Challenges of sustainable mental health care and psychosocial support in low- and middle income countries

Petra G.H. Aarts

Colophon

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The opinions are purely those of the author.

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Foreword

Since its establishment in 1997, the Dutch War Trauma Foundation (WTF) is dedicated to the realisation of hope, peace of mind, and the full potential of communities impacted by individual and collective trauma, particularly in lower resourced settings. WTF works towards its vision together with local communities in development and exchange of knowledge, capacity building and innovation in psychosocial support. The vision is achieved through technical training and supervision, financial support, development and promotion of local and regional networks, and the compilation and dissemination of resources in several languages.

In our experience of more than a decade in working together with local organisations, we understand that recovery of persons and communities from individual and collective trauma often requires time, commitment and patience. However, the complexity and fragility of settings where traumatic events have occurred, or continue to occur, challenge the efforts of those who attempt to lighten the psychological and social burdens of adversity of impacted communities. Particularly, how to achieve the required coverage and efficacy, the embedding in local infrastructures and durability of effects, we feel as challenging questions in our organisation. In the early days of 2007 the initiative taken by the director, Maurits Cohen (1997 – October 2009) to study the current opportunities and hindrances of sustainable care and support in low and middle income countries, became concrete thanks to the support and funding of the Dutch Ministry of Health, Wellbeing and Sports.

The present report of this study underlines first of all the indissoluble relation between effective and adequate interventions and their sustainability. Sustainable recovery from the effects of war or organized violence recognises not only the innate capacity of persons to heal and rebuild their lives, but also the usefulness of culturally relevant and well thought out programmes to enhance natural coping and to open the way for new and creative ways to solve complex problems. Achieving sustainable care and support absolutely requires local commitment and institutionalisation, and respect for wisdom and knowledge of local persons who have lived the experience and dedicated their efforts to help.

Beyond psychosocial support programmes themselves, advocacy, awareness raising, psycho-education, the promotion of human rights and sometimes reconciliation, may well enhance the growth of mutual responsibility and civic commitment in these fragile environs. In concert with the *IASC Guidelines* of 2007 this report emphasises the importance of inter-sectoral collaboration. Although teasing out the critical elements of sustainability of psychosocial recovery in very different settings does not always yield one concrete solution, the present report moves the learning a step further by pleading for additional collaboration of relevant agencies aimed at sustainable care and support.

The War Trauma Foundation expresses their thanks to Petra Aarts for her efforts to describe the contexts and particularities of present mental health care and psychosocial support, and to identify and summarise some main obstacles for its sustainability. In the general awareness of such challenges, the opportunities rest to enhance the efficacy of all our mutual efforts. War Trauma Foundation also expresses gratitude to the Dutch Ministry of Health, Welfare and Sport for its support and funding of this study, and to each of the members of the committee that supported and advised the author in her endeavours. Finally, our kind and sincere thanks go to the organisations and local experts that so generously provided time, relevant information and reflections based on their direct experiences in this field.

It is our hope that this report will function as a basis for further consideration and the development of sufficient consensus and direction of all relevant agencies in this quest.

Marieke Schouten
Director War Trