for this in Bosnia and Herzegovina through the Harvard Program in Refugee Trauma and in Turkey through the Marmara Emergency Earthquake Reconstruction Project (MEER).

WHAT CAN BE DONE TO IMPROVE MENTAL HEALTH

Depending on the condition, effective treatments exist and patients can lead productive lives. It has been demonstrated that community mental health programs can be effective even in poor populations. Public health interventions such as immunization and prevention of nutritional disorders will help prevent developmental disorders. School health services, adolescent health services, and maternal health services all contribute to the prevention of mental disorders and

the promotion of mental well-being.   A life cycle approach shows how to integrate mental health into other health services.

Where to Start?

- ➢ **Policy/Program Development**: Establish or strengthen the mental health delivery system within the framework of PHC, community based rehabilitation and school based health care.

- ➢ **IED**: Increase awareness of what mental health and mental disorders are, their causes and prevention, and the availability of effective interventions.

- ➢ **Training:** Increase the numbers of health workers and other relevant personnel (teachers, social workers, community based rehabilitation workers, psychologists) who can recognize and manage or refer patients with mental health problems.

- ➢ **Quality:** Develop and implement standards and guidelines for the management of common mental health problems.

- ➢ Establish or strengthen a **support supervisory system.**

- ➢ Establish or strengthen the **referral system.**

- ➢ Develop and implement a **mental health management information system.**

RECOMMENDATIONS FOR RESEARCH.

Some of the areas for potential research include:

1. Impact of income generating activities on mental health for population affected communities. If conflicts lead to mental disorders and mental disorders lead to dysfunction, is it feasible to invest in income generation activities? On the other hand,

poverty resulting from the conflict may lead to mental disorders, and investing in income generating activities would in turn lead to a resolution of the mental disorder.

2. What is the role of mental health programming in peace and reconciliation programs? Are these programs effective? What would such a program look like and what lessons can we learn from evaluations?

3. Further research has to be carried out to standardize psychosocial approaches, study the costs and the effectiveness, and develop indicators.

4. Evaluation of school based mental health and psychosocial programs for orphans and vulnerable children. What are the models of best practice, what are the costs? How long should programs be carried out for and how long do the effects last? As an example, if children receive psychosocial support for 7 or 8 years before the age of 15 years, is this going to last them the rest of their life times, or would they require further support in later years? What is the optimum duration as well as the most cost-effective?

5. Evaluation of mental health programs for conflict affected populations and documenting models of best practice.

Table 1: An OVC Taxonomy: Conflicts and Mental and psycho-social Disorders Perspective

	AIDS affected	Conflict affected	Street children	Children in worst forms of labor	Disabled Children
Orphaned children	Evidence of spread of HIV within armed forces Orphaned children more susceptible to HIV/AIDS Many parts of Africa have double burden of HIV/AIDS as well as conflicts	War orphans are more vulnerable to abuse, lack education, and lack access to health services	Some of the street children are orphans In rural areas, they wander around the villages Likely to abuse drugs and alcohol, some are sexually abused	Orphaned children may end up in the worst forms of labor In conflict situations, orphans may become child soldiers	Conflict situations may increase the numbers of children with disabilities, amputees e.g. in Sierra Leone, Poor health services may lead to polio, epilepsy, cerebral palsy. Mental retardation
Children separated from parents	Breakdown of social support systems during conflicts will lead to AIDS orphans not getting support from the community	Displaced and unaccompanied refugees Increase in the numbers of child headed households	Children separated from parents as a consequence of conflicts are at risk of ending up on the streets	Children separated from their parents are at risk of being recruited as child soldiers	Many children with disabilities are abandoned by their parents during times of crisis.
Children living with dysfunctional parents		Living with parents who are injured or traumatized by the war do not get adequate stimulation	Stress in the home resulting from the conflict may lead to abuse of the children who will in turn end up on the streets	Children running away from dysfunctional homes are easy prey for the army	Children living with dysfunctional parents are at risk for emotional disorders of childhood
Children	Not possible to have	Ex-child soldiers	Children who may be	Child soldiers	Amputees

with needs beyond parental care	PMCT initiatives in conflict situations Children born with HIV during situations of conflict	Ex abductees	abusing drugs Those in conflict with the law Female ex-abductees with children	Abductees still under the control of the rebels Girls forced to marry rebels	Mine affected

Adapted from OVC in Sub Saharan Africa, by Anne Kielland. This version first published in the Conflicts and Mental Health Discussion Paper of the World Bank.

CHAPTER 12

POST-CONFLICT CONSTELLATIONS OF VIOLENCE AND THE PSYCHOSOCIAL APPROACH OF THE INTERNATIONAL ORGANIZATION FOR MIGRATION (IOM)

Natale Losi, PhD and Renos Papadopoulos, PhD

The conversations and stories that people construct and exchange in situations of conflict are clearly important, whether they influence the conflict's resolution or, on the contrary, contribute to its perpetuation. These stories are constructed within the wider context of relevant societal parameters such as media reports as well as more specific social and mental health theories. When these stories are woven into the context of an international conflict situation, even the staff of international organizations that is working to minimize the destructive consequences, often unwittingly, tend to get involved actively in their construction and dissemination. This is especially the case for that group of staff who are sent to work "on the ground". In addition to these co-producers and co-narrators of conflict situation stories, there is an overarching constellation, a set, within which the specific meaning of the conflict is constructed. This constellation consists not only of the relevant societal parameters but also of three principal players: the aggressors, the victims and the authorities. Using this constellation, one would be able to derive a typology according to the unique dynamics of each given situation. In most cases of conflicts, the international personnel tend to consider themselves as playing the role of an overseeing, managing and pacifying authority, whereas, in fact, they can also be perceived, according to different points of view and independently from their own intentions, as being either saviors or aggressors. Unwittingly, many members of such international organizations tend to contribute to the formation of a constellation, which tragically perpetuates the very premises that gave rise to the original conflict. In other words, by their very intervention, the international actors risk to perpetuate the specific form of the narrative constellation of aggressor/victim/rescuer (cf. Losi, 2002, Kuscu and Papadopoulos, 2002; Papadopoulos, 2000b, 2001a; 2002) As a result, the peacekeepers or re-builders often fuel the very conflict they attempt to resolve with their intervention.

CONSTELLATION OF VIOLENCE
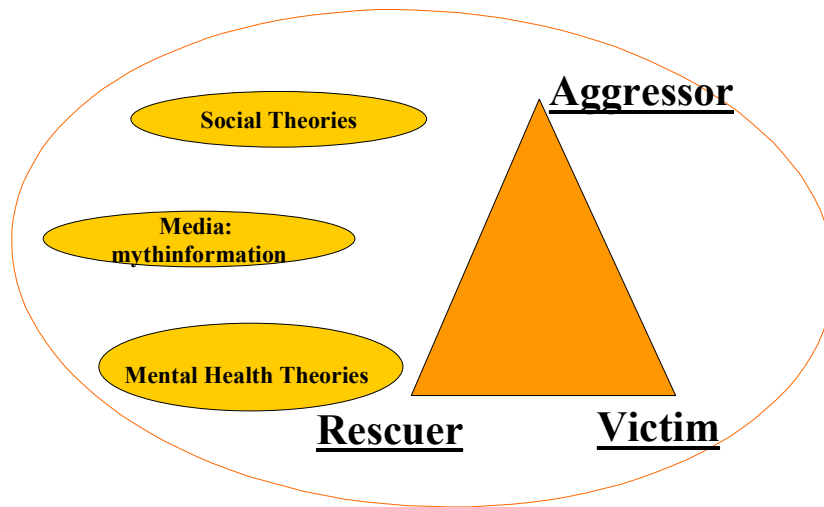
The pervasive nature of this constellation and more specifically of the triangle of conflict has become the subject of study by many different disciplines. The anthropologist R. Thornton suggests that:

> Narratives of violence have a specific social and cultural function. By narrating events, we link a series of actions – whether by chronology, conspiracy or psychological predisposition – into a comprehensible framework. In this way the violent event that has radically disrupted the flow of normality appears to have been predictable, and the moment of chaos that has challenged order is tamed (Thornton, 1999, p. 3).

In other words, when we "clothe" an experience or a situation of chaos within a story or narrative, we transform it, give it sense and, in a way we attempt to tame chaos. However, this is not a neutral activity. As A. Feldman notes, "Narratives not only explain events; they are integral to how we decide what is an event and what is not" (Feldman, 1991, p. 27). More specifically, with reference to destructiveness, Papadopoulos observed disturbingly that 'Within the cloud of the inherent epistemological confusion and the anguish emanating from the unintelligibility of …

[these complex destructive phenomena], the theories mental health experts advance in attempting to understand destructiveness may ultimately amount to being not much more than ornate psychologisations and pathologisations which are intended to ease the resulting distress. Thus, unwittingly, I would argue that we are used by society, as experts, to explain away the disturbing complexity of destructiveness and replace it with sanitised theories' (Papadopoulos, 1998, p. 459; cf. also Sironi, 1999 and Vinar, 1989).

In many international crises, like in the case of Kosovo, it seems that the triangle of conflict (originally described by Karpman in 1968 using the terms 'perpetrator', 'rescuer' and 'victim') tragically becomes the recurrent pattern. Characteristically, Bruck wrote that "The human community needs to be split into perpetrators or transgressors, objects or victims, and responsible authorities" (Bruck, 1992, p. 72). This well described assignment into the various different roles tends to get entangled within every type of organised intervention by the different agencies and NGOs.

The media exposure/transformation of wartime events, that was so particular to the Kosovo crisis and more recently in Iraq, also allowed the journalists to co-produce the diverse versions of this basic conflict plot. This specific function of the media, i.e. to break up the facts and then put them back together to produce a telling story, has been aptly characterized as *mythinformation*,[1] a word which evokes the means by which stories can be tied to objects, intentions and events within a strong blend that appears true and credible because it is familiar, and it is familiar because it includes the fundamental triangle: perpetrator /victim/rescuer. External (international, humanitarian, etc.) intervention does not arrive within a neutral situation, but rather in one where

mythinformation has already and effectively fossilized the environment, interpreting it through the variations of the plot of the basic protagonists: perpetrators, victims and rescuers.
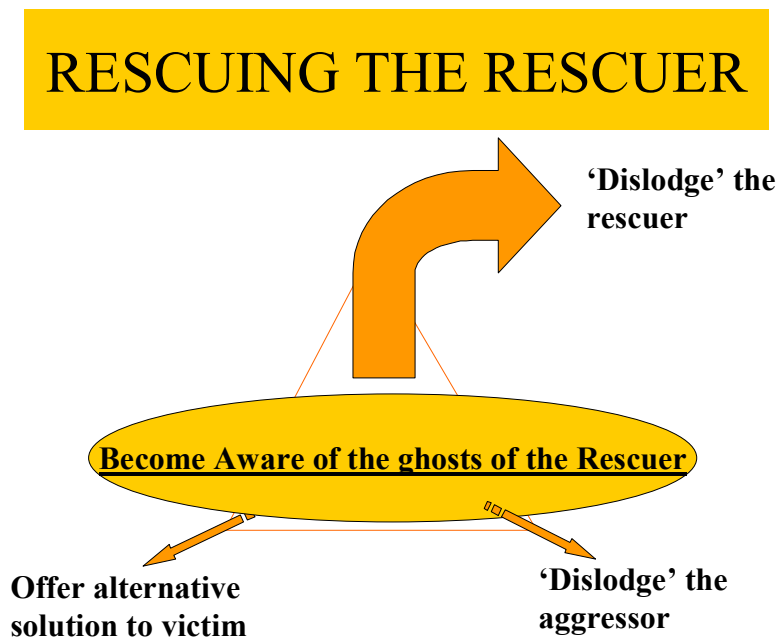
RESCUING THE RESCUER

One of the main tasks of the IOM (International Organization for Migration) Psychosocial and Cultural Integration Unit philosophy of intervention is, indeed, the attempt to alter the disabling effects of this stifling constellation.

However, to be effective in these complex emergency circumstances, it is important to remember that the basic reality of this constellation is not limited either to the specificities of the field conditions of a given conflict or to the strict time-frame of the conflict. Indeed, this constellation lasts much longer than the duration of the actual conflict and it extends to subsequent strategies of support of refugees and asylum seekers, which are designed by the receiving countries, and it can even last for many generations.

As Papadopoulos noted, in working with traumatized individuals in these settings, 'the … triangle of victim-savior-violator tends to keep perpetuating itself creating endless variations with different people in the same roles' (2001, p.8). Indeed, one of the most destructive effects of this triangle is that it keeps re-producing itself in different formations by either shifting the actors into different positions or by recruiting new persons and assigning them to the existing three set roles. As experience shows, both the victims as well as the rescuers can easily shift into the perpetrator's role when, for

example, they become tyrannical over others with their demands, which originally were legitimate and benevolent. As international mental health professionals, our only chance to modify this triangle is the possibility to alter and depotentiate the rigid role of the only one component of this constellation with which we are directly implicated - the "Rescuer".

RESCUING THE RESCUER

'Dislodge' the rescuer

<u>**Become Aware of the ghosts of the Rescuer**</u>

Offer alternative solution to victim

'Dislodge' the aggressor

To be able to break away from the debilitating effects of this suffocating triangle, those who are assigned to the role of rescuer must be aware of the multitude of figures and scenarios that weave its complexity. Only if the humanitarian workers are able to have substantial awareness of the labyrinthic implications of their pre-assigned role in this triangle (i.e. as rescuers), can they offer other members of the constellation (such as the "Victim") solutions that are not repetitive and fatal; otherwise, the 'solutions' they will

offer will inevitably reproduce the same dynamics of violence that created the initial conflict.

In other words, it is by breaking away from the fossilized set pattern and prescribed positions that the rescuer might help construct a future less exposed to the systematic repetition of violence.

Every act of international co-operation, especially if it occurs in the context of humanitarian intervention in a transitional situation immediately following a conflict, and even more so in the field of psychosocial support, is susceptible to a series of pre-assigned models, and "ghosts". The word ghosts is used here to refer to the invisible elements included in the complex role of any person in position of power over another person. This includes the host of attitudes that are accompanying such a role, e.g. the combination of pity and care. This term is used by Eugène Enriquez (Enriquez, 1980) in relation to the "educator" figure. Losi (Losi, 1983; Losi et al. 2001; Losi, 2002) uses this word and notion of "ghost" to refer to the rescuer figure, in order to offer an alternative to this rigid constellation.

The usual ingredients of these types of interventions are idealism and passion as well as disappointment and frustration and these are what tend to create the fertile ground from which these models and ghosts emerge. The attraction for this kind of work probably resides in contemplating and sharing the desire of omnipotence along with the fear of impotence; the wish to be (at least in intention) a bearer of life, and the fear of (unwittingly) repeating destructiveness and inflicting further pain. Accordingly, it could

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be claimed that psychosocial humanitarian workers tend to follow the following possible models and ghosts:

1. One that offers a good model/form (a trainer);

2. One that heals and restores (a therapist);

3. One that gives life, enables and facilitates (a midwife, a performer of maieutics – the art of giving birth);

4. One that interprets, bring about awareness (an interpreter);

5. One that initiates action, movement and change (a militant);

6. One that is committed to improving and repairing (a repairer);

7. One that is free of taboos and prohibitions (a transgressor);

8. One that acts unconsciously in ways that may produce disturbance in others (a destroyer).

The coping mechanisms of individuals affected by conflicts, tend to activate and often facilitate in the rescuers the enactment of one or more of these ghosts and it is imperative to find ways to comprehend them in a deeper way. Based on the relevant literature as well as field experiences, one of these ways would be to construct a tentative typology of coping mechanisms that are engendered in these emotionally charged situations.

The ideas expressed here are based on the experiences of three field and research projects. Two of them were directly run by IOM through its Psychosocial and Cultural Integration Unit in Kosovo, Serbia and Italy among IDPs and asylum seekers respectively in 2000-2001 and 2003-2004, while the third one refers to a research conducted among asylum seekers in the Netherlands (Losi-Passerini-Salvatici, 2001;

IOM, 2004; Kramer-Bala, 2004). Based on these experiences, it could be claimed that not only humanitarian workers, but also the refugees and asylum seekers themselves tend to act and react in certain stereotyped forms which could be broadly described as follows:

1. The drifter: who believes to have no chance to influence the outcome of events.

2. The hibernator: who avoids change and remains fixed in the current situation.

3. The fighter: who is always looking for ways of changing the situation.

4. The explorer: who is open to new and flexible options and opportunities.

Therefore, in order to comprehend deeper the complexities of possible permutations of interactions between the caregivers and the care receivers, it would be instructive to relate these two typologies. In doing so, the first objective is to show that if humanitarian workers choose to adhere completely to any one or more of these set models/ghosts, they are likely to fall into a trap which would perpetuate violence and destructiveness, regardless of their personal selfless intentions to contribute to the creation of a better humanity. The second objective is to show that it is possible for humanitarian workers to adopt a series of possible positions that would enable them to reduce the risk of perpetuating the rigid role of rescuer, thus releasing the other implicated players (aggressors and victims) from the rigid bond of their reciprocal role as generators of violence.

Here are some possible variations of the set roles for humanitarian workers:

1. The Trainer: The trainer is interested in "forms" and intervenes in order to re-form, trans-form, de-form, etc. If the humanitarian workers' representations of themselves fit within the common category according to which they view themselves as "model figures," by implication, they deprive their interlocutors of their own experiences, their difficulties, their anguish and their trial-and-error progress; instead, the approach of such workers aims, unwittingly, to substitute the others' experiences with a "good form" that is fixed, that is repetitive and it is, ultimately, sterile. Enriquez notes that this temptation is very common mainly among psycho-sociologists, "in that they believe to have realized, in the balance reached, a particular ideal that they wish to transmit, as is the case with educators, who desire to reform those who were ill-formed..." (Enriquez, 1980, p. 116).

2. The Therapist: In cases of humanitarian intervention after a conflict, it is easy to feel immersed in a universe that is considered "abnormal" and therefore to assume an attitude that attempts to readapt the individuals affected by or involved in the conflict. It is easy to feel a duty to restore them, to heal them of their "behavioural and emotional insufficiencies," and to help them lead a 'normal' life. This is the explicit or implicit policy of most organisations that work with trauma. Implicit in their idea is the model that they are dealing with an affliction that requires healing. Moreover, this model

- Assumes that the afflicted person had been in a stable state (healthy status) which was then upset by external agents (in this case, the violence and aggression of war), and that, by applying the appropriate therapy to such persons, their state of initial health will be restored;

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- Therefore, it presupposes a perfect reversibility of the organism: that once healed, it will not feel the consequences of the "illness" (aggression).

It is important to reflect upon the roots of this model, this ghost. In fact, at the basis of this *restitutio ad integrum* obsession, we find a very real tendency in our society to form a dichotomy between the "sick" on one hand, and the "care givers" on the other. This model tends to be exported in international actions, when international actors medicalise the social with each glance they cast at it.

Papadopoulos expressed this dynamic as follows: '… inevitably our identity as mental health professionals imposes on our observations the … constraints [of] … the pathology-health polarity; this results in us combining the causal-reductive approach within the oppositional narrative of pathology and destructiveness which then together produce an inevitable psychologisation and pathologisation of destructiveness. By no means do I wish to suggest or imply in any way that destructiveness is 'normal' or acceptable. But is placing it on the 'normal' - 'abnormal' polarity the only way out? … Perhaps the first step towards such a deeper understanding would be for us to appreciate the fact that we are indeed trapped and imprisoned by and within these constraints where the pathology narrative occupies a key position' (Papadopoulos, 1997, p.460).

3. The Practitioner of Maieutics (Midwife): The objective of those who adhere to the maieutic model is not to restore or heal but rather to give birth to or favour development and maturity, to permit the realisation of inaccessible, prohibited or repressed potentials. Implicit in this approach is an idea of man as essentially good. In this context, the

humanitarian worker will not try to impose form, but rather to share a bond of trust with the interlocutors, who can let their (true essence flow), liberating themselves from the elements that oppressed them.

The maieutic model, which idealizes human nature, has an important corollary in that it also idealizes the humanitarian workers, who are then considered to be the incarnation of goodness. The unique understanding and maieutic attitude that such workers adopt and propose, imply an enhanced and idealized image of themselves and others, diverting their gaze from the catastrophic situations in which they work.

4. The Interpreter: Essentially, the vocation of an interpreter is to interpret everything, to find an interpretation, a cause and a reason behind every behaviour, action and phenomenon. Often, these interpretations also imply justifications in so far as they tend to offer the deeper motives behind the actions. One of the difficulties with this 'ghost' is the confusion between ethical / moral considerations and the intelligibility of a phenomenon. In addition, behind this interpretive "at all costs" stance there is a hidden power dynamic; the worker feels powerful "to be the one who has the right to speak because he/she is the depository of knowledge, …., the one who will not be challenged by the word of the other, but to be the one who *spies* on each word so he/she is able to grab it, to stereotype, to minimize" (Enriquez, 1980, p. 122).

5. The Militant: According to this ghost, the humanitarian worker believes that it is possible to intervene everywhere in order to bring about social transformations. In this role, such workers proceed by somehow comparing themselves to a kind of a prophet,

confirming a rather simplistic idea that evil comes from outside, that everything is due to society, or to the part of society which plays the role of aggressor. Such an implied view casts aside the many complexities of these phenomena, which include the existence of destructive conditions, which give rise to unwilling (and indeed unconscious) connections between dominator and dominated, persecutor and victim of persecution.

During our first training program (in December 1999) for psychosocial counselors in Kosovo (Losi, 2000), a young interpreter pondering on certain events said, "While the Serbs were still here, everything could be blamed on them. Now that young women are disappearing from the streets, we need to accept the idea that there is evil also among us."

It is evident that a Manichean interpretation of dichotomous reality facilitates the creation of an environment that blends relations between the humanitarian worker and those whom he/she assists / rescues, bringing them to an euphoric situation or to a comfortable enthusiasm, blocking their views from a clearer vision of the obstacles that they will have to overcome in relation to the various power relations, including that of their own.

6. The Repairer: This figure shares many aspects with the previous one (the "militant"), but with a substantial difference. Similar to the militant, the repairer perceives society as inadequate and guilty of imperfection, but unlike the militant, the repairer considers that political and social transformations have objectives that are too vague and unrealistic

and, hence, dedicates his/her time directly to those in need in order to repair and improve society.

The repairers' objective is to promote activities by which the community can be reborn, through the reparation of damages suffered. They will sacrifice themselves for others, will not waste time and energy, and will lose themselves in their work, which they see as a true mission. In other words, such workers are not far from being almost missionaries. The repairer "does not want to be identified as a prophet embracing a cause, but, similar to the militant, he/she feels also the temptation of sanctity". (Enriquez, 1980, p. 124). The question that needs to be asked of these workers is who invested them with this mission? Then, will the act of restoring, helping and saving the "victims" not help to perpetuate structures of exclusion? What secondary benefits do those who thus sacrifice themselves receive? It might be suspected that the repairer, through sacrifice, also sacrifices the others, by being immersed in their problems, and "devouring them" with affection. Those who live *within* the sacrifice, also live *through* the sacrifice and *for* the sacrifice. In other words, the repairer, with his/her sacrifice, also sacrifices the others by over-protecting them, regulating their problems, ultimately, alienating them from the reality of their problems.

7. The Transgressor: Although this figure is part of the typology that Enriquez originally proposed in connection with his classification of the educators, it can be adapted fruitfully to situations of humanitarian intervention. Admittedly, the transgressor ghost as a whole is not one that is encountered often in these situations. Yet, it is an important one because elements of it appear more frequently. The fundamental characteristic of this

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model is to favour the emergence of spontaneity, pushing of boundaries and direct or indirect irreverence of the given, the institutionalised, the traditional, the accepted. In the context of humanitarian interventions, this model "expresses a sort of megalomania of being the father, the parent that generates the unknown and promulgates transgression and generalized instability" (Enriquez, 1980: 126-127).

8. The Destroyer: The destroyer ghost functions, essentially, at an unconscious level in interpersonal interactions following the defence mechanism of reaction formation. This means that unacknowledged and repressed desires may emerge to make an individual act in opposition to his/her conscious intentions, beliefs and ideals. According to Enriquez, who refers to Searles (1978), "This kind of desire is present in every affectionately healthy individual," and therefore comes into play in every therapeutic or training relationship. In such relationships, humanitarian workers following their conscious function as "helper of 'unfortunate people' " and their desire to heal them may also activate a reaction-formation according to which they may inadvertently act in ways that cause harm to others. The intention to form and heal can be altered by the opposite desire to de-form, break, and shatter the other.

We can understand this ghost in a more concrete way when we consider the oppositional duality of action by humanitarian workers. On the one hand, they can provide those they help with an incentive for autonomy and encourage them to search for their own resources, whilst, on the other hand, they may also lock them within their own closed interpretative system, leaving them with a regressive situation and dependency. The swing from one to the other polarity is substantial at the external level, yet at the deeper

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unconscious level these polar opposite possibilities are extremely close to each other and the humanitarian worker may unconsciously flip from one to the other.

This brief overview shows that the humanitarian worker is very likely to be possessed by one or more of these ghosts in the course of his/her work, especially if this is conducted under stressful conditions in post-conflict environments. It is therefore advisable that such workers devise conditions within which they can have the possibility to recognize the complexities of these ghosts and endeavor to trace their impact on themselves and on others. Otherwise, by offering their services as "rescuers," such workers are likely to transform their interventions into dangerous situations that perpetuate violence.

Having discussed the various ghosts that condition the rescuers, it is important now to examine the way that these interact with the various styles and attitudes that refugees or other vulnerable people tend to function in such situations. Both rescuers as well as their clients tend to have styles that vary in rigidity. By crossing these two styles we will be able to identify potentially beneficial or detrimental combinations. The general principle seems to be that when both sides have similar styles they would tend to multiply the negative effects of their interaction. For example, when the humanitarian worker's predominant ghost is that of a trainer (characterized by high degree of rigidity) and he or she works with a refugee whose predominant style is that of a fighter, then this particular combination is likely to produce an escalation of the conflictual situation; whereas if a caregiver worker interacts with a drifter refugee, then the latter would accept most willingly the rigidity of his or her worker.

In the table below (Losi, 2004a) the two styles are crossed to indicate the degree of potential positive or negative outcomes of these combinations. The positiveness is marked as plus and the negative as minus.

	Drifter	Hibernator	Fighter	Explorer
Trainer	+	+	---	-
Therapist	+	+	---	-
Midwife	---	---	-	+
Interpreter	---	---	--	--
Militant	+	+	---	-
Repairer	--	--	---	--
Transgressor	---	---	---	-
Destroyer	---	---	-	-

The IOM approach as applied to the Psychosocial and Trauma Response projects

The Psychosocial and Cultural Integration Unit of the IOM initiated and conducted a major project in Kosovo that lasted several years, immediately after the end of the war hostilities. This was called 'Psychosocial and Trauma Response' (PTR) and another project is currently being conducted in Serbia based on the same philosophy but adapted to the new and different realities and specificities. Both projects are grounded on the acute awareness of the complexities discussed above. This awareness was operative at all stages of the projects, from their conception to their final evaluation. Conscious of the dangers of these ghosts, we endeavored not to introduce pre-fabricated approaches and instruments to reach pre-established objectives; instead, our projects began with wide

and in-depth consultation meetings with local resource people along with international experts. These consultation phases produced the specific nature of the projects, which essentially consisted of the psychosocial support to a population traumatized by war and its horrors, through the training of psychosocial counselors. Moreover, the training courses were not pre-planned in an abstract manner and they were constructed on the basis of consultation and feedback within the context of close collaboration between the local resource people, the IOM Unit and the international consultants. We endeavored to avoid the tendency to use exclusively Western European criteria in our training curriculum; that would have meant falling into the contradictions and traps described above. It was on the basis of this awareness and these collaborative consultations that innovative paths emerged which included the use of community theatre work, *Archives of Memories* and the community trans-cultural (ethno psychiatric) clinical approach (Losi 2000, 2002, Kuscu and Papadopoulos, 2002; Papadopoulos, 2002). All these approaches are based on the understanding that trauma cannot be understood and treated as being exclusively a phenomenon that is confined within an individual and within a solely pathological connotation.

The body-community theatre was the first component of the training and was intended to facilitate the trainee counselors address their own traumatic experiences as well as to enable them to develop group cohesion in order to form themselves into a good working group. Specialist trainers encouraged participants to tell their stories of the war in non-verbal ways and gradually these were combined into an actual theatrical production which relied heavily on body expression rather than the verbal medium.

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The *Archives of Memory* took this work further by collecting in a systematic way stories, diaries, drawings, from the wider community with the main aim to deconstruct the rigid narratives of helplessness and to develop enabling alternatives. The methodology used was mainly based on oral history and other relevant anthropological approaches. The trainee psychosocial counselors participated actively (under the guidance of specialist researchers) not only with their own stories but also in the collection and systematization of these stories.

The ethnopsychiatric approach is based on the principles of cultural sensitivity and the active attempt to reconnect communities with their own (often lost or undervalued) cultural traditions of healing. It was used in this project in combination with a systemic narrative approach to enhance our understanding of the complexities of the various overlapping systems and the way dominant stories or descriptions of key events and experiences tended to restrict the potential and resilience of individuals and communities, thus enabling them turn their adversity into positive development. This means that, in effect, the project's overall approach could be called 'ethno-systemic-narrative'.

More specifically, trauma was appreciated as a highly complex systemic concept which could not be limited to the psychiatric Post Traumatic Stress Disorder (PTSD). This understanding can be expressed in the 'Trauma Grid' which outlines the 'consequences and implications' of trauma along with its basic meanings and levels (Papadopoulos, 2004).

To begin with, it is important to consider the different meanings of the word 'trauma'. The common meaning of trauma (in Greek) is wound or injury and it comes from the verb *titrosko* - to pierce. This means that the original meaning of trauma is the mark, the injury that is left as a result of piercing. Papadopoulos' etymological investigations (2000b; 2001a; 2001b) revealed interesting new perspectives: i.e. *titrosko* comes from the verb *teiro* which means 'to rub' and in ancient Greek it had two meanings: to rub in and to rub off, to rub away. Accordingly, 'rubbing in' produces an injury, a wound,, whereas 'rubbing off' or 'rubbing away' has the effect of cleaning up a surface from whatever it was marked on it before, like an eraser erases the writing on a piece of paper. In the reality of clinical contexts as well as in post-conflict situations, the second meaning of trauma refers to the experience of renewal, of the need to reshuffle one's life priorities; people who had been traumatised often express spontaneously this need for looking at life afresh. This means that despite the painful and distressing effects of the trauma, people may also experience that the very power of trauma can also have another impact on them, e.g. making them revise their life's philosophy, appreciating more the fact that they are alive, valuing friendships, assuming a new zest for new activities, etc.

If we were to apply these meanings to the psychological reactions in conflict-situations, we may distinguish the following three categories of possible responses to trauma (Papadopoulos, 2004). People may indeed be traumatized (in terms of being injured or wounded psychologically), or react with renewed energy and zeal for life; in addition, it is also possible that at least with reference to certain functions, they may not be affected at all. For example, certain skills and abilities may not be negatively affected by their traumatic experience. This means that such functions are resilient to change (even of the

negative kind) and they remain intact, despite the power of the trauma. Resilience is a term that has many meanings. Here it refers to those functions and abilities that are not negatively or positively affected by the traumatic experiences.

For completion, it is also useful to discern three sub-responses to the first category (of wound and injury). It could be argued that people respond to traumatic experiences in three possible ways within the context of being injured: (a) by Ordinary Human Suffering (OHS) – for this kind of response, no professional intervention may be necessary; (b) through Distressful Psychological Reactions (DPR) which again may be of a transient nature and they may not require specialist attention. Internal resources as well as appropriate support from their families or communities may help them overcome any negative consequences, again without the need for professional assistance. However, it should not be forgotten that there is a third possible response to traumatic experiences; (c) people may indeed develop diagnosable psychiatric disorders, PTSD being the most common.

Finally, the last category of possible responses to trauma could be called Adversity-Activated Development (AAD) (Papadopoulos, 2004) and it refers to the group of possible positive consequences that can be activated by the very trauma. The relevant literature uses different terms for this type of responses, e.g. Post Traumatic Growth, Adversity-activated growth, Stress-related growth/development, Perceived benefit, Thriving, Adversarial Growth, etc. Essentially, AAD refers to the processes that turn adversity into growth. People who had been exposed to severely traumatic experiences, in addition to their negative reactions, they often also experience fundamental re-viewing

and hence renewal of their lives. Persons say that having come close to death they now value life and close relationships, and they do not wish to waste their lives away but they want to use them in a more consciously positive way than before.

All these three main types of responses (along with their sub-categories) can be observed in individuals but also in families, communities as well as at the level of wider society and culture. This means that if one wanted to examine the implications of trauma in a conflict situation, it would be important to have in mind the totality of all possible responses at all levels, as illustrated schematically by the Trauma Grid (Papadopoulos, 2004) below.

THE TRAUMA GRID

	INJURY, WOUND			RESILIENCE	ADVERSITY-ACTIVATED DEVELOPMENT (AAD)
Levels	Ordinary Human Suffering	Distressful Psychological Reactions	Psychiatric Disorders, PTSD		
Individual					
Family					
Community					
Society/culture					

PHASES OF TRAUMA

As discussed above, the Aggressor/Victim/Rescuer constellation occupied the dominant story in Kosovo, and its pervasiveness did not leave room for other narratives about

either individuals or communities affected by the war. As Papadopoulos (2000b) clearly describes, after an event that caused traumatic experiences, people and the community at large tend to block their wider understanding of events and tend to fix their interpretations of these events on narratives that focus on the traumatic episode/s. Such fixed stories provide people with a certain meaning and identity that enable them to survive. However, such stories tend to be extremely limited in terms of their complexity and they also tend to be highly polarized. They tend to be fixed on the traumatic episodes and hence they tend to undervalue (if not suppress completely) both the periods that preceded and indeed anticipated the catastrophic events as well as the periods that followed these events. Accordingly, the phase when the devastating events occurred seems to remain fossilized and it is this phase that tends to fix the meaning of everything else. This means that the totality of the different phases of trauma is suppressed under the weight of the simplistic narratives of the imposing triangle of conflict (aggressor/victim/rescuer). Yet, as Papadopoulos (2000b, 2001a, 2001b) emphasized, there are at least four phases of experiencing trauma in conflict situations. These he identified as 'Anticipation' (when people sense the impending danger and try to decide how best to avoid it), 'Devastating Events' (this is the phase of actual violence, when the enemy attacks and destroys, and the refugees flee), 'Survival' (when refugees are safe from danger but live in temporary accommodation and uncertainty), and 'Adjustment' (when refugees try to adjust to new life in the receiving country) (Papadopoulos, 2001a, p.6). Schematically, (Papadopoulos, 2000b, 2001a, 2001b), this can be illustrated as follows:

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              Devastating        Survival
                Events
                                                    Adjustment
    Anticipation

Before                                                      After
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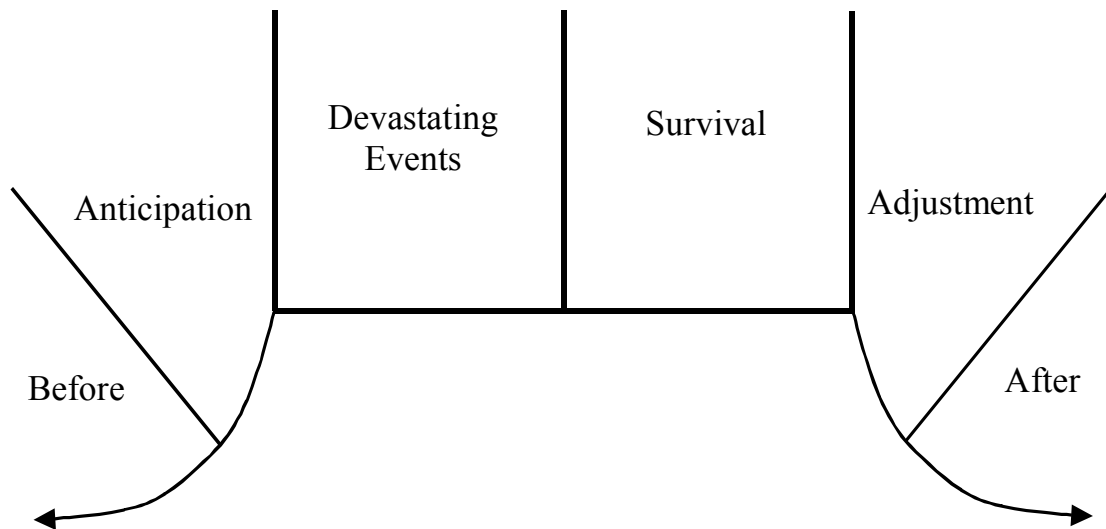
FROM INDIVIDUAL TO COLLECTIVE EXPERIENCES

To be able to help people and communities that have endured these shattering experiences, it is necessary to create conditions that can enable different narratives which, in turn, can empower people to reconsider their current dominant stories (often dictated by the simplistic tyranny of the triangular constellation of conflict), to explore the totality of their pain (not only restricted to one phase of trauma), and to activate their resilience and their adversity-activated development potentialities. However, as the Trauma Grid suggests, this needs to be done not only at the individual level but also at the various other collective levels (i.e. family, community, society, culture). Thus, all these collective forms need to be allowed to move beyond the reduction of all of their resources to the ashes left by the devastating events. They deserve to be treated with the dignity of their potentialities as well as of their suffering.

Therefore, it is important in our perspective to provide the means that these shattered communities be freed from the oppressive simplicity of the conflict triangle and to be enabled to access their resilience and potentialities.

The *Archives of Memory*, as well as the theatre work and performances are some of the tangible ways that offer individuals, families and communities these potentialities. The Archives facilitate the reconstruction of the complexity of the experience (in Kosovo by Kosovars themselves), [1] thus avoiding dominant constellations. They offer the necessary starting points, even in clinical work, to begin re-narrating, and re-story-ing (cf. Papadopoulos 1999b) in the communities and families damaged by unhealed wounds and deaths. The Archives of Memory offered less restrictive and more vital alternatives to the fossilized story, frozen around the dominant constellation, which is maintained by the tyranny of the phase of the devastating events.

On basis of the above, our recommendations to policy makers in post-conflict situations would include the following:

1. Adopt a policy of "selective inclusion" encouraging interventions of national and international actors following approaches oriented to reinforce community residual resources and resilience, avoiding a narrow medical/psychiatric reductionism. All these approaches should be based on the understanding that trauma cannot be understood and treated as being exclusively a phenomenon that is confined within an individual and within an exclusively pathological connotation.

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2. Set up a mixed (national/international) interdisciplinary committee, with the specific task to develop guidelines addressed to define professional criteria for an effective policy of "selective inclusion".

3. This interdisciplinary committee should coordinate the development of a deeper understanding (in the context of the local specificities) of the implications of the triangle of conflict, of the combinations of interactions of ghosts between care-givers and care-receivers, of the Trauma Grid, and of the phases of trauma. Above all, it would be indispensable that this committee ensures that there are sufficient mechanisms for enabling reflection about all these processes, interactions and complexities.

4. Adopt policies linking emergency with long-term capacity building. War, conflict and violence, if not appropriately understood and addressed, will result in long term and intergenerational suffering/pathologies.

CONCLUSION

It is important to clarify that the strong community emphasis of our approach did not exclude or even minimise the individual experience. On the contrary, throughout, in our projects we have endeavoured to locate these experiences in a context within which it was possible for individual experiences to take on culturally shared and appropriate meaning. Individuals are part of stories as well as they create stories (Papadopoulos, 1999b; Losi, 2000a). We not only give sense to our lives through stories, we not only tell the stories of our lives, but our actual lives are the makings of stories. The IOM Psychosocial and Trauma Response (PTR) approach (which includes the Archives of Memory) enabled the emergence not only of forgotten, repressed and unspoken stories

but also of stories that were not even thought of before. Stories that often no one had asked anyone to tell stories in the making, stories that were part of other stories, stories unimaginable. Stories that can cause pain and stories uplifting that can heal profoundly the wounds of the spirit. It is within this perspective and in this spirit that the PTR projects emerged and need to be appreciated.

Finally, it is worth remembering that countries and communities, as well as families and individuals, need help when they attempt to cope with very difficult circumstances. However, the pressures of the post-conflict situations make it difficult to seek and create the best possible conditions for this help to be offered. It should not be forgotten that if such help is inappropriate, then it is likely that it may (inadvertently) worsen the situation and contribute to furthering the conflict and suffering instead of ameliorating them.

According to our perspective, emergency and post-conflict interventions, in the field of mental health, should adopt approaches based on the understanding that trauma cannot be understood and treated as confined within an individual and within an exclusively pathological connotation. Interdisciplinary action-researches are needed to identify the best combinations of tools/approaches, which are culturally-appropriate in order to reinforce resilience and stimulate further Adversity-Activated Development. In our experiences, sensitive combinations of body-community theatre, "Archives of Memory" within an ethno-systemic-narrative oriented approach to clinical work, have proved to provide effective responses with long-term benefits in post-conflict situations.

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CHAPTER 13

ROLE OF MIGRATION IN POST-CONFLICT RECOVERY

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ABSTRACT

The number of migrants, refugees, and civilian returnees in the world is considerable and has increased greatly in the last ten years.

Each phase of the migratory process is characterized by numerous social-environmental circumstances that jeopardize mental health adjustment. Certain risks related to migration (i.e. the goal of migration, geographical and cultural distance from the country of origin, social support, loss of social status, and others) play an important role in the onset of psychiatric disorders. Protective resiliency factors protect mental health and rely on individual characteristics and the conceptualization and realization of the migratory project.

Scientific studies reveal the high prevalence of psychiatric disorders among those immigrants submitted to loss, oppression, torture, and other forms of organized violence. Those subgroups of migrants forced to leave home and exposed to the trauma of war manifest high long-term morbidity. Moreover, post-migratory experiences (deculturization, loneliness, exposure to triggering stimuli, loss of identity and social status, racism, and discrimination) may worsen the situation and result in powerful re-traumatization.

Countries that grant asylum should construct a service network providing trained reception personnel, adequate medical assistance, suitable lodging, as well as accurate and rapid procedures to recognize refugee status. It is extremely useful to promote meetings between fellow countrymen, in order to protect cultural identity.

Forced migration should be avoided, and native countries should minimize the risks of exile protecting civilians, giving priority to relations with humanitarian Institutions, and favoring evacuation into the internal regions of the refugees native country rather than their escape out of the country. Governments should promote psychiatric prevention programs**,** facilitate contact with expatriate populations, and endorse specific repatriation programs. Repatriation not only protects individual mental health, but also improves the country's socio-economical conditions and social capital.

THE MAGNITUDE OF THE PROBLEM

The number of migrants in the world has increased considerably in the last ten years and continues to increase; International Organization for Migration (IOM) for 2003 reports approximately 175 million migrants (2.9% of the world's population) and, by the year 2050, 230 million are expected. These figures do not include large numbers of undocumented migrants; the total population involved in migration is even larger if we consider the families and communities the migrants have left behind.

According to the United Nations High Commissioner for Refugees (UNHCR), at the beginning of the year 2003, refugees in the world were 10,4 million, and the number is continuously increasing. They are mainly hosted in Asia, Africa and Europe. Once again, these figures do not include undocumented migration and some countries that do not record all entrances. In the year 2003, the UNHCR calculated that persons of concern (including refugees, internally displaced persons and a certain number of returnees) were 20.6 million. Furthermore, the population of civilian returnees is considerable and increased from 500,000 in 2001 to about 2,500,000 in 2002.

MIGRATION AND MENTAL HEALTH

Migration is a complex and heterogeneous process comprising both pre- and post-migration events; it begins with pre-migratory experience in the native land and continues through migration itself and first adaptation in the land of destination, ending with long-term post-migratory experience.

Migration from developing countries is composed of a series of intense difficulties and barriers. Hence, migrants have to be dextrous, courageous, motivated and healthy persons to overcome these challenges. Their resources have a protective role in migrants' mental health and, along with other individual characteristics (gender, age, status,

personality, biological characteristics, coping styles, expectations, attitudes, moral values and personal resources), they constitute a solid base to protect the migrant in the first stages of migration. This form of selection is applicable to the so-called "*pioneers of migration*"; in other words, those that first decide to migrate are highly motivated. This condition ceases to exist in successive migratory waves (for example, in family reunification) and for refugees, i.e., people driven from their native land forcibly, either chased by others or escaping dangerous conditions.

Each phase of the migratory process is characterized by numerous, variable and interactive social-environmental circumstances that can seriously jeopardize mental health adjustment. The migratory process reveals the remarkable individual differences in the vulnerability of migrants that depend on their pre-migratory migration experience (Mazzetti, 1996).

Risk Factors

A wide range of factors make it extremely difficult to trace a psychopathological and epidemiological profile of immigrants and identify related risk factors. An analysis of evidence on migration and mental health (Bhugra, 2004) further complicates the picture by describing numerous methodological limitations (such as different samples from ethnic and migratory viewpoints; different research and assessment settings; lack of long-term studies) that lead to contrasting data and to difficulty in extrapolating and generalizing. Recent studies have shown higher rates of certain psychiatric disorders among immigrants (for example, schizophrenia) and lower rates for others, as compared to the non-immigrant population. Overall, however, it appears that immigrants with time tend to regress towards the mean, i.e., achieve a mental health profile closer to that of the hosting population.

What emerges from the scientific literature is compatible with our research and clinical experience, i.e., some migrant subtypes have a higher risk for becoming mentally ill, inasmuch they are exposed more to some contextual characteristics, which increase risk, and in turn, explain the higher prevalence of certain mental disorders.

Although the potency of various risk factors and their interaction are presently unclear, certain variables related to migration seem to play an important role in the onset of psychiatric disorders. The goal of migration appears to be one of the most significant risk factors. In the case where departure from the native land is voluntary and organized, there is an objective, desire and the expectation of a better life, in other words a solid pre-migratory preparation, the subject's resilience increases. When migration is forced and there is no planning, the subject is left with only the strength to escape, migration has an unfavorable impact.

Psychological distress increases when pre-migratory expectations are unmet, and the project cannot be realized. Geographical, but more so, cultural distance from the country of origin, determines "*transculturalization stress*". For example, the transition from socio-centric societies (in which personal identity is mainly determined "to be part of a group") to ego-centric cultures (as in most western cultures are, where identity is based upon personal characteristics and achievements), can traumatize and provoke what anthropologists call "*culture shock*". Transitions from rural to urban settings can also cause culture shock.

The presence of family members or people from the same ethnic group or cultural background remarkably increases social support, a buffering factor that protects against stressor reactions. However, the same presence may constitute an obstacle to social integration if the relatives and friends are not motivated to overcome cultural gaps

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between their land of origin and that of destination. This phenomenon can be observed in the second generation of migrants, when the family imposes their native land's life style and rules that hamper the natural social integration of the second- generation youths in the hosting country.

The loss of social status is related to the frequent phenomenon of overqualified persons carrying out an underqualified job and is accompanied by economical and housing difficulties in the hosting country, which can damage self-esteem and determine distress. The migrants' health status can also be negatively influenced by the loss and/or grief for what has been left behind.

Among vulnerability factors, individual characteristics also play an important part (figure 1):

1. Fragility of the person, that is, a personality unskilled to cope with stressors/difficulties, and to build satisfactory relationships;

2. Fragile and/or rigid cultural identity, that is, a personality with a weak identification with the culture of origin, leading to an inadequate basis to deal with the new reality, or with a strong and rigid identification with that culture that impairs the flexibility needed to cope with the new environment;

3. Pre-migratory psychiatric morbidity: these characteristics, apart from being pathogenic, may lead to failure of the migratory project.

These characteristics, apart from being pathogenic, may lead to failure of the migratory project. Factors such as trans-cultural stress (the impact with a new and different social environment), loss of social status, lack of or inadequate social support (for example, when family and community support the individual but prevent him/her from integrating within the host culture) can interact with individual factors to negatively affect the outcome of the migratory project.

Resiliency Factors

Resilience factors (figure 2) rely on individual characteristics. These are elements related to the individual's personality, as well as the solidity and flexibility of cultural identity (that is, solid identification and affiliation to their native culture along with the ability to understand and handle the cultural mood of the hosting country) and excellent pre-migratory mental health. Another factor depends on how the migration process/project is carried-out. It consists of motivations that lead a person to migrate, that are powerful elements of psychological support. Other factors, those that provide meaning to an individual's life, allow the migrant to keep two self-images of the individual's life united (pre and post-migratory self-images), thus avoiding a break in the continuity of the existential pattern. A migration project foresees the future, and is prepared for it, is very positive. The more the project is realistic, the more it is successful as the migrants adapts to life in the hosting country. Individual characteristics positively influence the conception and realization of the migration project. Furthermore, social support (family and friends that sustain the individual during migration) plays a protective role.

FORCED MIGRATION AND MENTAL HEALTH

If the criteria of Figure 1 and 2 are applied to refugees or to those asking for political asylum, a high number of vulnerability factors exist. The traumatic experiences of a refugee can severely damage individual characteristics, especially if he/she is a victim of violence or torture. Systematic violence damages the human personality by destroying coping mechanisms and upsetting personal relationships with others.

The effects of the refugee experience on cultural identity can be severe. Focusing on patients with posttraumatic stress disorder (PTSD) reveals a reduction in their personality and cultural repertoire. The effects of systematic violence on personality were masterfully described by the later Italian writer, Primo Levi, a victim of the Nazi

concentration camps, much before the description of PTSD became fashionable among psychiatrists. His description of life in Auschwitz in his novel: *If This Is A Man*, introduces the phenomenological experience of those victims of violence better than any scientific work.

> Imagine now a man who is deprived of everyone he loves, and at the same time of his house, his habits, his clothes, in short, of everything he possesses: he will be a hollow man reduced to suffering and needs, forgetful of dignity and restraint, for he who loses all often easily loses himself (…) It is in this way that one can understand the double sense of the term "extermination camp", and it is now clear what we seek to express with the phrase: "to lie on the bottom."

And further ahead:

> We would also like to consider that the Lager was pre-eminently a gigantic biological and social experiment. Thousands of individuals, differing in age, condition, origin, language, culture and customs, are enclosed within barbed wire: there they live a regular, controlled life which is identical for all and inadequate to all needs, and which is more rigorous than any experimenter could have set up to establish what is essential and what adventitious to the conduct of human animal in the struggle of life.

Levi describes what the ethnopsychiatrist François Sironi (Sironi, 1999) calls *universal reduction,* that is, separation of an individual from his own people and all human beings.

Competently described by the French novelist Daniel Pennac "…torture is not only inflicting pain, it consists in devastating a human being till separating him from human species, nothing else but howling solitude…"

In the last decade, torture, and the political application of systematic violence in genocides in Cambodia, ex-Yugoslavia and Rwanda have in many individuals achieved these results. Human beings have been separated from their humanity by destroying their culture, because humanity is expressed through culture.

Scientific studies have revealed the high prevalence of psychiatric disorders among those migrants submitted to oppression, torture and/or other forms of organized violence

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(Steel, 2002). Post-migratory experiences can worsen this situation. Social distress and psychiatric symptoms can deteriorate in the hosting country. Epidemiological studies reveal that PTSD and depression (often associated with grief) are the most frequently occurring diagnosis in refugees, regardless of cultural background. Prevalence rates are much higher than in non-traumatized populations (Mollica, 1999).

Cumulative exposure to trauma (torture, violence, forced to leave home, shelling or shooting at close range, threats to self or significant others) corresponds to the progressive increase in psychiatric morbidity (Mollica, 1998; Turner, 2003), consistent with the vulnerability of those chronically traumatized before their migration experience. Among those refugees from countries in war, multiple exposures to traumatic events over time is very high (Turner, 2003).

Victims forced to migrate are void of any migratory project. In the majority of cases the choice of country in which to ask for asylum is dictated by contingency and not by favorable opportunities. Among refugees, loss of social status is the rule; many leave behind a successful life-style and excellent employment (health professionals, teachers, etc.). Many have difficulties having their qualifications recognized in their new hosting countries (Burnett, 2001). These populations have experienced a loss of their native land, their social world and death of significant others. Social support and understanding is often missing in the hosting country. The refugee is often alone, and not in a country of his/her choice. This is a very common situation in Italy. On the other hand, when a refugee escapes into the countryside or into a neighboring country in a group, his/her companions, who are also traumatized and suffering, cannot provide each other with social and psychological support.

A refugee is considered a migrant whose risk factors exceed their resilience factors. In these conditions, migration can prove to be a powerful re-traumatizing agent, leading to serious mental health problems.

MIGRATION AND RE-TRAUMATIZATION

The few studies that exist on post-exile factors influencing psychiatric morbidity of refugees agree that psychiatric symptoms increase after the arrival of refugees in the hosting country. Among different refugee populations, pre- and post-migratory factors interact in a complex manner to cause the onset of serious psychiatric disorders (Steel, 1999; Turner, 2003). However, some refugees who are exposed to the terrible experience of war are sometimes able to overcome migration-related difficulties when they find favorable conditions and adequate social support in the host country; and they may even contribute to the development of the hosting country.

In contrast, lack of adequate reception programs and poor contact with their family and homeland can reduce adaptation. Furthermore, difficult access to health service aggravates the health of migrants from war areas. Reception and health services in the hosting countries are often unprepared to cope with the migrants; personnel is often untrained, and will not look after these patients psychologically, especially if they are unable to ask for assistance (Burnett, 2001).

The mental health of refugees (and those who seek asylum) is often jeopardized if they are re-subjected to the violence they had escaped in their native land, including racism and discrimination. This may result in a powerful re-traumatization. An individual who has suffered trauma will be easily re-traumatized if exposed to stressors. For example, soldiers who have suffered traumatic disorders in battle cannot be sent back to the front

to fight, because their symptoms will surface again when faced with even minor stressors.

Migration is a traumatizing event, composed of three main parts:

(1) Deculturalization: deculturization stress is deep and violent when the migrant has a cultural identity crisis because he/she has been stripped of their culture by violence, social upheaval and/or torture.

(2) Social Loneliness: Often those who have asked for asylum are lodged in places with others whose legal status as an asylum seeker is their only common denominator; they have to cohabit with people who do not speak the same language and who do not understand each other's habits. This enhances the perception of isolation and alienation from the surroundings. This is a retraumatizing event for those who have lost social contacts with family, friends and intimate relations.

In a study on Iraqi refugees, the different social situations during exile, in particular the levels of emotional social support, had a major association with PTSD and depression. Lack of social support resulted in a stronger form of depressive morbidity than traumas the refugee had experienced at home (Gorst-Unsworth, 1998). Major risk factor for psychiatric disorders is separation from family (Turner, 2003). Difficult living conditions and isolation have also been associated with higher levels of depression among refugees.

(3) Exposure to Triggering Stimuli: the first human contacts for migrants in the hosting country are usually soldiers or the police. The sight of uniforms for individuals with increased arousal and anxiety, typical of PTSD, can provoke violent anxiety reactions. The places and conditions where refugees are lodged during their first period in the hosting country are often similar to detention buildings (isolation, barred windows, often former prisons), and may induce retraumatization in subjects who have already been

isolated in their homeplace (Silove, 2001). However comfortable the lodging, locked doors, the noise of cell doors closing and the sight of uniforms can evoke strong traumatic memories (Burnett, 2001). The procedures for people asking for asylum (repeated interrogation, often with overt expression of mistrust on behalf of the hosting country's officials) can represent a repetition of a prior situation, detention and interrogation by the military forces in their native land. One must not forget that this occurs under conditions of emotional difficulty; political asylum is a complicated procedure and is characterized by the continuous terror of being sent back home (Sinnerbrink, 1997).

Similar considerations may apply to apparently harmless procedures such as a medical consultation, where a naked body among dressed ones, to be examined by strangers, can provoke anxiety attacks among those who have previously been tortured.

Repeated deculturization trauma, isolation, the threat of separation, and stimuli that lead to reexperiencing past terrifying events, increase the risk of severe mental disorders that hamper adaptation in the hosting country and have long-term disabling effects.

THE PRINCIPLES OF BEST PRACTICES

As Plato states, "A foreigner separated from his fellow citizens and family should receive more love from men and Gods." Retraumatization through forced migration should be avoided; vulnerability factors will not dominate resiliency factors. At this point, mental health management depends not only on the mental health personnel, but mostly on adequate social interventions. We may group working indications according to issues (summarized in figure 3).

Countries That Grant Asylum

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Reception Personnel

The first welcoming committees should be composed of civilians, not military forces or police, even if the latter are often well trained to face the situation, since their view could trigger anxiety reactions among PTSD patients.

The personnel must be efficiently trained to handle the complex relational stimuli of asylum seekers. For example, sudden dysphoric crises and controversial statements are not a sign of an aggressive personality or an attempt to lie, but could be a sign of psychic illness. All asylum seekers must have counseling aimed at screening people at risk for psychiatric disorders. An active offer of help is fundamental, because those affected by PTSD or certain forms of depression do not ask for help, as this is part of the clinical picture of their disease.

Medical assistance must be provided, and the doctors, as previously mentioned, must have relational skills. When a subject who has been tortured is seen by a doctor the risk is present for severe anxiety reactions, hence, the doctor and his assistants should be careful not to induce them inadvertently.

Reception lodges

Apart from basic services, the building must be in the midst of peaceful surroundings; it must be a place where the refugee can create his/her own corner, where he/she can rest. We often meet migrants who suffer from insomnia; at night increased arousal determines frequent awakenings and anxiety attacks.

Asylum seekers are often forced to live in overcrowded surroundings, hearing people coming in and going out and slamming doors. These people live in surroundings whose activities are not under their control. Obviously prison-like environments must be

avoided. The countries that grant asylum must have clear, comprehensible, accurate and rapid procedures to recognize the refugee status (in Italy, in 2004, one can wait up to two years for an answer).

The personnel that compose the Commissions that grant asylum must be trained to understand the difficulties subjects will have in telling their story. Among victims of torture, possible contradictory statements may only be a sign of transient disorientation, not lies. In our experience, some people were refused refugee status because they were unable to correctly reconstruct their story.

Subjects seeking asylum should have the opportunity to be accompanied by someone whom they trust; this is granted only to children in Italy. With someone to share this delicate phase, the asylum seeker can have the emotional impact of interrogation alleviated, the impression of having a police interrogation reduced and sense of social support strengthened. The bureaucratic procedures for reunification of the family must follow an easier and quicker path in comparison to what happens to other migrants: this must occur as soon as is possible.

People seeking asylum should be informed at the beginning since the beginning of the bureaucratic procedures about the advantage of having an appropriate medical or psychiatric certification to go with their audience with the Commission that grants asylum; and they should be informed about how to obtain one.

The primary aim of services is the promotion of protected socialization. This can be reached in different ways: discussion groups that aid the subject to reappraise past experiences, group activity such as art therapy, language courses with teachers that are aware of how migrants' distress can lead to learning difficulties. The refugee must be

reassured that any difficulties are normal reactions to abnormal situations and not a sign of weakness.

Ongoing mental health monitoring of the refugees can lead to immediate therapeutic interventions when necessary. Mental health should focus on:

(1) Construction of services network: The refugee needs various types of services, such as medical, psychological, social and legal services, instruction courses, the possibility to be accompanied to work, the search for living quarters. These services must be organized as a network so as to facilitate the refugee in establishing social relationships and preserve his/her mental health through ease at "going along pathways" and breaking social isolation. The optimal solution would be that a professional figure (social assistant or such like) to accompany the refugee.

(2) Protection of cultural identity: It is extremely useful to promote meetings between fellow countrymen, but only if the social and political conditions of the hosting country and individual health conditions will permit. This will strengthen or restore the sense of belonging to a community. Parties, cultural activity by small groups, the support of their native country, obviously if new political conditions, different from those that pushed the refugee outside from his/her country, are established, will be fundamental, mostly if repatriation is planned.

NATIVE COUNTRIES

Many governments consider future exiles, refugees and asylum seekers as enemies: this attitude can reduce and damage the possibility to implement the following suggestions.

Even with this awareness, it seems useful to know which are the best practices to promote:

(1) Minimize the risks of exile: We are all aware of the fact that recommendations have a limited value when applied in a country at war. In this unsteady situation it is difficult to imagine protecting refugees, but in any case we think this is important. Often a simple change of mentality can yield favorable results. If the government of a country at war remembers that its human capital is its most important capital, then it can start thinking of its refugees.

This means priority for the protection of civilians must be given, such as favoring evacuation into the internal regions of the refugees' native country rather than favoring their escape out of the country. Priority to relations with humanitarian Institutions must be given to protect the evacuated populations, facilitating those projects that not only protect individual and physical survival but that also protect socialization.

(2) Promote primary (early detection of subjects at risk, adoption of risk avoiding behaviors, and promotion of healthy life-styles), secondary (treatment of the disorder and reduction of its probability of relapse and/or recurrence), and tertiary (reduction of the impact and consequences of the disorder and social integration strategies) psychiatric prevention programs. In particular, favor assistance programs with strategies aimed at mental health; promote prevention of psychiatric disorders among populations at risk, prevent immediate crisis for traumatized populations (by offering information on events and on "normal" reactions, provide early diagnosis of illness and the care.

(3) Promote contact with expatriate populations; this entails cooperation with projects we previously discussed when dealing with *countries that grant asylum* (protection of

cultural identity). This not only will be of great help to possible repatriation but also to the individual mental health, the perception that their native land still exists, that the condition of its citizens in and out of the country is important, can be decisive to protect cultural identity and break the state of social isolation. It can consist of information on the refugees' native countries, organization of contacts with family and friends, formation of discussion groups and other forms of social events, cultural, religious etc.

(4) Facilitate specific repatriation programs: Repatriation not only protects individual mental health, but also the country's socio-economical conditions, by aiding the country in regaining its fundamental human capital. With the aid of international organizations and NGOs, repatriation must not only emphasize logistic aspects, but socio-cultural aspects. The aim must not be the mere return of populations to their homeland, but also the construction of a social network and the rebuilding of a cultural basis for everyday life, paying attention to the needs of specific groups, such as women, elderly people, children and adolescents. Today, experience and scientific literature can help organize this type of program.

It is useful for those who in one way or another care for migrants, to remember that assistance to these people is, as Plato says, a humanitarian issue. It is investing in the future, for those countries that grant asylum, and for the native country that allows repatriation. Every country is interested that their fellow citizens be healthy, solid and in condition to contribute to the life of their homeland.

RESEARCH ISSUES

Taking into account existing information on migrations, forced migrations, and mental health, three main future research areas emerge:

(1) Longitudinal studies on migrants' mental health: most existing evidences comes from research on selected groups of migrants, in which some socio-demographic features are related with mental health status, but there is a lack of follow-up information. What is needed are longitudinal studies to evaluate (using standardized assessment instruments) the health status of the same sample in relation to the factors suspected to be relevant in protecting or impairing mental health.

(2) Long-term studies on refugees' and asylum seekers' mental health. Longitudinal studies are needed, to study refugees' and asylum seekers' mental health in relationship to the reception by host countries.

     (3) Qualitative studies to focus on the phenomenological experiences of migrants: qualitative studies to determine how they experience their lives, their psychological needs, and those psychosocial supports that are most conducive to their health and well-being.
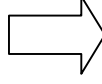
FIGURE 1

MIGRATION AND MENTAL HEALTH

VULNERABILITY FACTORS

INDIVIDUAL CHARACTERISTICS
Frailty of the self
Fragile cultural identity
Rigid cultural identity
Maladaptive attachment styles
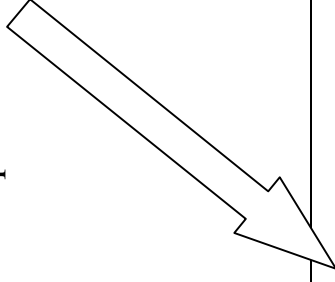Ineffective coping styles
Pre-migratory morbidity

MIGRATORY PROJECT
Absent (forced migration)
Failed (risk of failure)
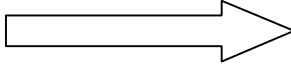
OTHER FACTORS
Transcultural stress
Loss of status
    Homesickness, grief
SOCIAL SUPPORT
- Absent
- Inadequate

PSYCHOLOGICAL DISTRESS

SOCIAL EXCLUSION, OSTRACISM

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FIGURE 2

MIGRATION AND MENTAL HEALTH

RESILIENCE FACTORS

INDIVIDUAL CHARACTERISTICS
Solid individuality
Solid cultural identity
Flexible cultural identity
Effective attachment styles
Effective coping styles
Pre-migratory health

through

MIGRATORY PROJECT

PRE-MIGRATION
- Pre-migratory preparation
- Pre-migratory will to emigrate
- Realistic expectations

POST-MIGRATION
- Post-migratory project achievement
- Effective post-migratory working-

EFFECTIVE SOCIAL SUPPORT

MENTAL HEALTH

SOCIAL INTEGRATION

FIGURE 3

FORCED MIGRATION: PRINCIPLES OF BEST PRACTICES

I. COUNTRIES THAT GRANT POLITICAL ASYLUM

Choice/training of reception personnel
Adequate reception camps
Procedures to grant asylum
- clear, comprehensible, accessible and rapid
- a commission trained in dealing with psychiatric disorders of people applying for asylum
- escorts during interrogation sessions
- facilitate family reunification

Organization of services
- socialization
- psychological condition monitoring

Construction of services network
Protection of cultural identity

II. NATIVE COUNTRIES

Reduction of number of exiles
Promotion of psychiatric prevention programs
Contact with expatriate populations
Specific repatriation programs

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CHAPTER 14

THE ROLE OF NON-GOVERNMENTAL ORGANIZATIONS IN POST-CONFLICT RECOVERY

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ABSTRACT

Non-governmental Organizations (NGOs), and organized civil society associations in general, are indispensable interlocutors in identifying and tackling the needs of the most vulnerable and marginalized people. This chapter presents an overview of the role of NGOs, as an expression of civil society's reaction to those whose who have suffered the devastating effects of war.

The work of NGOs in emergency situations over the years has been characterised by a concrete and professionally qualified presence, aimed at protecting the most vulnerable by encouraging contacts between institutions and populations via specific, targeted and visible actions. The complexity of the problems to be dealt with time after time has increasingly demonstrated that such measures are insufficient.

NGOs may only assume a relevant, irreplaceable and concrete role when, in addition to specific action, they offer public opinion an exact and substantiated reflection on the root causes of poverty, injustice and social exclusion. This dual approach of action and condemnation is the framework in which NGOs should define, plan, implement and evaluate their work, in order to be valid social actors capable of contributing to a culture of justice and peace.

NGOs AS A PART OF CIVIL SOCIETY: A NEW ROLE TO ACHIEVE A SIGNIFICANT PRESENCE

In many countries, non-governmental organizations (NGOs) are the part of civil society, which at various levels works with the most vulnerable sectors of the population in situations of social and politico-military conflict. In such situations NGOs have always strived to promote and organise a working approach based on the most serious and apparent social problems. Therefore, they provide an opportunity for those who wish to take part in the processes of change regarding the most problematic global issues, starting with a needs assessment that defines the social, healthcare, cultural and economic context. Over the years they have increasingly taken on a role that is geared towards development as well as aid. While NGOs have traditionally been considered as organisations that are able to act in timely fashion, they have also developed a social and political identity that has led them to interact with institutions on the one hand, and with the causes and most serious aspects of the issues they deal with on the other.

Their role, based on their ability to draw up and plan specific projects on behalf of local populations in the poorest countries by taking advantage of a methodology of cooperation, has turned NGOs into important and historically significant interlocutors that have a permanent presence in theatres of humanitarian action. This chapter will be limited to a reflection on NGOs that intervene in humanitarian emergencies caused by wars or environmental disasters, based on an awareness that NGOs are extremely varied and encompass many different ways of undertaking civil participation.

NGOs are involved in such fields of operation as development, education, water and land protection campaigns, large-scale vaccination programmes, and publishing and printing activities aimed at guaranteeing freedom of speech. We wish to reflect on the thorny

issues regarding a precise intervention model, with consideration of its role in the light of conflicts that, through violence and destruction, have led to breakdowns in social relations and injustice.

CURRENT ISSUES REGARDING NGOs IN EMERGENCY SITUATIONS

For a long time public opinion regarded NGOs as organisations consisting of groups of volunteers which, motivated by a deep sense of solidarity, helped men and women in emergency situations. In most cases, technical expertise (engineers, nurses, agricultural experts) was deemed sufficient to ensure management of certain specific projects that aimed to provide an immediate and appropriate response in social and healthcare terms and to improve the quality of people's lives. But what was left after the initiatives were implemented? What did they represent for the future? How could these projects sustain local resources?

NGOs have posed these key questions within the context of conflicts which has obliged them to review their role both in terms of the various capacities to be acquired (e.g. peace-building) and regarding the political role that they have inevitably been obliged to play. NGOs are called on to assess the way in which they operate during conflicts, the extent to which they are involved and, inevitably, how they form part of them. In recent years, for example, certain interventions defined as "humanitarian" have been closely linked – and even at the service of – military interventions. This has aroused many doubts and questions regarding the means of operation and reasons for the presence of NGOs and international organisations in post-conflict emergency situations. NGOs must inevitably give answers that go to the very heart of their mandates and roles. Should they

simply provide assistance and first aid initiatives, or should they take part in processes aimed at dealing in the long term with the causes that have led to emergency situations and conflict in an area? Is it enough to heal the wounds, or should these wounds be healed by condemning what causes them so as to prevent them being reopened in the future?

A Reflection That Concerns Everyone

Providing only aid runs the risk of creating chronic emergency situations and absolving the responsibility of politicians and institutions regarding the real problems faced by populations. The total delegation of responsibility for managing social problems to NGOs, even though in an emergency situation, reveals how people's problems are secondary compared with political problems. This entails the risk of not tackling the root causes, but rather accepting a mechanism that makes further emergencies sustainable given that there are people ready to manage them. Moreover, with an entirely political approach there is a risk of bypassing the problems that people are facing. In actual disaster situations people often have to manage complex emergencies without the support of any organisation. In the face of hunger, violence, poverty and illness people have to find the necessary courage and wherewithal to act.

Many NGOs have adopted a rationale borrowed from social and healthcare services. In the face of serious emergency situations first aid is a necessary phase, which must be ensured with any available means or facility, but at the same time obviously it cannot suffice.

"Humanizing humanitarian aid" is the mission of NGOs that wish to go beyond a mere relationship of functional subsidiary and regain ownership of the ethical value of participation. This is the challenge we are facing. Otherwise, one risks indiscriminately using the same working methods and intervention processes over and over again when faced with disasters. This method is apparently efficient in the short run and undoubtedly ensures achievement of certain minimum objectives that define the scope of intervention and reassure the organisational and economic components for those who propose them. However, it runs the risk of wasting the human assets, which should characterise the specific expression of civil society that is represented by an NGO. An NGO fulfils its mission if, through its organisational methods and strategic choices, it is able to complement governmental structural initiatives. However, in order to achieve this it must be able to develop specific and alternative strategies.

Some Operational Considerations

NGO presence should envisage planning with local collaboration rather than theoretical planning. Planning policies should meet the administrative requirements of financial backers, but such policies should constitute a tool for the NGO rather than a constraint. With expertise and experience, via careful analysis, an NGO should be able to assert the need to set up projects that are created on the spot and which are developed and amended through comprehensive and ongoing dialogue with local interlocutors.

Studies and target groups should be identified by focusing on people's everyday lives as the principal tool of analysis. While there are disaster intervention procedures that are shared by all NGOs, it is also true that only encounters with and the involvement of

people in defining operational aspects render them genuinely effective. NGOs may become a resource for local areas if they are able to listen to them by creating opportunities for assessment. They must also learn to make use of the institutional and informal networks that comprise them, and which are attempting to respond to manifest needs. Only in this way can NGOs avoid wasting their potential and succeed in becoming stable and significant actors for the whole social system, which may also reap immediate benefits from their actions.

In this sense NGOs have become players who, by "doing", promote an effective educational methodology that is capable of bringing local elements back into the limelight. The business of NGOs is not to replace but to facilitate and accompany what is happening in a local situation.

Some of the projects drawn up with social coordinators for the benefit of Rwandan widows just after the 1994 massacres still provide a forum for meeting and solidarity among various ethnic groups. Patient mediation efforts have given rise to a project which, starting from sustainable and credible agricultural production of staple items, has been able to accompany the social process of reconstruction and meetings between people who lived through - from different standpoints - the same tragedies of genocide.

What emerges from this analysis is the complexity of the work of NGOs, which cannot be managed by creating projects that underestimate it. Such complexity needs to be tackled with a planning concept that is able to reshape itself in terms of the needs that emerge and the working prospects that are identified. In this way local elements should

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be identified and appreciated as privileged partners, by taking advantage of their skills and investing in them. Such elements include social and healthcare institutions; voluntary associations; work cooperatives; municipalities; organised groups operating locally; and initiatives – even small ones – that are striving to provide responses. NGOs should bring out their abilities by building relationships based on trust, with patience and professionalism. Local actors should be the first planning resource to make use of, supported – where necessary – by technicians and experts. The skills that emerge constitute sure and undeniable added value only when combined with a long-term planning process that provides for investment in training, and not just the mere exportation of decontextualised working methods. The history of humanitarian aid is full of examples of great but unsustainable works and grand projects disconnected from everyday reality, which are feasible in terms of visibility but highly ineffective for a local area that wishes to invest in its future.

In terms of methodology this implies interpreting a local area and its needs which reveal themselves over time, by meeting people, getting to know the social networks that comprise it and delving into its history and prospects without being satisfied with sociological interpretations and statistical data that fit every situation. Such patient efforts enable identification of clear, defined and sustainable work goals that can be connected into an effective and functional network. This hard and unseen work turns a humanitarian operator into an expert in "humanity". Not just someone who implements projects but rather a facilitator of processes in which he or she is one among many other actors.

EXPERIENCE IN MITROVICA, KOSOVO

Between March and June 1999 we witnessed a terrible and violent war that had a huge media impact. The war in Kosovo captured the collective imagination in a devastating fashion. In three months more humanitarian aid and NGOs poured into Kosovo, a region just over half the size of Belgium, than went to assist the large-scale crises in Africa. The options taken by Western nations show how the "Kosovo" problem was not exclusively humanitarian in nature, but also had a strategic and political relevance that inevitably affected the choices made by governments involved in the matter.

NGOs went there immediately and were immediately obliged to deal with and operate on several fronts: military, ethnic and religious, economic, political and social. For many NGOs choosing to be present represents the ethical requirement to say no to war by being on the spot, as a sign of sharing with and closeness to a civilian population that is a predetermined victim of political schemes.

Such presence is therefore strategic, with a view to working effectively, given that many NGOs' projects are aimed at providing psychological support, rebuilding relations between people, and bearing witness by sharing in everyday life through simple actions and choosing to pool experiences of poverty, solitude and the sense of helplessness. Many operational decisions were made and, while in general public opinion focused on the larger agencies' programmes, it should be pointed out that great efforts were – and still are – made by small NGOs that have remained to tackle the aftermaths of emergency situations with people who are still impacted by the social and human disasters that a terrible experience such as war entails.

Therefore, if they are to be significant actors, NGOs must deal not only with the problems of "here and now" but must also assess and consider the consequences and sustainability of their actions "afterwards", when the spotlight of public interest has faded, while tragedies remain.

A Significant Experience

The aim of the Mitrovica project was to work with the most vulnerable families. Vulnerability criteria were recorded through interview and home visits, and often highlighted the impossibility of accessing humanitarian networks. The presence of the elderly, the disabled and those traumatised by war prevented families from easily accessing the humanitarian aid system. This approach enabled us to define working methods that we believe can help to make actions in complex crisis areas more efficient.

Presence

NGOs should have a living local presence. They cannot do without relations with the actors with whom they must operate, nor dispense with an examination of their experience. In Kosovo a choice was made to live with the people, in the same houses and with the same problems of lack of running water and electricity, enduring the same transportation difficulties and experiencing the same atmosphere of insecurity.

Presence enables getting to grips with the problems. A critical interpretation of a local situation takes place within the context of events that involve the people who live there. Interviews are the tool that should be used to supplement the everyday relationship which is built up by living and spending time in the same places as the local people. The role of operators - "experts in humanitarian aid" - is to be in the midst of problems in

order to perceive them as people experience them, and come up with possible solutions by seeing them through the eyes of the people themselves.

Relating and communicating experience

Giving shape to accounts and making them come alive entails going beyond the rationale of the kind of cooperation that is protected by the typical tools, places and forms of expression of international operators. If an account is to take on the kind of vital, solid shape that makes it authentic, parallel ways must be sought to the rationale of interviews in order to make headway in terms of intimate and sincere communication. This can be achieved by opting to experience the same problems and the same places. It means being patient in an encounter that inevitably is initially based on a balance of power between those who are able to give and those who are obliged to receive. Time is a resource that often clashes with a certain kind of planning, but it is often a necessary condition for activating processes of radical change.

Planning Together

Planning together means interpreting a situation in order to create opportunities for assessment and sharing with members of the civil society who live in an area. Planning together means moving on from good intentions to the challenge of sharing, with all the risks that this entails. It means putting fine words into fine deeds.

Starting from the needs assessment phase, NGOs should know how to involve the network of players who can make the intervention effective. This is not easy because it requires the courage to build up trust via adult and mature negotiation. Planning independently is easier and also enables the construction of tailor-made assessment tools.

Planning together adds assessment elements and makes them more complex, but it reduces the risk of having a project that is distant and without roots in the local situation.

Trusting people

This aspect calls for a culture of trust and respect for people. We believe that NGOs should develop human relations professionals within their organisations who are capable of building trust by offering working tools and opportunities to use them. All too often NGOs show up with their technicians and skilled workers who tend to define and wish to solve problems on behalf of others.

A careful assessment of cultural contexts should be aimed at developing working methods that regard the people involved as active players in projects. They should not just be seen as logistics people and interpreters but also as local citizens capable of being the centre of attention and genuine key promoters of change. Also, in this context our experience has confirmed that the role of NGOs cannot be limited to dealing with an emergency. By taking advantage of the opportunities of a more participatory approach, it should also be to encourage professionalism, promote working methodologies and propose actions that go beyond the implications of the emergency.

A WORKING APPROACH THAT IS ABLE TO COMBINE ENTHUSIASM WITH PROFESSIONALISM

NGOs have long since developed an awareness that the complexity of humanitarian interventions calls for a high degree of professionalism and training in "human relations" and management of the change processes which characterise a society that is obliged to shift from immediate emergency management to development projects that may redefine the social and healthcare framework of a region. NGOs often have to deal with a degree

of wariness towards them from large agencies, and also frequently from the academic world. Their history and identity set their actions among institutions and in local contexts, which means that they are undoubtedly difficult to govern. NGOs have fewer constraints and have developed practical know-how directly in the field, which means that is hard for them to accept institutional working methods and forms of expression. NGO operators who are in touch with people's problems on a daily basis and who wish to remain true to their identities often grasp the gap between large-scale programmes, which are inevitably slow and complicated, and people's everyday lives. Everyone's aim, whether NGOs or not, is to reduce this gap by seeking and taking advantage of working methods that provide for analysis, frameworks of intervention and shared planning. Whatever kind of relationship is established between NGOs and public bodies (for example, government ministries), NGOs should maintain a style of intervention that best favours support to the most vulnerable and the poorest with whom they are acting. NGOs should continue along this road in line with a professionalism that surely guarantees effectiveness and credibility towards genuine development support action. Institutions should carry on attempting to deal with post-conflict situations, with various viewpoints and methodologies, but which through support actions are able to complement processes aimed at recovering a better quality of life for people.

Negotiate By Managing Conflicts In A Non-Violent Way

NGOs, therefore, have the possibility to play a mediation role in humanitarian action in general. Current theatres of war have confirmed that not just any kind of intervention, and even less so a military one, can be presented as a humanitarian mission. A military presence is often deemed necessary to maintain law and order and specifically uses weapons as its means of action.

On the contrary, an NGO presence is aimed at building relations of trust with the population, which means that dialogue and negotiation are an essential element of any

humanitarian action. Long-term goals need to be very clear to avoid overlapping - or even worse manipulating - such different types of intervention.

We have seen how populations are extremely cautious in giving trust. If this trust is to be capable of building meaningful relations that are not distorted by humanitarian spin-offs (wealth, Western goods, etc.), it must be based on an adult footing that transforms the relationship between beneficiaries and donors into one between people with relations of mutual trust striving to achieve common goals. Among other things, this process could have a decisive effect in terms of more responsible management of law and order.

Working By Investing In People Rather Than Structures

Our experience in recent years has led us to opt for making use of people rather than creating infrastructures. Obviously this became possible when other players assumed responsibility for meeting structural needs. A local area draws from its history the necessary resources to tackle problems. Imposing use of such resources without sharing implies carrying out an excellent first aid action, but it risks being thwarted because it has no local roots.

The immediate efficiency of many structures, such as hospitals, rehabilitation centres, schools and vocational training centres, has been delusory, as later on they have turned out to be useless because they are unsustainable in a local context. In Africa, we saw a woodwork shop that was set up for vocational training, which had marvellous and highly sophisticated machinery delivered by large companies from the North Europe. Unfortunately, those who finished the course had difficulties in entering the job market,

partly because no local woodwork shops owned and used such excellent machinery. Hospitals have been built with outstanding equipment which few people know how to use or even less maintain. Education authorities have been alarmed by management and maintenance costs that schools have asked them to sustain. Sports facilities have been built in places marked by chronic emigration, thus obliging families to go elsewhere in search of work and safety, prematurely leaving behind completely deserted playing fields and gyms.

The primary resource for any kind of project is people, together with whom initiatives should be created and planned. Local areas and situations, together with a careful needs analysis, are the prerequisites of effective and sustainable planning.

Working By Taking Advantage Of The Social Fabric

Areas of operation normally have different forms of participation and local organization, which are often underestimated because they are structured in a different way from ours. Yet they often comprise the informal indigenous framework of the civil society for whom we are called on to operate, which is the real protagonist of change. The somewhat paternalist attitude, which has often led us to export our mechanisms and organisational methods without assessing the local impact they might have, only serves to emphasise a rift which - already by nature of the events - is perceived as soon as we arrive from another country because we have the "power" to help. Whether we like it or not, we are seen as people who have wealth and skills and decide to offer them to those who don't have them. Interacting locally and offering trust, without unduly succumbing to illusions, can narrow this gap and build more authentic relations as long as, in

practice, experience is valued and acknowledged and not based on mere management of resource flows.

Local Grassroots Networks: A Resource to be Developed

Local networks of solidarity, both formal and informal, are the key resource that people have, and they should be activated by teaching that derives and develops from actions and practice. It is vital to promote encounters and the sharing of elements of history in order to encourage exchanges between people, the sharing of hopes and fears, awareness of the past and confidence in the future. Believing through deeds in the people with whom one operates means telling them that are able to work, that they can be concerned about those who are suffering, that they don't need to depend on anyone and that, via a genuine and adult relationship, they can become the protagonists of their own liberation.

Several years of working with widows in Rwanda, ex-prisoners in Kosovo and home-help facilities in various regions of the Balkans by setting up self-help groups has enabled us to operate in a very decisive way in dealing with some of the poorest situations in these countries. Without top-heavy structures these interventions have taken advantage of people's desire to move forward and given them back their leading role in bringing about change in their situations. Self-help was introduced in the context of small enterprise projects, via microcredit support and the setting up of small cooperatives. This led people to deal with each other on a daily basis - involving joking, eating, sleeping and a love for building - which in turn resulted in relations and actions based on trust.

Taking Advantage Of The Institutional Network

The network of local players, institutional and otherwise, comprise the assets that NGOs are endowed with. This local working structure guarantees the prerequisites for actions that can be developed in the long term regarding the emotional and economic recovery that is needed to encourage steps towards justice and peace. Projects do not exist in a vacuum, but there are paths which each time come into contact with local NGOs, local institutions and governments.

NGOs that are expert in humanitarian aid may play a vital part that is based on their own freedom and non-institutional role. They can become the link that connects up the network among institutions, by taking on the onerous task of exploiting them as a resource, and preventing any outbreak of conflict that might lead to disintegration of their specific functions in sterile - and thus useless - actions, with regard to people who have already endured too much suffering.

Training Local Operators

In this perspective NGOs have no option but to invest in people and take account of the training needs called for by support work, and gearing it towards processes of change. It is vital that training should develop people, by empowering them and not just giving them knowledge. Power, resources and the capacity to operate independently comprise the tool that enables people to turn themselves from mere beneficiaries into self-sufficient political and social players.

Training should also provide for development of sharing and consensus on the goals of projects underway and those for which training is being given. Allegiance to the mission

is not always automatically guaranteed by the skills developed to achieve it. The process of sharing motivations is long and sometimes difficult, but highly necessary.

Therefore, training should deal with the value options that are at the heart of projects. We can train good nurses, primary school teachers and instructors, but it might not be sufficient. Often such training investment is used almost exclusively by those who have benefited from it. In the light of their history and identity, NGOs should first of all ensure that this work be turned into a service for the most vulnerable. NGOs should be the bearers of such added value. Not only market actors should be developed, but also civil society protagonists who are able to protect the most vulnerable.

FROM AID TO A POLITICAL ROLE: EVER-DEBATABLE ISSUES

Regarding NGOs, above and beyond their development potential, there remain - and probably will do for a long time to come – controversial issues that we shouldn't try to hide. Humanitarian aid still bears the legacy of a series of contradictions that must be reflected on.

A large uncontrolled amount of interventions, in whatever situation, distorts the market and, in terms of repercussions on economic and human resources, cannot be neutral in the local area. In such situations there is an obvious need for coordination of methods and the approach used in interventions, which is still at a highly embryonic stage.

Intervention is not valid for all contexts and situations. "Basic" manuals strive to provide the starting point for an experience to be implemented and do not represent the outcome -

the perfect snapshot - of an accomplished experience. Complexity is often not in harmony with the need to be immediately operative, but this requirement is often a necessary condition for gaining media visibility, legitimising one's actions in the eyes of public opinion and obtaining the funding needed to support projects. NGOs should have the courage - even when this entails the effort of working in the dark – to opt systematically for the well-being of people.

In many cases, NGOs are the operational arm of governmental programmes. This gives rise to the problem of NGOs freedom with respect to their governments, which are often involved in the environmental or political disasters with which NGOs are concerned. Therefore, NGOs have to choose between supporting the state, which implies a degree of economic security whilst doing something useful and important, or attempting to assume a decisive role with respect to the state with which they wish to interact, even though this may result in conflict. The latter option leads to the creation of a civil society model that promotes other forms of expression, methodologies and objectives with a view to integrating and humanising strategic choices that are inevitably conditioned by a host of compromises.

Obviously we want civil society to emphasise its non-governmental nature, not through a sterile ideological dispute, but rather as part of an uncompromising dialogue in favour of a policy that starts with people - and above all the poorest – in order to guarantee their rights and justice.

CONCLUSIONS

Civil society, including through NGOs, can play a vital role if it can manage to organise itself to represent needs and requests that are concealed in the mesh of interventions and which are often unable to emerge. Therefore, NGOs can be privileged interlocutors with institutions if, starting from the bottom, they represent the demands arising in the areas where they are set to operate.

The definition of "non-governmental" points towards a working methodology regarding problems and solutions that are different from or complementary to those which are "governmental" and therefore institutional. The role of NGOs is to be "in the midst" of the tensions and problems of civil society and institutions.

It is an indispensable dimension that enables assumption of a vital role in accompanying local social reconstruction processes. Their mission - to encourage linkage and coordination with other situations - makes them an indispensable element, in operational and cultural terms, in making their presence effective and useful in areas at risk. Consequently, the management of all kinds of problem in these areas cannot do without an ongoing and proactive synergy between NGOs, local resources and situations, civil society and institutions. Only the capacity of these players to work together, by taking advantage of their characteristic approaches and methodologies, can set in motion actions which, supported by appropriate management, can lead to the onset of a desirable process of change.

NGOs are aware that they must continually monitor their work in order to put forward their vision of humankind and their action strategies in a credible way.

An important indicator is the sustainability of their actions beyond emergencies: a project aimed at people should contain possibilities for going beyond the immediate intervention. A project does not belong to an NGO, but should rather become a local asset to be taken care of seriously. NGOs should define the amount of time needed for this to happen. This period helps to determine how and by which means the work is carried out.

Another yardstick is provided by the gradual liberation of people from dependence on an NGO. A steady decrease in the number of people turning to NGOs, who increasingly address their requests to local structures, makes the work of the NGO itself more convincing. Until people acquire or reacquire confidence in their local area, their doctors, their administrators and their social operators, NGOs will continue to be a parallel superstructure that reinforces a sense of impermanence and dependence. An NGO should aim to overcome this perception that people have of its presence, and ascertain how many persons manage to distance themselves from it, in order to evaluate whether its doing a good job.

A third indicator is the capacity to update local needs analysis. Even though a project is tied to a host of economic and time factors, a local area and the people who live there should, however, be the real yardstick. Making do with a preliminary analysis, without taking account of new elements that inevitably arise in a crisis area, runs the risk of distancing planning assumptions from people's needs. By interviewing and asking people for an assessment of how they are experiencing the presence and action of an NGO can be an important tool for ascertaining how it is achieving the objectives it has

set itself. Basically, an NGO should act as a driving force in order that trust, planning and the capacity to manage and solve a population's problems should become the people's own assets and resources. If an NGO replaces all these things, then it betrays its own identity as a promoter of social change.

But this is not enough. NGOs also have the duty to transform their efforts into a contribution towards the growth of a culture of solidarity and justice. Wars and violence are not natural disasters. They are the outcome of precise political, economic and social choices. NGOs should continue to propose reflection on the motivations behind these choices, and study and investigate the problems they end up dealing with, so that, with consistency and conviction, they may carry out the necessary function of condemnation to tackle with determination the tragedies affecting those who subsequently pay the price for such choices.

The work regarding provision of information, analysis and condemnation gives meaning to projects in the field. If NGOs were to evade this task, efforts might become futile and also unwittingly hinder the processes of change that in theory they wish to promote. This is of no use to anyone: neither to NGOs, who would thus become a rough copy of the existing government agencies; nor to institutions which would thereby lose a interlocutor who is critical but provokes and stimulates them; and nor, above all, to all those who live in a state of poverty and injustice due to war, because they would only be victims designated as beyond hope, at the mercy of everyone's indifference.

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CHAPTER 15

MENTAL HEALTH DISABILITIES
AND POST-CONFICT ECOMOMIC AND SOCIAL RECOVERY

Robert J. Muscat, Ph.D.

ABSTRACT

The interactions between mental health and socioeconomic functioning are complex and much remains to be learned. Causation certainly runs both ways. Problems of mental ill health affecting the economic, social, and learning behavior of significant numbers of people can have deleterious effects on post-conflict socioeconomic recovery. Community dynamics and recovery experience, and general employment and economic conditions, good or bad, feed back on the prospects for individuals' mental health recovery. It would be surprising if, for many of those who have experienced these traumatic recovery conflicts, the interactions were unimportant for the restoration of either mental health or effective socioeconomic functioning. This chapter reviews the relationship between mental health and social and economic recovery.

The economic losses stemming from ill health - for the individual, the family, and the society and economy generally - have been well established and quantified in the large literature on health economics. These losses - more documented and analyzed in developed than in developing countries - consist of a) the costs of medical treatment; b) costs imposed on family care-givers; c) in the case of mortality, the years of work unrealized and the loss of the individual's human capital; d) from disabilities, the income foregone during lost work days or from reduced productivity at work; d) the costs of welfare support of the ill and disabled. To avoid such losses and the suffering involved, societies also spend substantial amounts on health maintenance and disease prevention, including health education, inoculation, natal care, potable water, environmental sanitation, etc.

In developing countries, health status is typically poorer than in wealthier countries. Resources available for health maintenance and disease prevention are generally very inadequate. Treatment resources are often concentrated in urban areas. Some diseases long reduced to minimal occurrence in wealthier countries remain widespread in developing countries.

Although health statistics are relatively weak in developing countries, they are sufficient to outline the enormity of the unmet needs. The WHO Commission on Macroeconomics and Health found that the economic losses from ill health in developing countries have been large and underestimated. The Commission cited quantifiable losses from major specific diseases. "In sub-Saharan Africa losses due to HIV/AIDS are estimated to be at least 12% of annual GNP. Economic development in malaria-free zones is at least 1% higher per year than in areas where malaria is endemic." Evidence suggests "each 10% improvement in life expectancy is associated with an increase in economic growth of about 0.3% to 0.4% per year, other growth factors being equal." Most of the world's children who are not immunized, and virtually all of the women who die annually in pregnancy and childbirth, live in developing countries (1). The Commission estimated that eight million lives could be saved every year and very substantial economic benefits could be realized if their recommended increases in health investment were realized. The projected economic benefits were on the order of six times the recommended investment.

All of the above addresses problems of physical illness and applies to developing countries under "normal" circumstances. In those developing countries emerging from violent conflicts, the problems of ill health are greatly compounded. Depending on the scale, duration, and intensity of the violence, post-conflict countries have been left with problems such as a) large numbers of disabled persons and a continuing long-term increase in the disabled as vast numbers of land mines claim new victims month after month; b) a collapsed health infrastructure; c) cohorts of children unprotected due to lengthy suspensions of inoculation programs; d) large numbers of widow-headed households with nutritional and other health risk exposures, often compounded by legal and traditional gender biases that create land, credit and other obstacles for female cultivators; e)obstacles to rural economic recovery, even to subsistence levels, when displaced populations return to holdings that have been degraded due to destruction of irrigation facilities, terraces, storage and marketing structures, and environmental damage; f) degradation of cultural and social capital, and of pre-conflict communal networks and authority and dispute-resolution systems.

The mental health consequences of these conflicts have been much less studied than the physical consequences. Nevertheless, there are indications that mental health consequences may have wide ramifications for societal recovery and for economic behavior - e.g. labor force participation, individual productivity, production-related collective or cooperative action, investment and savings behavior, school educability or the processes of economic recovery. Such deleterious effects may need to be taken into account by non-health professionals responsible for designing and implementing

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recovery programs in agriculture and rural development, and education, in particular, and possibly in other areas. Such consequences could be particularly significant where the numbers of individuals and households affected by these problems is large. As the survey results presented in earlier chapters indicate, the numbers can be especially substantial as a proportion of a population when large fractions of that population have experienced displacement, deprivation, and torture and other physical and emotional trauma. In short, the scale and severity of these consequences moves the problem of mental health beyond the confines of the health system per se.

Studies in a few countries with advanced health data show that mental health problems can be extensive even in societies that in their recent history, and for most age cohorts, have not undergone anything remotely resembling the violent conflicts many developing countries have experienced in the last three-to-four decades. For the European Union countries as a whole it has been estimated that 20% of the adult working population has some type of mental health disorder at any given time. In the US more than 40 million people are estimated to have some mental illness. Studies also show the economic consequences for both the individuals and families affected and for the enterprises where they are employed, in the form of lost income, the costs of treatment, work errors and accidents, work days lost, rapid labor turnover, conflicts with fellow workers and supervisors, and so on. In the US, mental/emotional disabilities are cited as causing 200 million lost workdays each year; in the UK, 80 million (2). In the EU, the three leading causes of disability are mental disorders, cardiovascular disease and muscular-skeletal disorders.

If comparable studies were available for post-conflict developing countries, one would expect high incidence but very different profiles of mental disorder, etiology, and behavioral consequences. We know from studies of a few refugee populations that the incidence of acute clinical depression and PTSD can range between 40-70%. Prevalence among the population that has remained in place during these conflicts is probably lower, but still above the rates found in non-conflict countries (3). A good portion of a total post-conflict population will be able to adapt and cope well, as individuals, if the post-conflict environment is secure and experiencing economic recovery. But sizable fractions will remain suffering from either disabling psychiatric illness or severe psychological reactions to trauma (4).

Instead of deriving from dysfunctional family environments, abuse in childhood, employment anxieties, individual physiological imbalances, etc., the large scale of mental illness in post-conflict developing countries is seen to derive from the widespread physical and emotional trauma, fear, destruction of communities and institutions, betrayals and loss of trust, and social and cultural degradation that have characterized many of these conflicts. Persons with mental health problems in developed countries have the substantial advantage, compared with those in post-conflict developing countries, of residing in relatively supportive circumstances. The former have the benefit of an array of mental health institutions and cadres of mental health professionals; easily accessed modern medication; financial support networks; supportive legislation; and specialized training and employment opportunities. The prospects for their broader environment, their communities and cultures, are relatively peaceful and assured. In

short, the environment is positive and enhancive for treatment and socioeconomic integration.

In post-conflict situations, the conditions surrounding the ill are typically very different. Health providers of any kind may be in very short supply. Mental health professionals are likely to be few in number. Extended families may generally be reduced in size where the violence has been widespread. Early return to economic viability, even at subsistence levels, may be difficult for families now short of former adult male heads of household. Destruction of farm tools, irrigation channels, seed stocks, and other agriculture production requirements creates great uncertainty and anxiety over near-term, rural living standards, if not over sheer survival. Urban areas typically suffer from high post-conflict unemployment. Returning refugees and resettled displaced persons, already likely to have the highest incidence of mental health disorders, may also have higher rates of unemployment than other groups (as in Bosnia, due to employment discrimination and weaker social networks and job connections). Traditional communal and religious support networks have frequently been degraded. The future may appear highly uncertain and still threatening; the conflict may not have been completely resolved through peace accords accepted by all the antagonistic parties; widespread banditry may undermine local security; land mines may continue to claim new victims. A general social breakdown may result from mass ethnic conflict, causing a loosening of traditional restraints on criminal activity, domestic violence, rape, kidnapping, and emergence of youth gangs. In short, the environment is not enhancing for those afflicted

with mental health problems. The realities of post-conflict conditions are likely to reinforce and compound the anxiety and depression of the trauma survivors.

The effects would also have to be measured in different forms. In many third-world countries, much of the labor force is rural and self-employed in individual household units. Lost work days or impaired productivity on the job, easily measured in the urban employment context, are more difficult to identify in third-world agriculture, even if effective statistical services were available. In addition, persons initially resettling into bare subsistence, unable to fall back on formal social safety nets and surviving with extended families or communities too decimated to provide much material support, may not be able to afford outright idleness if they are to survive. Families in such dire straits are often supported by international humanitarian aid. Such aid can have the undesirable effect of creating dependency on the part of the beneficiaries, thereby delaying the recovery process and undermining a return to self-confidence and self-reliance.

Examples of behavior that is dysfunctional from a socioeconomic recovery perspective have been cited by observers and development practitioners in countries where one would expect such problems to be evident, perhaps measurable. We cite some examples from Cambodia, Rwanda, and Guatemala.

First, there have been indications of a highly foreshortened view of the future. In economic terms, people apply a high discount rate to the present value of potential future income or benefits. They are willing to forego very little short-term benefit in exchange

for the possibility that longer-term benefits will thereby be higher. In an early post-conflict example this writer encountered in Cambodia, widowed heads of households being helped under a UNICEF project resisted the project workers' advice that they turn some of their land from rice to fruit tree cultivation. The trees would take 2-3 years to bear the first fruit crop. The higher monetary income from selling fruit - but only after a delay of 2-3 years - was less valuable in their perspective than the lower but faster return from rice cultivation. Although these farmers would have been better off within a "relatively short" time by normal calculation, their lack of confidence in the predictability of even the near future led them to make decisions that were not (in the view of the aid providers) to their best advantage. They were not willing to forego relatively quick and certain consumption in order to make an investment in larger future consumption. After the passage of some time, according to one observer, the planting of fruit trees was resumed.

In Rwanda, now 10 years after the genocidal conflict, some lasting dysfunctional patterns may reflect a similar high time discount, or relative disregard for long-term consequences of present actions. Efforts to stem the spread of HIV/AIDS by inducing people to reduce widespread high-risk sexual behavior have apparently made little headway. One possible explanation is that people discount the risk of a long-gestating disease in a context where they see short-term survival as uncertain. Another possible dysfunctional effect of depression over future uncertainties would be a neglect of capital maintenance, i.e. present effort needed to maintain future consumption, comparable to the fruit-tree foregone-investment example. In Rwanda, it has been observed that

numbers of farmers - ten years after the country's genocidal conflict, and contrary to their traditional, pre-conflict practices - are still neglecting the maintenance of terracing. Terraces are essential for cultivation in Rwanda's hilly environment. Agricultural revival has also been hampered by the disappointing scale of farmer replanting of coffee trees, an important source of pre-conflict income and of export earnings (5).

Second, effects on educability of children have been seen in Rwanda. Young children who experienced the genocide and its aftermath are now teenagers in secondary school. The schools at this level are reported to have problems with students expressing rage and acting violently. In the primary schools there are also behavior problems that may reflect inter-generational effects of lingering psychological dysfunction within families. In Burundi, poor school attendance has been associated with "distress" of the household heads.

Third, trauma survivors may be unable to work individually, or to participate in economically-relevant collective action. The individuals, and the community as a social entity in all its aspects, may have been rendered incapable of internally generated recovery. The depth of individual depression or lack of energy, the length of time it takes for individuals or the community as a whole to recover, has been observed to depend on the local context. Thus in one Guatemalan village where lives had been "shattered," "resignation and passivity as a strategy for survival is a heavy albatross that chokes the possibility of recovery. Everyone in this ethnic Mayan village [San Andres] experienced a tremendous sense of guilt, fear, depression, loss, abandonment, despair, humiliation,

anger, and solitude. For some...the blow was so devastating that it shattered their faith in God."

> In some Guatemalan villages, the burden of the past has paralyzed the present. They have retreated into passivity, conformity, and mistrust...No crime, no matter how excessive, no matter how cruel and degrading...was ever punished. There were no limits, there was no recourse, and the result is a profound sense of continued vulnerability...The past lurks in the present and threatens to overwhelm the future (6).

In another Guatemalan village, by contrast, the inhabitants were able to shake the hold of the past.

> The unspeakable horrors this village [Santa Maria Tzeja] suffered should logically throttle any progress, optimism, energy, confidence, enthusiasm, ambition, or collective action (political or social). Yet this extraordinary community has become a model of success...Through human rights workshops, speaking about the past...they have moved forward. Key to this process is the public nature of their grieving...receiving responses and reactions to their deep pain...Nevertheless, the process of healing will take time (7).

The nature of anthropological observation - close, but one community at a time - makes it difficult to draw generalizations about scale. Anthropological work on Cambodia shows similar contrasts. Some observers have described what they perceive as general psychosocial collapse, an inability to reconstitute the community as a functioning entity. Others have described vigorous revival of social and economic life. Note that the author of the above citation on Santa Maria Tzeja village considered its recovery "extraordinary," implying that lingering communal torpor was the more common Mayan post-conflict experience.

Ebihara and Ledgerwood, two anthropologists who have studied post-conflict Cambodia,

refer to assertions

> In some development (and other) literature that Cambodian society
> was so fragmented and atomized by the horrific conditions of [the
> Khmer Rouge period] that people, even kinsmen, no longer help one
> another. Frings...argues that Khmer no longer care about each other,
> have no sense of moral obligation or genuine desire to help, are
> motivated only by self-interest, and will provide assistance only if they
> get something in return. Ovesen et al ...take this argument a step
> further to assert that a Cambodian village is nothing more than a
> cluster of houses that does not constitute a significant social entity, let
> along a moral community (8).

Ebihara and Ledgerwood see a very different Cambodia. They speculate that perceptions

of more selfish and self-interested behavior than in the past might simply have been

drawn from the fact that post-conflict social circles are smaller; their internal assistance

behavior would be harder to see. Or a paucity of assistance behavior might reflect

necessity; people are too poor to share more than a food subsistence minimum. The

village (Svay) they have closely observed is different in many ways compared with its

pre-conflict social structure and dynamics. But the more positive picture it presents,

nevertheless, for both psychosocial and economic recovery may not be representative, or

may represent only a portion of rural Cambodia. The fact that Svay is only ten miles

from Phnom Penh and has good road access to the capital may mean that its conditions

are more favorable for recovery in all respects than the majority of Cambodia's villages.

Despite the apparent building of a functioning village society in Svay, based on a

configuration of old and new relationships, authorities, and modes of interaction, the

inhabitants continue to report mental health disabilities nearly 20 years after the end of

the Khmer Rouge regime. Some of their reports point clearly to reduced work capacity.

> Despite some material improvements to their lives, present-day
> villagers obviously bear scars, both physical and emotional, from the
> horrors of the Pol Pot regime...[M]any survivors are plagued by
> profound fatigue, lack of strength, weak limbs, faulty memories, and
> other problems that are thought to be the consequence of overly
> arduous work, severe deprivations, and beatings during DK
> [Democratic Kampuchea, the Khmer Rouge name for their state].
> Villagers report such difficulties as: "My legs are still weak from all
> the work; sometimes I collapse and fall down."…. "I can't lift heavy
> things." "I've forgotten how to read and write Khmer since Pol Pot."
> …We found no other evidence of serious psychological problems,
> although it is quite possible some of the villagers' physical ailments
> could be somaticizations of emotional reactions to past horrors (9).

While Ebihara and Ledgerwood record the emotional scars in Svay, they dismiss

"periodic statements...that Cambodia has become a nation of the mentally unbalanced."

The effects of lingering psychological disability on social and economic behavior are

obviously subtle and difficult to separate from the complex of motivations and

circumstances that shape human behavior. The anthropological literature on Cambodia,

and the village observations cited from Guatemala, suggest that behavioral disabilities

have persisted long after the cessation of the period of genocidal trauma; that they can

affect, injuriously, work capacity and the rebuilding of communities and social capital;

and that the outcomes will vary widely from place to place.

A final example that illustrates economic constraint from social breakdown also comes

from Cambodia. A team from USAID studying post-conflict gender issues reported that

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women (in interviews and focus groups) complained about "a lack of trust and unwillingness to help in time of need," compared with pre-conflict days.

> This problem has had a profound effect on micro credit programs in Cambodia. It is noteworthy that the average size of self-help group for credit ranges from three to five, quite low compare with other developing countries. A number of women indicated that they would only join immediate family members for group credit programs. Because of the difficulty of convincing non-related individuals to work together, credit groups have established new requirements. Relatives may be members of the same economic group, but they must physically live in separate households (10).

To develop an accurate picture of prevalence and of the specific ways post-conflict mental health disabilities affect both household and communal economic recovery we need a different source of information and data, viz. household sample surveys of living conditions and health, including mental health, status. The World Bank has made a start in this direction. Data sets that may yield some of the needed insights appear to be available for a (very) few post-conflict countries (Rwanda, Burundi, Bosnia, Cambodia). Inserting critical mental health status questions into the Living Standards Measurement Surveys (LSMS), which are the standard survey instruments the Bank supports for poverty studies, could provide reliable quantified (single country and comparative) analyses of disability prevalence and the association of such disabilities with other household characteristics and dynamics - of health behavior, school attendance, labor force activity, income, and so on. (Unfortunately, the modest funds needed for analyzing some of this data are not yet in hand.) Other sources are needed to increase our understanding of the psychological dimensions of post-conflict community reconstitution. A systematic mining of available anthropological studies should be helpful and not very costly. Another source could be a review of donor project

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experience as captured by easily accessible project completion reports and evaluations of post-conflict projects in which community response has been a central component. Longitudinal studies would greatly enrich our understanding of the conditions that enhance recovery and coping behavior over time. Service information routinely obtained from people who seek mental health assistance in primary care or referral facilities could be enriched with a standard set of questions on household economic status and activity, and on the situation of the household's children. Such information, gathered over time, could provide direct observation on linkages between mental health, socioeconomic functioning, and inter-generational effects. The richest source (probably the most difficult to arrange and finance) would be longitudinal studies that combine individual and household, and community, level observation and analyses, i.e. individual/family psychosocial and economic tracking set within analyses of the socioeconomic evolution/recovery of the same set of (selected, representative) communities.

CONCLUSIONS

The interactions between mental health and socioeconomic functioning are complex and much remains to be learned. Causation certainly runs both ways. Problems of mental ill health affecting the economic, social, and learning behavior of significant numbers of people can have deleterious effects on post-conflict socioeconomic recovery. Community dynamics and recovery experience, and general employment and economic conditions, good or bad, feed back on the prospects for individuals' mental health recovery. It would be surprising if, for many of those who have experienced these traumatic recovery

conflicts, the interactions were unimportant for the restoration of either mental health or effective socioeconomic functioning.

Our review points to two areas for next steps: (1) advancing the state of knowledge, an endeavor where the international agencies can make major contributions, and (2) at the national level, ensuring that problems of the conflict's psychosocial effects are fully understood by the general recovery planning authorities, and that potential complementarities between psychosocial recovery and economic recovery are identified and acted upon.

(1) Advancing Knowledge: The need for, and increasing availability of, effective (and cost-effective) mental health interventions, is becoming more widely recognized. More needs to be done to advance our knowledge of the interactions between mental health and socioeconomic recovery. For example, building on the results of the first inclusions of mental health questions in LSMS surveys, the World Bank should expand the data-gathering referred to above by introducing the relevant (and perhaps more numerous) questions in similar surveys in more post-conflict countries. For selected countries where the results of such surveys, plus the knowledge of the national health authorities, indicate that mental health consequences are of a serious magnitude, the Bank and WHO should consider undertaking more in-depth research on consequences and economic interactions, along the lines suggested above. Greater understanding of scale and interactions - and the effects on overall recovery would be very useful for both the health authorities and the planners of general recovery. As the authorities most knowledgeable

and most responsible, the national health professionals are in the best position to make a case for such research to their overall recovery planning authorities and to WHO, the Bank, and other relevant international agencies.

(2) Psychosocial and Economic Complementarities: Greater dialogue between national authorities responsible for mental health and those responsible for overall socioeconomic recovery should serve to strengthen professional understanding and the whole array of recovery interventions. Mental health professionals should be included in the planning of service and reconstruction programs at the community level, especially programs involving populations that have experienced violence, fear, economic devastation and other war trauma, such as widow-headed households, child soldiers, and refugees and internally displaced persons. Stronger dialogue and coordination between health authorities and general planning authorities (planning commissions, ministries of finance and/or economics, etc.) would benefit both sides. Overall planning authorities would gain greater understanding of how conflict's psychosocial legacies may be affecting and constraining the general recovery/reconstruction effort. They would gain a heightened understanding of the need for allocating resources to address these legacies. Working together, both sides would be better able to identify specific policies and programs that have the potentiality of complementing the direct programs and therapeutic interventions of mental health professionals. Examples of such areas would include job training, job creation and food-for-work programs, community development, agriculture extension, sports and physical education, adult education and literacy, and preparation for demobilization and reintegration of adult and child ex-combatants.

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CHAPTER 16

EMPLOYMENT FOCUSED INTERVENTIONS IN POST-CONFLICT

SOCIETIES

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ABSTRACT

The Swedish Development Assistance Agency (1) (Sida) amongst others emphasise that human rights needs to be introduced into development to sustain peace. A major dilemma is the few resources and need for special skills (2). Four concepts of public health: equity, participation, subsidiary, and sustainability are essential to violence reduction, and are vital to healthy societies (3). This chapter focuses on these four areas with a special emphasis on the association between employment and mental health.

PRINCIPLES GUIDING THE UNDERSTANDING OF HEALTH

Post-conflict countries are at risk of experiencing a conflict trap, i.e. a negative circle where war risks repetition through the erosion of social supports, and where adults' risks bringing the conflict to their children. To secure the constructive process of national and local recovery, peace needs to be based on activities guided by evidence and not ideology (4). However, according to Silove (2) "mental health issues are poorly understood both by helping agencies and affected communities, interventions often are undervalued, and controversy amongst professionals about priorities tends to undermine advocacy of services" [(page 95)]. Many different factors are of importance such as rebuilding infrastructure, securing food provision and production, reconciliation, securing community health and mental health indigenous service provision especially for those with pre-existing mental disturbances as well as to those with normative communal

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reactions to stress, and restoration of trust and a hope for the future. Important to this process is the definition health its social impact. An understanding of the latter draws from our currently on-going research project entitled *Health Promoting Introduction* that focuses on the development of a model to be used in the reception and resettlement of persons of refugee or forced migration status in Sweden.

In this project, we use a theoretical framework comprising dimensions of health at different societal levels: individual, interpersonal, organizational, community, and at the policy level, as suggested by McLeroy et al (1988) (5). The framework is grounded in the World Health Organization's (WHO) understanding of health promotion, which recognises that health is strongly related to the life circumstances of people (6). Health is understood as a) every person having the possibilities to realize their ambitions, have their needs met, and change and cope with their environment, b) living in their everyday environments and c) having access to health care, regardless of their personal characteristics. Also embedded in health promotion theory is the standpoint that public policy, in different societal fields and supportive environments promotes these values (7), and are necessary for action taken to promote health, mental health, and well being (6).

To further understand the particular life - and individual mental health context of refugees or people with refugee like background, we are using the five adaptive systems developed by Silove (1999) (8), for reflection at each of the different societal levels. In short, the five systems can be described to include: (1) restoration of interpersonal bonds

at different levels of society; (2) the re-establishment of security and safety; (3) the development of a social framework that promote development of new identities and roles (eg work, training and leadership); (4) respect for justice and human rights, and (5) respect for peoples' need for meaning and their belonging to religious, political, spiritual or social or other important existential sources.

HEALTH AND HUMAN RIGHTS – THE MEETING OF PSYCHOSOCIAL NEEDS

Societal responsibility for the health of individuals has evolved through parallel developments in the fields of health and human rights, and nowadays the fields are merged into one (9). The WHO states that the most effective way to promote sustainable long-term peace is a commitment to social justice (10). Health definitions, as clearly proposed in the health definition by Mollica, 2003 (11), states that "Health is a personal and social state of balance and well-being in which people feel strong, active, wise and worthwhile; where their diverse capacities and rhythms are valued; where they may decide and choose, express themselves, and move about freely". The understandings of well-being, such as in Buchanan's (12) argument that "the prospects for individual well-being dependent on the justice of social conditions", also express the linkage between health and human rights, and emphasizes that an individual in an unhealthy environment minimize the options to experience health or well-being.

Considering this relationship, Murray and Lopez (14) have highlighted the WHO and World Bank's prediction that war will be amongst the top ten causes of disability and

death by 2020. Much evidence exists regarding high exposure to traumatic life-events in complex emergencies (14) and the seriously health damaging effects it has on individuals and societies (15). Unique differences exist; for example, the historical background underlying the type of outbreak of war, which in turn creates different post-conflict recovery settings (16). Moreover, human rights and trauma reactions may vary depending on context including for example type of warfare, length of conflict, and actors involved in conflict (e.g. the use of child soldiers). Today, it is globally recognised that the tackling of basic threats to health such as hunger, poverty, illiteracy, insecurity, poor health, and mental illness may reduce outbreaks of war, terrorism, and other violence. There is, however, still little consensus on how to eliminate these basic threats. For example, models of best practice, services and donor involvement coordination in the context of complex emergencies exist in theory but are limited in relation to sustainable activities and follow-up (17). Additionally, as further argued by Mollica and McDonald (11) the "existing paradigm for humanitarian assistance and post-conflict recovery is limited, and attention to mental health issues is inadequate. This is largely the result of a flawed model of assistance, where refugees are defined by their plight, with little regard for their identity prior to the conflict and with little consideration for their participatory role in their society's recovery and rehabilitation" [page 2]. Concerns have also been raised that donors need to address a minimum amount of key mental health indicators when supporting development in complex emergencies and post-conflict societies (18). Furthermore, many conflicts and their victims are not recognised and aid not directed due to …"lack of media attention and donor funding combined with bureaucratic barriers and xenophobia"(19). Other criticism lifted regards that of non-

transparent organisational boundaries, poor inter-organisational communication, lack of mutual awareness and understanding, and inter-organisational competition.

Employment is a human right as set out in Article 23 in the Universal Declaration of Human Rights and, it is an area in which society can have a large impact. Despite this, violations of the right to work are amongst those of recorded human rights violations happening in more than 100 states and territories around the world (20), and the International Labour Organization (ILO) states that the world unemployment rate raised above 6 % providing a figure of the number of unemployed to be over 180 million in the year 2000 (21). Identified globally as one of the most important social determinants of health, employment is often seen as key in tackling social exclusion (22) i.e. the multidimensional disadvantage of access to societal resources such as education, networks, and support (23). Nevertheless, of those in the world's population who are in employment, ILO estimates 20 – 27 % to be categorised as 'working poor' (those who work and belong to poor households) (24), and argues for making "decent work" (i.e. the productive and secure work, the respect of labour rights, the provision of adequate income, the offering of social protection, and the inclusion of social dialogue, union freedom, collective bargaining and participation (24) a global goal (25). Decent work is seen by the ILO as a key ingredient in the work for a fair and inclusive globalization to build a more secure world (29), and the… "urgent priority is to combine the creation of a large number of jobs to decrease the unemployment rate with a reduction in the number of working poor and an increase in the quality of employment" [page 7, 24]. However, as we will show, research and knowledge gathered in post-conflict societies or amongst

populations of refugee or forced migrants, focusing on employment's role for mental health is limited.   In international initiatives, the view of employment as a social determinant of health is rarely acknowledged in practice and not a part of health or mental health programs.

SOCIAL AND HEALTH BENEFITS OF EMPLOYMENT

In the Western scientific research literature, evidence exists concerning the relationship of employment relates to ill health (including the social, and health benefits of employment).   This relationship is often described in terms of selection and causation (26)(27). The selection hypothesis states that poor mental/health increases the risk of unemployment[7], whilst the causation hypothesis states that lack of work leads to poor mental health and that re-entry to employment leads to recovery of good mental health[6]. Existing evidence supports both hypotheses (28), however, little is known about these processes in refugee populations or post-conflict settings, processes that may have been triggered by the outbreak or recurrence of war (29).

Because of the limited attention to employment's role in health promotion, lessons may be learned from other research fields in non-conflict societies. In an extensive review, Kasl and Jones (2000)[29] argue that a) the evidence indicates that the impact of unemployment on mental health and well-being negatively is strong, despite the fact that it is a complex and multifaceted experience, b) psychological distress, specifically depression, increases through unemployment, and that reemployment can reverse this increase in distress. The reasons for unemployment's negative effects on health seem to

relate to the often multiple and accumulated disadvantage among people in unemployment situations, and a wish has been expressed in Western societies for a combined approach in policies to provide for …"positive help in the shape of social and emotional as well as improved financial support, as well as the opportunity for education and training" (30). Further supporting the role of employment is the ILO, who argues that economic security not only promotes personal well being, happiness and tolerance, and benefits growth and development, but also, in combination with other factors, promotes social stability (36)(31). Nonetheless, the type of employment matters too, and segregation between younger and older workers, and between men and women remains globally high in all informal and formal economies. Women constitute the majority of the world's poor (70 % of 1.3. Billion), and earn less than men and are largely undertaking unpaid work (32). Still, evidence relating to whether the negative impact of unemployment differs depending on gender is, nevertheless, inconclusive[29]. However, a seemingly successful method (33) used to tackle this gender inequality is the micro-enterprise method, referring to the "small scale income generation projects" (34) where loans or credit is given to poor people, particularly women (35) living in for instance refugee camps[18]. Conclusive evidence supporting a direct positive health effects is, to our knowledge, not yet available (36)(37). In addition some studies exists, conducted in developing country settings, with findings of higher prevalence of common mental disorders amongst informal workers (self-employed and underemployed) than amongst persons in formal employment (persons formally placed in the labour market) (38).

Our conclusions from available research are that employment works as a protective factor against the development of mental health problems in the local post-conflict context. Moreover, it is possible that employment can be seen as a contributor, as it could works against what Marsella, Levi and Ekblad (39) acknowledge as… the "sense of hopelessness and anomie that often occur when political instability undermines the possibility to change" [(page 58)]. In addition, employment can aid in the empowerment processes needed, as argued by the same authors: …"[w]hen citizen helplessness occurs, efforts should be made to encourage grass-roots movements to promote perceptions of empowerment and to minimize stress. Whenever possible, development should use the strengths and resources of the people affected to minimize the experience of alienation, helplessness, and dependency" [(page 58)]. A significant method to use to combat the social problems associated with violence is micro-enterprise. It is also useful to understand the importance employment has in post-conflict settings in providing salaries and self-sufficiency. Employment's contribution to other areas in the post-conflict setting, for example in relation to the rebuilding of infrastructure in the context of urban planning (such as the restoration of roads or water supply) (40), the strengthening of identity/roles in individuals, the creation of future hope, the prevention of social isolation, the securing of housing and/or in providing a 'socialization context' (41), which aids in the shaping of society's well-being and future, should also be acknowledged. Salaried adults in just and favourable work is, naturally, what to strive for and is one of the most important factors in tackling and preventing poverty amongst families and in contributing to human rights and human dignity (42).

MENTAL HEALTH PROMOTION EMPHASISING EMPLOYMENT

In order to promote good mental health and well being and prevent poor mental health through interventions supporting self-sufficiency amongst civilians and stability in local contexts, and at the same time improve the knowledge base in the post-conflict society, we suggest a combined research and action method entitled *Mental Health through Employment*. The idea and design of the model derive largely from theory used, and evidence and experiences collected in our current research project *Health Promoting Introduction* (HPI). After a brief presentation of the suggested design, some experiences and preliminary results gathered in the HPI project are presented. The chapter ends with a concluding summary and discussion on the usefulness of the model in post conflict settings.

Action Plan: Mental Health Through Employment Model Development

As presented in Figure 1, the suggested research-based model development of *Mental Health through Employment* involves four phases, of which the first phase is split into two.

1. **Survey phase:**

    a. Rapid post-conflict and health appraisal (RCHA) of the local post-conflict context, refers to the process of collecting background data of importance for coming interventions, and is complementary to the strategy development process. The data of interest could relate to what current knowledge indicates, i.e. the effectiveness of interventions …"depend on the resources, context, culture and historical background of the affected

society" [(page 93, 1)]. After completion, a decision can be made on whether it is appropriate to continue with the next step below.

b. Strategy development, refers to a process of four stages, where: 1) *Identification*, that is, actors important for the implementation of the interventions are identified; 2) *Formation*, that is, individuals and service system collaboration are strengthened. For example one significant component would be to form multi-agency 'steering' groups, in which actors identified in the previous stage can participate. 3) *Implementation,* that is, participation-based activities for the local population through collaborative efforts, under supervision and support from external researchers are being implemented, such as in order to co-ordinate the recruitment and integrating the perspectives of rehabilitation and "decent work", multi-professional teamwork involving actors like mental health specialists and employment professionals could work with local inhabitants in strengthening participative decision-making and collaboration, including for instance, the recognition of motivation and talent in relation to employment and individual future employment related ambitions. Finally, 4) *Follow-up* that is, where interventions are followed-up.

c. The sum of knowledge: This final stage involves the assessment and integration of all experiences and data collected through previous stages, the definition of locally identified key indicators concerning health and

employment, and where the knowledge and experiences gathered is addressed in a document describing the locally defined model.

2. **Establishing a Sustainable Model**

3. **Implementation Phase**

These two phases include the establishment of a sustainable long-term model of *Mental Health through Employment* in the local context; and implementation of it in one or more settings with an emphasis on structure rather than exploration. Comparisons with other possible *Mental Health through Employment* settings can also be made to inform the evaluation with a stronger evidence base.

4. **The Evaluation Phase**, the final phase, refers to the evaluation of the model in relation to other models and/or other settings, the analysis of evidence collected and experiences in accordance with the key indicators identified in phase 1, and the reporting of results. The evaluation of the process could also include the assessment of health, employment, participation, and collaboration. In addition, it would be appropriate for it to be in line with human rights principles and assess the availability, accessibility, acceptability, and quality[6] of the service/s provided.

Our Experiences From Using Health Promotion With Employment Focus

Brief project description:

The first author of this chapter (SE) was commissioned and financed in 2001 to co-ordinate a project entitled *Health Promoting Introduction* by the Swedish Integration

Board (co-financed by the European Refugee Fund). The board undertook a study into the consideration of health and health challenges in the reception of newly arrived persons of refugee or forced migrants. This project includes the following objective: "[T]o develop a model, focusing on the psychosocial health of newly arrived persons, that can be used for collaboration between different departments within the public sector, the private sector, social networks and the newly arrived immigrants in the municipalities" (43).

Through this project we have arrived at the following findings on health/ mental health and employment. We explored employment in relation to mental health through a cross – sectional survey in 2001 directed to a sample (not included in our intervention study) drawn from the largest population of refugees immigrating to Sweden in the 1990's (44). Although no cause – effect relationship can be drawn from the data, associations were found supporting earlier findings conducted within non-refugee populations, as outlined in this chapter. One outcome measure used was the experiences of 30 symptoms, which were grouped into a low symptom group and a high symptom group in analysis. In the low symptom group the majority was working, while in the high symptom group a minority was working. The latter group showed higher proportions of unemployed, females and persons living in an urban as opposed to a rural setting. Persons in the low symptoms group showed significantly higher proportions of feeling important and of being understood, at home, at work as well as in society in general than did persons in the high symptom group.

The design of the project was also based on the ambition of developing sustainable mental health promotion strategies for refugees through participative and collaborative interventions. The interventions we run are currently in the implementation stage, equivalent to that of the implementation stage in phase 1b in Figure 1. In brief, our intervention research and experience so far show (45)(46) that in order to build capacity to affect mental health through participation, the necessary actors and relations between actors have to be identified, and their commitment to contribute to this agenda must be developed. A basic precondition for constructive development in favor of mental health strategies is to support the local agencies to engage in joint problem-solving and information exchange, aimed at setting up good collaborative relations to each crucial actor. Local systems, where appropriate methods of collaboration at the planning/administrative and operative levels are used also experience a possibility to better meet the goals of employment and education in language than other types of systems, and to enhance the development of positive reciprocal images between the collaborating actors. Nevertheless, the process of collaborative development is a challenging one where continuous struggles have to be overcome and new phases can be entered only if the latest struggle was solved successfully.

In our project, we have experienced the formation of new relationships between employers and agencies supporting the unemployed refugees. These relationships seem to have made it easier for transitions into practice and new work opportunities for this group. Furthermore, collaboration in this context appears to contribute to improved breadth of services, and to compatibility of services. In order to achieve accessibility to

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services for participants with health problems, primary health-care need to be involved in planning the process for the individual participant or in administrative/planning of the programme. Finally, although measurable and achievable targets in the Swedish reception program still needs to be developed, findings from our project indicate that methods for participative decision-making around person's (of refugee or refugee-like background) own processes are positively related to the number of participants among the refugees in the Introduction in Sweden that are in employment after ending the Introduction.

The Usefulness Of The Mental Health Through Employment Model

Mental health promotion and employment implies long-term programs with decade-long thinking for development, demanding focus and time. The *Mental Health through Employment* approach described in this chapter has not only the ambitions to implement the guidelines set out by the WHO regarding health promotion components. The approach also aims to provide an integrated approach linking traditionally separated fields together with the purpose of promoting mental health and societal recovery through employment, embraced in an evidence-based framework. Much emphasis is on the co-ordination of several sectors (e.g. public, business, voluntary) acting at different levels to meet expressed as well as unexpressed psychosocial needs among persons who are refugees or have refugee-like backgrounds. Collaboration between all levels together with the experience of learning exchange and capacity building is embedded in the framework with the intention of creating a "bottom-up-top-down approach", where people are seen less as targets for intervention and more as responsible co-creators. This

process may involve identification and support to local bottom-up initiatives but also new innovative initiatives identified through the process. Strategies could involve, for instance, the engagement of the local population in identifying and carrying out needed work for the improvements of the local area, and the whole process would probably benefit from monitoring by human rights organisations. Specific areas of interest for gathering evidence about are outlined in figure 2. These relate both the suggested model itself but to needed knowledge in general, in the post-conflict setting.

Through the *Mental Health through Employment* model there is an opportunity to, at an early stage to assess who does what, where, how and at what level to enhance the process efficiency. This demands, however, the sharing of information, expertise, and learning of progress and knowledge gaps with other actors, including donors, and needs to be built on the development of trust between parties (47). For this reason, participation should be voluntary and based on human rights principles. For collaborative action, all parties must stimulate joint problem solving and creative solutions, and collaborative structures are needed at planning, administrative, and operative levels. Certain risks may be identified, such as whether all adult civilians wanting to work are allowed to work because of discriminative structures is still in action or the potential obstruction to peace caused by unresolved, latent or reoccurring conflict. In case of rapid changes, new rapid appraisals will have to be conducted and fed into the strategy development (Figure 1). Instruments to collect this information already exist such as the rapid appraisal approach developed by the WHO (48). In the post-conflict setting, it could however be of relevance for the rapid appraisal not only to include assessments in relation to health (including mental

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health) status/problems but also understandings of the conflict (including for instance the occurrence, frequency, and nature of human rights violations) and current context (such as the community's sense for reconciliation).

Moreover, the experiences and identification of key stakeholders experiences is necessary in the strategy development process. Key stakeholders in the post-conflict setting may include locally represented actors from the local, national and/or international community acting in different areas such as local development (e.g. local existing micro-enterprise), health and aid, human rights, truth and reconciliation but also religion, culture and/or sports etc. Important knowledge for the actors to learn about through the process relate to the understanding of the differences between ..."those with disabling psychiatric illnesses; those with severe psychological reactions to trauma; and the majority who are able to adapt once peace and order are restored" (49). International researchers of relevant knowledge and background can contribute to this knowledge. Moreover, research involvement may also be beneficiary to the process, as researchers collect evidence and experience of success, contribute in reflection of the process, and act as coordinators of the process. Finally, it is appropriate for the interventions to work within a human rights framework, and to be based on experiences gathered from stage 1a) and b) (figure 1).

National policymakers have an important role in creating an environment in which local bottom-up initiatives may be acknowledged and supported in collaboration with the international community. The promotion of health and prevention of poor health implies

working with determinants of health and demands collaboration with other political sectors, emphasising healthy public policy. Policy makers have the opportunity to act as role models through the building of trust, vital to collaboration at all levels, and through making policy makers' accountability to the people i.e. to all civilians within the nation without discrimination, explicit. Strategies for combining mental health and employment might be stimulated by creating shared funds for the development of the economy, the rebuilding of social and physical infrastructure and mental health promotion. The realisation of shared funding demands flexibility in funding sources and probably de-categorisation of previously separated funding streams. International donors and agencies are important actors in providing for such changes. Creating and supporting policies and action, which allow for continuous learning from experiences and sharing with others, and which includes a vision of a constructive and health-bringing environment, would probably assist not only the individuals in local contexts which the politicians and policy makers serve, but also the nation in the wider globalized context.

FUTURE RESEARCH AGENDA

A future research agenda is displayed in Figure 2.

PHASES OF MODEL DEVELOPMENT

1 SURVEY

1a RAPID POST CONFLICT AND HEALTH APPRAISAL OF LOCAL POST-CONFLICT SETTING/S

2 ESTABLISHING A SUSTAINABLE MODEL

knowledge

follow-up

identification

1b STRATEGY DEVELOPMENT

3 IMPLEMENTATION
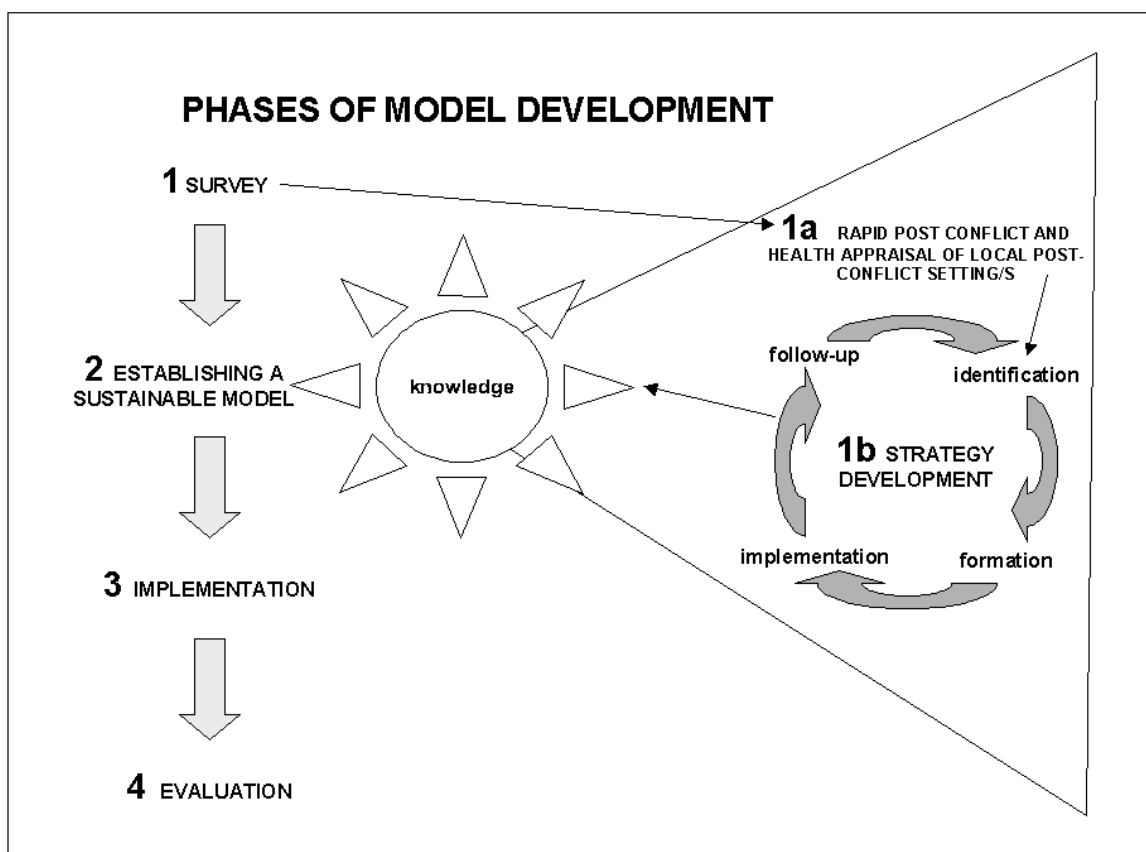
implementation

formation

4 EVALUATION

Figure 1. A model of Mental Health through Employment   LAYOUT: GUNILLA ANDERSSON

- Test the model for *Mental Health through Employment* stepwise from the survey phase to the evaluation phase in several post-conflict settings, and to make comparisons in experiences and outcomes between the different settings
- Identify the health implications of unemployment and deskilling among post-conflict inhabitants
- Explore further what specific role micro-enterprise may play in the *Mental Health through Employment* model, and to health promotion in general
- Explore in what ways employment may support mental health of men and women, and to identify if/what differences exists depending on gender
- Enhance the understanding of if and how employment may work as a protective factor against posttraumatic stress, depression, and impaired social functioning
- Explore in what ways employment can aid in restoration of a future hope amongst post-conflict populations
- Explore employment as a tool in contributing to stability in general in the post-conflict setting
- Identify barriers/facilities/facilitators and what is needed in order to support access to employment as perceived by post-conflict civilians

Figure 2: Research Priorities to further develop the understanding in this field.

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CHAPTER 17

HUMAN RIGHTS AND MENTAL HEALTH
IN POST-CONFLICT RECOVERY

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ABSTRACT

Inhabitants of post-conflict societies, already traumatized by definition, suffer from the loss of familiar structures of opportunity, and have higher proportions of psychologically disturbed individuals than encountered in more stable settings. In this context they are vulnerable to human rights violations, which further intensify the likelihood of psychiatric disorder. Persisting antagonisms between protagonists and opponents of the new order, and efforts to ensure security and behavioral conformity, can threaten civil liberties. Lack of material resources may make it impossible to supply social entitlements. Those who suffer most tend to be from previously marginalized and stigmatized groups, including the chronically ill. At the same time efforts to remove earlier restrictions on the freedom of some traditionally subjugated minorities, including women, may place them at greater risk of human rights violations than before; the efforts of international observers to ensure human rights standards can be impeded by adherence to the principle of national sovereignty as well as appeals to restrictive cultural standards. Efforts to deal with mental health concerns arising in the post-conflict context have included trauma centers, efforts at cultural change, centers for the study of violence and reconciliation, human relations training for police, human rights training for staffs of primary health care centers, national peace committees and other devices aimed at promoting inter-ethnic tolerance, attempts to train journalists for unbiased reporting, and institutions modeled after South Africa's Truth and Reconciliation Commission. In most instances modest, mixed or inconclusive results have been noted, with the greatest success seeming to require an emerging charismatic leader to work with the new institutional effort.

INTRODUCTION

This chapter addresses the human rights framework in which post-conflict, and by definition traumatized, societies engage in the work of recovery. Recovery or restitution may be aimed at restoring a previous status quo or at building a new social organization to help protect and repair the mental health of individuals and groups. In any event the process is one beset with uncertainties.

Uncertainties In Using The Designation "Post-Conflict" Society

The designation, "post-conflict" was initially used to indicate countries in the aftermath of civil war, ending as the result of negotiated peace accords or with the victory of one party (Kumar, 1999). However, "society", or "civil society" as the term is often used, refers to an evolving entity, which is not necessarily identical with a country, nation or state.

The designation, "post-conflict", can obscure continuing, often historically rooted, disagreements between factions, e.g. tribal, political, religious or ethnic groupings. Typically, the persisting antagonism between former adversaries is muted, despite mistrust and suspicion. Life for citizens following the cessation of overt conflict depends, in part, upon the nature of the victorious power, their relationship to it, and its relations with the vanquished. "Peace-keeping", "nation-building" and social reconciliation after overt hostilities have ended may have to take place in the presence of persisting external or internal threats as well as recurring humanitarian emergencies and the destruction of pre-war arrangements for keeping order and sustaining the population.

If the pre-war arrangements were oppressive, the victor will try (at least nominally) to avoid re-instituting them. In the absence of other viable arrangements, however, a lack of structure may contribute to prolonged periods of social disarray in which citizens, while theoretically appreciating new freedoms, may call for renewed authoritarian methods to restore freedom. This can be especially marked in societies, which are the residuals of failed dictatorships. People suffering from organizational disarray after actual hostilities have ceased, may, in retrospect, forgive dictatorial methods as the price for an orderly society. However, uncertainty about putting a new government in place, and distrust of new centers of power, can be significant no matter what the character of the previous leaders. Under these circumstances, as the loser in the conflict is the target of the new authority's efforts to maintain order, they may be experienced, as oppressive and a violation of human rights.

Uncertainties In Using The Designation, "Human Rights"

Interpretations of the concept of "human rights" depend upon who uses it and in what socio-economic and political context. It can be used in a cynical, idealistic, philosophical or legal manner. The establishment of international rights tribunals has made it possible to publicly try national leaders for rights violations and for citizens to file complaints regarding such violations. But the concept is vulnerable to exploitation. Nations have sought election to membership in the contemporary United Nations' Commission on Human Rights as a way of deflecting criticism of their own internal rights violations.

The human rights characteristics of post-conflict societies can impact mental health directly, through the establishment of health and social support policies, the actualities

of therapeutic or preventive endeavors, and the availability of institutional aids to individual and group coping. Rights sometimes appear to be in conflict with each other. Thus, the efforts of open societies to protect themselves from destructive influences raise the question of whether or not civil liberties must be sacrificed in order to ensure the right to security.

Civil rights cannot logically be considered in isolation from socio-economic (basic survival) and health rights. When the resources basic to survival, also considered rights, cannot be obtained because of scarcity, efforts to obtain them are typically granted priority over civil rights.   However, most conferences on human rights, and most accusations of rights violations, have focused their attention on freedoms, including that from cruel and unusual punishment or bodily violation, rather than the support necessary for health and basic physical survival.

CONCEPTUAL FRAMEWORK

The Assumptive Basis Of Agreed-Upon Human Rights

The idea of "human rights", like other ideas about right and wrong behavior (implying the presence of a moral decision-making faculty) is a human construction. Despite the influence of local culture and environment people everywhere share assumptions about their own nature and that of others who resemble them (see Brody, 1993). Central is some approximation of the idea that a special quality at the core of being human is inherent to one's status as a self-reflective, sentient being. In the case of pre-literate societies this quality has often included the element of uniqueness, the self-designation

of the group in question, in contrast to all others, as "the" people. When humans are conceived as creations of an all-powerful God, the special quality, not shared by other living creatures, may be considered a divine spark.

In developed societies this quality at the core of human-ness has most often been identified as worth or dignity. The ancient Romans believed that such worth or merit deserves respect, and, therefore, just treatment. Blackstone (1765 et seq. in Golding, 1981) described "the absolute rights of man" endowed...with "the natural liberty of mankind". Kant viewed human beings as self-legislating moral agents.

The respect accorded to human status carries with it the privileges and protections essential to maintaining personal integrity. It is these privileges and protections, which have come to be called "rights", i.e. they are unarguable, universal rather than unique, and inalienable corollaries of being human. In sharp contrast to the familial, tribal and other local loyalties of most human groups, international acceptance of a universal concept of rights implies allegiance or loyalty to humankind as a whole, not divided by national, ethnic, religious, gender or other socially constructed boundaries. This kind of recognition is essential to any concept of world, in contrast to purely national, law.

Thomas Jefferson, even as he was a slave owner, wrote that all men, as equal products of a Creator, have inalienable rights to life, liberty and the pursuit of happiness. However, before and since Jefferson, communities have not been willing to grant everyone the status of being fully human with its associated dignity and rights. This was not only true for slaves. Strangers have been particularly vulnerable to being dehumanized, especially

in societies under stress. The same has been true for non-citizens, enemies, prisoners of war (and of criminal justice systems who may lose their right to vote), members of minority groups (including refugees and other migrants), women, children and mentally impaired or psychotic individuals. In some contemporary societies women still do not have the personal and political rights accorded to men. Even in the industrial democracies, notably the United States, women's reproductive rights or freedom to manage their own fertility, i.e. to control their own bodies, is under intermittent governmental attack. To the extent that ideological considerations have led the government to withhold funding from international non-governmental organizations concerned with women's health in post-conflict and other settings, this constitutes an assault on human rights with mental health consequences.

The Internationally Agreed-Upon Concept Of Rights

Within this assumptive framework two major categories of rights declarations have been articulated by the United Nations'1948 Universal Declaration of Human Rights. While both are intended as universal, each depends significantly upon the support of an intact nation-state. If the attention and energies of the state are diverted by conflict it may suspend its support for the civil rights of its citizens in the name of maintaining security.

The first category of rights offers protection to the integrity of individuals through guarantees of personal freedoms. It emphasizes rights of personal self-determination, freedom from domination by a single, impenetrable authority, and the inviolability of one's own body in the face of such threats as torture aimed at effecting a change of mind.

It promotes a vision of a pluralistic civil society based on mutual tolerance and respect for co-existing differing groups of people (variously defined) with differing views. With diversity and free expression at its core it requires the protection of the nation-state of which it is a part. Its freedom or civil rights are understood as "negative" since they depend on the absence of state coercion and political suppression as well as state protection against such coercion by others.

The second major category of rights declarations recognizes and protects individual worth and dignity through guarantees of socio-economic and cultural entitlements. These are understood as "positive" rights since they require the state's active provision of the conditions necessary to well-being. They include employment, medical and social services, and access to the fruits of scientific research important to the attainment of mental and physical health.

The Declaration's consideration of research led to a major twentieth century rights development, termed "bio-ethics", to deal with rapidly advancing biomedical technology in such fields as artificial reproduction, organ transplantation and genetic manipulation. This was formalized in UNESCO's formation of a bio-ethics committee. A major effort was to develop international instruments to protect human rights in the face of broadening possibilities for technical intervention into individual psychological and physiological functioning (Brody, 1993).

A significant obstacle to an operational rights standard regulating the behavior of national governments toward their own citizens is the principle of national sovereignty. This forbids human rights interventions by outside entities (states and non-governmental organizations, i.e. NGOs) to protect citizens from collective abuse by their governments. Such intervention is regarded as interference with the "internal affairs" of the nation in question. This principle has become more porous with the passage of time, especially with the rise of a definable world public opinion based on nearly universal news coverage in mass media, but it remains a barrier.

THE DEVELOPMENT OF INTERNATIONAL RIGHTS AGREEMENTS

Inter-Governmental Accords

For at least a century governments have been aware of the need for human rights protection under circumstances of conflict between sovereign states, even as they tried to exclude outside influences on their internal affairs.

An early step was the 1894 Geneva Convention for victims of armed conflict which, by giving neutral status to medical personnel, recognized the individual soldier as entitled to "at least a minimum of respect for his essence as a person...." (Forsythe, 1989, p. 7). This convention was later revised to focus on prisoners of war. In 1926 The League of Nations breached national sovereignty by influencing a large group of countries to adopt a 1926 convention outlawing slavery. Finally adopted in the 1950s (Forsythe, 1989), it continues to be transgressed in some countries.

The first set of twentieth century international standards with human rights applications, including the prohibition of child labor, was that produced by the International Labor Organization (ILO) reviewed by Valticos (1998). A first Convention in 1930 prohibited forced labor, particularly in the colonial territories. By 1957 forced labor was regarded as a form of racial discrimination. Valticos noted that many labor-related rights, formulated in individual terms, such as hours of work or social security, are meaningful only when exercised in a collective manner.

The founding Charter of the United Nations adopted immediately after the end of World War II in April 1945 stated that the UN would promote "universal respect for and observance of human rights." Its Article 55 committed it to promoting "higher standards of living" including the remediation of "social, health and related problems". In November of that year the Preamble to the constitution of UNESCO (the UN's Educational, Scientific and Cultural Organization) referred to denial of "the democratic principles of the dignity, equality and mutual respect of men...." as a cause of war. In 1946 the UN appointed a Human Rights Commission. It met under the chairmanship of Eleanor Roosevelt from January 27 to February 10, 1947 to draft an "international bill of rights" (Glendon, 2001). Meanwhile, in 1948, the UN passed a Genocide Convention, which forbade "acts committed with intent to destroy, in whole or in part, a national, ethnical, racial or religious group".

On 21 August 1948 the first international mental health NGO, the World Federation for Mental Health, proclaimed its founding document, *Mental Health and World Citizenship.*

It called for "an informed, reflective, responsible allegiance to mankind as a whole...a world community built on free consent and respect for individual and cultural differences' and concluded that "the ultimate goal of mental health is to help [people] live with their fellows in one world."

On 10 December 1948, still in the brief window of hope and optimism between the end of World War II and the onset of the Cold War, the UN General Assembly approved the Universal Declaration of Human Rights submitted by Eleanor Roosevelt's Commission. Its assertion of the "inherent dignity...and equal and inalienable rights of all members of the human family" reflected the values of the industrial democracies. Although it was presented as a non-binding set of universally applicable guidelines, it had to overcome the reservations of several totalitarian states of the period. This was especially true for its Article 18 assuring the right to freedom of thought, conscience and religion, including the right to change one's religious beliefs. Some states asserted that it represented an inappropriate imposition of Western and Judeo-Christian values upon non-Western cultures, indeed, a form of cultural imperialism. The "Western" states were mainly the industrial democracies. The others were, in the main, less developed and more authoritarian. At particular issue was the matter of individual expressive-political freedom versus collective well-being requiring communal order and the fulfillment of individual needs for food, shelter and work. Authoritarian governments asserted that the individual autonomy viewed as a "right" by "Western" governments was incompatible with the value of supporting the community and extended family. In this view

community welfare should take precedence over that of individuals. In the opposing view, community welfare flows from that of free individuals.

Key precipitants for the declarations protecting personal freedoms were the Nazi atrocities of the 1930s and 1940s predicated on the belief that certain categories of people were less than human, and, in terms of Nazi doctrine, not worthy of life. Life unworthy of life, and, therefore, ineligible for rights associated with being human, was defined on bases fitting the beliefs of the most powerful and socially dominant group: racial, ethnic, religious, health and developmental, and, while not specified, inevitably political. Although the Declaration has not been adequately followed it has provided a set of principles, which have served as standards for inter-group discourse, including that between nations. The freedoms, i.e. principles of civil liberties, for example, have served as reference points for dealing with perpetrators and survivors of gross violations of personal integrity suffered during periods of political violence, as in South Africa (Zungu-Dirwayi et al, 2004).

Children's health rights were included in a 1959 UN Declaration of the Rights of the Child, elaborated in a November 20, 1989 Convention. In 1966 the Declaration's freedoms or negative rights, embodied in a Covenant on Civil and Political Rights, and the entitlements or positive rights, embodied in a Covenant on Social, Cultural and Economic Rights, were adopted as treaties by the UN. The freedom to be self-determining was associated with the freedom from torture and "cruel, inhuman or degrading treatment" (Article 5 of the Declaration) and linked to rights to an inviolate

personality, and freedom of speech and expression. It included a reference to the importance of education for the "free and full development of ...personality" within one's community. Women's health rights, including that to plan a family, were elaborated in the 1967 General Assembly Declaration on the Elimination of Discrimination Against Women with more specific recommendations in later declarations. Authoritarian governments, sometimes while publicly embracing many of the civil liberties principles, have continued to regard them as threatening their established orders.

Social entitlements, especially those to "medical care and the necessary social services" have been viewed by United States authorities less as rights than as privileges, requiring the assumption of relevant responsibilities. They have been more emphatically espoused by socialist and welfare-oriented countries, such as the former USSR, in part as a counterweight to accusations that they had violated their populations' civil rights.

Article 3, guaranteeing that "everyone has the right to life, liberty and security of person", especially the idea of a right to security, has only begun to attract significant attention since the rise of international terrorism.

In 1985 the UN General Assembly passed a Declaration of Basic Principles of Justice for Victims of Crime and Abuse of Power. While its advocates viewed it as a possible opening for external intervention in case of a government's collective abuse of its citizens, its main significance was to articulate the importance of mental health

impairment in consequence of governmental victimization and the need, under these circumstances, for reparative mental health services.

MENTAL HEALTH AND HUMAN RIGHTS CHALLENGES OF RECOVERING POST-CONFLICT SOCIETIES

Contextual Change

Most aspects of life in post-conflict societies have the potential to threaten both the freedoms and entitlements, and thus the psychological security, of individuals, families and sub-communities. The post-conflict context is characterized by radically changed and diminished structures of opportunity for freely chosen political expression, religious observance, and informed decision making, as well as lost opportunity for employment, education, health care and other services which offer both actual care and possibilities for coping. The currently reigning authority can interpret the society's right to security as so all-encompassing that it overwhelms individual and community freedoms. In vulnerable individuals, including those traumatized by earlier conflict, as well as those whose self-protective mechanisms have been eroded by age and illness, loss of privacy rights can lead to defensive coping which proceeds to maladaptive anxiety and paranoid thinking. When those suspected of being enemies of the new order are apprehended, the right of judicial review may be withheld by the authorities. The mental health consequences of prolonged incarceration and isolation from friends, family and legal representation in the name of societal security can be devastating.

In a setting in which stable work- places and long time employees have been replaced by large numbers of refugees and migrant workers, their treatment by controlling authorities

can become an issue. It is a human rights issue insofar as it reflects discrimination against minorities as well as deprivation of the right to employment and all of its corollary benefits. It is a mental health issue insofar as it contributes to demoralization and depression.

Where customary ethical norms have been destroyed or diminished in effectiveness due to prolonged conflict and residual hatreds certain previously condemned behaviors may persist. Examples are arbitrary arrests, discrimination on ethnic grounds, and the continuing use of children as combat troops. These concerns are most prominent in societies where conflict between tribal-ethnic-religious groups has been central to the persisting trauma. In these instances the achievement of a national identity while preserving cultural diversity presents a major challenge with human rights implications.

The status of women is an indicator of the prevalence of civil freedoms in most societies. In certain traditional societies chronic violations of their freedoms and autonomy are most egregious in the case of so-called "honor killings" by male relatives when women's sexual behavior is deemed to have dishonored the family. Although post-conflict settings offer the possibility of escape from traditional restrictions, liberated behavior may place the woman at risk. Less extreme is the subtle encouragement of domestic violence under the guise of promoting strong families, as in contemporary Uzbekistan, through reinforcing the dominance of aggressive husbands. One approach to these issues is through empowerment of women by small grants permitting their entrepreneurial money-making activity.

Human Rights and Impaired Mental Health

In stable industrial democracies, the most obvious human rights issues for people with diagnosed mental illness concern their coerced incarceration and "treatment". Some totalitarian states, in an effort to maintain internal order, have tried to divest political dissidents of responsibility by labeling their views as symptomatic of illness, legitimating forced hospitalization and the administration of mind-altering drugs.

The unresolved challenge in stable or post-conflict settings is how to foster individual dignity and freedom and the patient's rights to autonomy while at the same time espousing communal well-being and preserving the social fabric. Some leaders of patients-rights movements have identified mental health as a human rights rather than a medical issue. That is, it is more effectively maintained by protecting personal dignity and the capacity for self-determination than by providing "treatment" for behavioral deviation classified as illness. Physicians, on the other hand, aware of the need to protect the patient and society, regard such an approach as medical abandonment.

In 1989   the World Federation for Mental Health issued a Declaration of Human Rights and Mental Health which made it clear that the fundamental rights of people defined as mentally ill shall be the same as those of all other citizens and that they have the right to be treated under the same standards of competent, humane and technically adequate care as other ill persons (Brody, 1998). The differential availability of clinical care for victims of violence, based on their identification as members of discriminated against groups, constitutes a clear rights violation. Lack of adequate personnel and facilities for

the identification and treatment of diagnosable mental illness can be viewed as a human rights violation. Even after changes of regime victims may not seek care because of continuing fear of retribution, concerns about privacy, fears of unsympathetic clinicians who may have belonged to a former oppressive regime, and wishes not to re-experience trauma. Interpretations of whether or not violations exist can become especially complex when therapist and patient belong to traditionally opposing, mutually feared or hated groups. This was obvious in the interaction between Israeli and Palestinian clinicians and patients in the mid-1980s (Brody, personal observation).

Repeated psychosocial trauma, including the loss of important relationships and familiar and reliable interpersonal support systems, can produce sequelae in vulnerable individuals which fit the criteria of mental illness. Along with physical trauma they contribute to undiagnosed psychological incapacity and loss of economic and interpersonal capacities. There is increasing documentation of the nature of the stressors. Recent data from Rwanda, for example (Republique du Rwanda, 2003), with a high post-conflict prevalence of orphans, suggest the nature of traumas experienced by children, 95 percent of whom were subjected to violence, including 88 percent who had expected to die from machete attacks. More than half and up to three-quarters had participated in massacres, seen corpses, and been threatened directly with death.

Zungu-Dirwayi et al (2004), reviewing the literature and reporting their own data from South Africa, note that particularly high rates of psychiatric disorder have been found among survivors of gross human rights abuses. The apartheid era in South Africa was characterized by frequent collusion between the health care sector and the state. Injured

political activists were reported to police, were subject to withheld treatment and doctors, themselves, were sometimes involved in torture: "It is clear that fear and distrust of state health services continues to the present day despite the demise of the apartheid regime".

In South Africa many anti-apartheid clinical groups would not allow people to work with them "who were not part of the struggle" (Brody, 1996).   Examples of trauma centers operated by politically sensitive staff include several established in the Republic's transition from a segregated police state to what was called a "government of national unity" or as some put it, from "a culture of apartheid" to "a culture of human rights" (Brody, 1996). Three such centers were The Centre for the Study of Violence and Reconciliation in Johannesburg, the Trauma Centre for Victims of Violence in Capetown, and the Child Guidance Clinic of the Clinical Psychology Department of the University of Capetown. All were involved in varying degree and focus with training staff members and others to be socially sensitive advocates as well as clinicians. When possible police and related personnel were among those receiving training. Visits to these centers made it clear that violations of rights to political freedoms and to freedom from intrusions into one's physical body, as in cases of torture, could not be separated from deprivations of social, economic and cultural entitlements including education, housing and health.

The Johannesburg Center, in addition to providing social support groups for people who had been imprisoned and tortured, and for relatives of those who had disappeared, was concerned with the prevalent domestic violence of the region, rape and gender

sensitization. Their police training focused prominently on gender sensitization and in some instances on their former roles both as perpetrators and victims of violence. Center staff did not regard their clients as psychiatrically ill, but as "emotionally challenged".

The Capetown Trauma Center included among its long-term goals "empowering communities to deal with the aftermath of violence". Its philosophy was inspirational described in terms of "the image of a young tree growing out of broken prison bars...to assist people in turning painful experiences into opportunities for growth and a new life." This center operated five special projects, all concerned with the turbulent and unsettled nature of the post-conflict society. The "urban violence" project, at a health center in a black township, dealt with teachers and children in schools, victims of street fights, gang fights, community conflict and "taxi wars" between minivan operators seeking monopolies. The "rural violence" project dealt mainly with problems of unpaid farm workers still flogged and treated as chattels by landowners in isolated areas, and beaten and starved by local police. These workers, because of their past history, tended to be passive in the face of landowners fighting legislation designed to protect their rights. The "refugee and returned exile project" dealt mainly with adolescents and young adults emphasizing education and counseling with a focus on self-esteem, identity formation, and skills for developing friendships, resolving conflicts and leadership. The "torture and captivity" project paid particular attention to children who had been prisoners. The final project, "training", aimed at both professionals and lay people, to build a core group of support-givers and counselors. They were helped by a volunteer network of physicians, nurses and pastoral counselors, all involved in human rights advocacy campaigns,

especially to reduce police violence and promote reconciliation between previously hostile factions of society.

The Child Guidance Clinic became politically active in 1985 when it began to work with child victims of the security forces. Later, however, "with a closer look we realized that the problem wasn't just violence. It was years and years of inadequate education, housing, social structure...our role is to come in and help the teachers work in what is on the surface a completely unworkable situation." Graduate students, thus, were selected on "the basis of their commitment to deal with community problems, and the focus is on advocacy and sensitivity to issues of society, culture and racism."

Conventional psychiatric and mental health centers in South Africa also demonstrated their capacity as loci of human rights advocacy. The Community Mental Health Centre of the Cape Mental Health Society, for example, supported school programs for teachers and preschoolers focused on 'anti-bias" and "anti-racism" work. While in 1996 the passing of *apartheid* had not had a major effect on the material lives of these disadvantaged people "it touches", according to the Society leaders on their "dignity and self-esteem". Lack of security, however, was a problem. In order to make social workers available to as many people as possible they were posted in community venues. Several of their vans had been high jacked from these localities.

Primary health care settings have been suggested as non-threatening sites for treatment and research in this area, with the proviso that staff members be given special training to

deal with such victims (Zungu-Dirwayi, 2004). The primary health care facility offers many advantages for those whose symptoms are primarily somatic in nature, as well as former victims seeking relative anonymity.

THE INTERRELATIONSHIP OF CIVIL AND ECONOMIC RIGHTS

Farmer (2003) makes a compelling case for the proposition that civil rights cannot be effectively defended if social and economic rights are not. He describes "a host of offenses against human dignity" (p. 8) in poor nations such as Haiti in the aftermath of prolonged civil conflict. These include prevailing AIDS, drug-resistant tuberculosis, the suffering and social impairments associated with pervasive and chronic ill-health, and the growing inequities of social advantage and health within as well as between societies. Central are inequities in accessible rights to food, shelter and health basic to simple survival. Those most routinely subject to these un-remarked human rights violations are the destitute poor marginalized as "undeserving" by the middle class of their stabilizing societies. They include, among others, drug addicts, sex workers, illegal non-citizens, welfare recipients and the homeless. Farmer also draws attention to the ways in which the national and international policies of corporations, governments and UN associated agencies (e.g. regarding trade, market-based medical care, lending and financial support, embargoes, apparent racial preferences in refugee acceptance) impinge on the lives and welfare of the destitute poor of many countries. He argues that the rights violations which characterize societies are not random, but are symptoms of deeper pathologies of power, involving the creation and management of institutional structures, determining who will suffer and who will be protected. Exclusion from the mainstream culture, from

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opportunities for health care, jobs, housing, and education, are conceived as violent consequences of global structural forces determining the survival rights of vast numbers of people in all of the world's regions. His key organizing concept of "structural violence", is borrowed from Johan Galtung (1969).

SOCIAL RECONCILIATION

The reconciliation of the citizenry with former state-based oppressors, as well as the coming to terms of formerly hostile factions, are essential to the political and human rights rehabilitation of post-conflict societies. This reconciliation provides a context for diminished fear, anxiety and depressive preoccupations, as well as anger and a wish for revenge, in the post-conflict society. A secure, non-hostile context promotes the emotional security of its inhabitants. However, mutual trust cannot be rapidly restored after brutal conflict with still-fresh memories. Further, intergroup harmony has not always existed prior to the immediately preceding conflict. Under these circumstances mutual acceptance of the adversary's right to exist, that is an increase in tolerance, is an achievement in itself.

The best-known institution developed to promote this process was South Africa's Truth and Reconciliation Commission established on 15 December 1995 and headed by Nobel Peace Prize winner, Archbishop Desmond Tutu. It was important to the many traumatized individuals who were ready to forgive if they could know "who and what to forgive" (Brody, 1996). Perpetrators of the earlier brutalities could apply for an amnesty

hearing, with a full, "not coerced", disclosure, proving that their acts were politically motivated. The cut-off date for amnesty applications was 16 December 1996. Even toward the end of its tenure, however, since the Commission represented a compromise between the security forces' effort to legislate a general amnesty and others wishing revenge and reparations, it remained controversial.. Truth commissions with variable outcomes have taken place in Argentina, El Salvador, Nicaragua and Haiti. The outcome of their efforts, in the absence of an emerging charismatic leader such as Nelson Mandela, has not been regarded as generally successful.

USAID's Center for Development Information and Evaluation (CDIE) has undertaken three case studies of social reconciliation activities (Kumar, 1999). One was of peace committees in South Africa in pursuance of the National Peace Accords signed in September 1991 to prevent violence and promote peace. A second study assessed the impact of collaboration between Israeli and Arab scientists on relationships conducive to peace. The third study examined the role of peace media in promoting inter-ethnic reconciliation in Bosnia and Herzegovina, and the effects of economic development initiatives in fostering ethnic tolerance. All data in these three studies were qualitative in nature, derived from in-depth interviews, document reviews and field observation.

These and similar studies report modest, temporary improvements in the desired direction between small segments of the societies in question, e.g. the collaborating scientists, business people, or journalists, themselves. Certain intervening objectives were significant steps in the direction of reconciliation. These included: facilitating

communication between parties; establishing reciprocal dialogue with acknowledgments of the past aimed at reducing anger, prejudice and misunderstandings (and, although the term was not used, achieving mutual forgiveness); establishing positive relationships through cooperative activities. Opening channels of communication between antagonists was a particularly important first step. An important secondary objective of collaborative activities has been promoting development in such areas as agriculture, trade, and small-scale industry. A sense of shared economic interest appears to often transcend ethnic considerations.

Most of these steps have been identified in earlier attempts at reconciliation, such as joint meetings between Israeli and Palestinian psychiatrists which took place over several years without a systematic record. Dialogue has been promoted through problem solving workshops between influential persons and community leaders on both sides. It seems especially important to bring to light the human rights violations experienced on both sides. Ethnic reconciliation commissions have been established n Poland, Bulgaria, and the Czech Republic. The same might be said for efforts to establish peace committees and commissions and peace research and training organizations in general. An example of the former is the Human Rights Chamber of Bosnia-Herzegovina (Newton, 2004) to which appeals can be made by parties who consider themselves victims of violations. Conflict management training has usually been undertaken by academic institutions and NGOs.

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Media experiments, some supported by USAID, have been tried in various parts of the world. Peace radios, established in Burundi, Rwanda and Somalia have helped correct extremist propaganda (Kumar, 1999). Efforts at training journalists for unbiased news reporting have not been regarded as successful.

SUMMARY

Despite the designation, "post-conflict", societies traumatized by recent civil wars and comparable disturbances remain vulnerable to human rights violations. These include both violations of freedoms, i.e. civil liberties including cruel and unusual punishments, and of entitlements or social supports, i.e. accessibility to survival needs including food, shelter, medical care and employment. Freedoms and entitlements are presented by the 1948 United Nations Universal Declaration of Human Rights as accorded to all humans by virtue of their inherent worth or dignity as self-reflective beings deserving of respect. The respect accorded to human status carries with it the privileges and protections essential to maintaining personal integrity which have come to be called "rights". Originally enshrined in the 1948 United Nations Declaration they were given treaty form in the succeeding Covenants of 1966.

Prominent among the elements contributing to the possibility of human rights violations in post-conflict societies is persisting antagonism between the original adversaries and hostility between adherents and opponents of the new post-conflict order. Prolonged periods of societal disarray, often involving these adversaries as well as common criminals, may call for authoritarian methods to restore order. Under such circumstances

attempts to ensure security may threaten civil liberties. Punitive actions, ostensibly aimed at maintaining security by currently reigning authority, may involve the dehumanization of prisoners as well as strangers and members of minority groups. Detained as possible enemies of the new order, their right of judicial review may be withheld. Where the effectiveness of customary ethical norms has been diminished and residual hatreds persist previously condemned behaviors may continue, e.g. ethnic discrimination and arbitrary arrests. While nominal efforts are made to improve the status of women in traditionally patriarchal societies, newly liberated behavior may place them at risk. In all of these instances the verification of conformity to human rights standards by international observers can be impeded by rigid adherence to the principle of national sovereignty.

A factor leading to apparent rights violations may be a lack of material resources requiring stringent conservation methods. This may make it impossible to supply the social entitlements promised in the Universal Declaration. Those who suffer most are marginalized groups, stigmatized as "undeserving" even in stable societies: the destitute poor including addicts, sex workers, illegal non-citizens and the homeless. After prolonged civil conflict they may include people with AIDS, drug-resistant tuberculosis, and other chronic illnesses for which care is not available. In conditions of scarcity, UN declarations permit entitlements to be regarded as valid claims pending improved economic circumstances. However, material scarcity is not a reason to suspend civil liberties.

In the aftermath of conflict people must confront the loss of familiar structures of opportunity, not only for free civil expression, but for employment, education, health care and services which offer both actual support and possibilities for coping. Restitution of the social structure is essential to the ultimate protection of civil liberties as well as social supports. However, restoration of such opportunities may be incomplete and the effort prolonged and complicated by large numbers of refugees and migrant workers.

Post-conflict settings tend to have higher proportions of psychologically disturbed individuals than encountered in more stable settings. The unresolved challenge in all settings is how to foster individual dignity and freedom and the patient's rights to autonomy while at the same time protecting communal well-being and the social fabric. The 1989 World Federation for Mental Health's Declaration of Human Rights and Mental Health made it clear that the fundamental rights of people defined as mentally ill shall be the same as those of all other citizens and that they have the right to be treated under the same standards of competent, humane and technically adequate care as other ill persons. Human rights violations can include the differential availability of rehabilitative care for victims of violence based on their identification as members of discriminated-against groups, and the failure of distressed persons to seek help because of continuing fears of retribution, concerns about privacy, and fears of unsympathetic health workers who belonged to a former oppressive regime.

RECOMMENDATIONS

International

Issues Relating to National Sovereignty

In 1985 the UN General Assembly passed a Declaration of Basic Principles of Justice for Victims of Crime and Abuse of Power. Its main significance was to articulate the importance of mental health impairment in consequence of governmental victimization and the need, under these circumstances, for reparative mental health services. It is recommended that conference participants consider the potential for building upon this Declaration already passed by the UN General Assembly. The possibilities for external, humanitarian intervention to limit governmental abuse of its citizens and care for its victims, inherent in this Declaration should be explored with the aim of developing a "free access" alliance of participating governments and NGOs capable of crossing national boundaries to achieve this goal. This might be conceptualized as a linking of health ministries permitting the exchange of information, equipment and personnel. It could begin with the "twinning" of two ministries and the eventual coalescence of others or of pairs of twins.

National

The keys to human rights promotion and protection in post-conflict civil societies may be summarized in terms of reconciliation (between former and newly activated adversaries), restitution or restoration (of social structures and capacity for social support), and rehabilitation (of victims of human rights violations).

RECONCILIATION

Achieving some level of reconciliation between former antagonists is essential to the human rights rehabilitation of a society.

(a) Consider developing a national institution analogous to South Africa's Truth and Reconciliation Commission and local groups based on South Africa's Peace Committees.

(b) Foster collaboration between scientific, clinical or economic development groups formerly affiliated with opposing antagonists.

(c) Explore ways of facilitating dialogue between parties, including influential persons and community leaders.

(d) Explore the possible role of conflict management training.

(e) Explore the role of media in perpetuating and/or reducing conflict and tension.

RESEARCH AND THE QUESTION OF SOCIAL JUSTICE

A number of studies indicate that PTSD and a variety of anxiety disorders are prominent in displaced populations as well as those in post-conflict situations. Informal evidence suggests that when most of a population at risk believes that former oppressors have been brought to justice they may experience a decrease in feelings of anxiety and sensitive wariness about eminent danger from others and from authorities in general. However, this issue has not been systematically studied. Among the related concerns are feelings of concern of former victims and their relatives about confronting perpetrators who have been released in consequence of reconciliation activities. The number of confounding variables and inability to use control groups in naturalistic settings of this kind suggest

the difficulties in designing research in these areas. Another complication might be the inability of an investigator to be ethically neutral, especially when dealing with former perpetrators.

RESTITUTION AND RESTORATION

The key element to the restoration of civil society with adequate human rights protection is the unwavering commitment of national leaders to this goal. Legislative and judicial initiatives aimed at protecting the rights of minorities and other vulnerable groups may be necessary. The same is true for protecting the rights of women whose chattel status can be taken for granted in authoritarian patriarchal governments.

At lower levels of government crucial elements of restoration of civil society are training and education. Special attention must be paid to general education, specific training in human rights for all students as well as law enforcement and judiciary agencies, and to the fiduciary and advocacy roles of health care professionals. A particularly sensitive issue will be preventing the dissemination of hate messages while maintaining the freedom of the press and other media

Economic recovery, addressed in other chapters, is essential to restoration of civil society and the availability of work, health care and education

SECURITY PERSONNEL TRAINING

As noted above training police and other security personnel in human relations is essential to the ultimate maintenance of human rights.
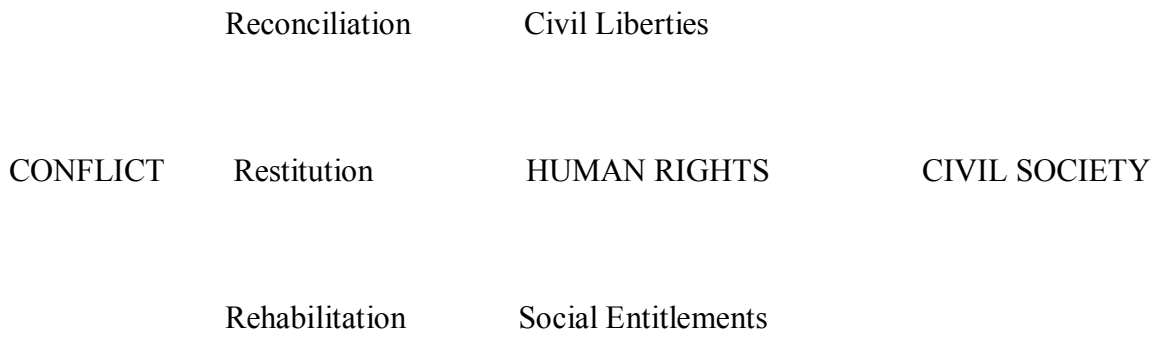
REHABILITATION OF TRAUMATIZED PERSONS

1. **Primary Health Care Centers**

Train the personnel of such centers to deal with victims of human rights violations. Especially, the importance is the development of their advocacy and fiduciary roles as essential complements to their clinical skills.

2. **Trauma Centers**

These, following the South African model, are conceived as operating in parallel fashion to the primary health care centers for clients who are less concerned about privacy and less fearful of retribution. Their goals would include providing social support groups not only for victims and families, but for perpetrators, and police. Police training in human relations is essential.

FIGURE I

	Reconciliation	Civil Liberties	
CONFLICT	Restitution	HUMAN RIGHTS	CIVIL SOCIETY
	Rehabilitation	Social Entitlements	

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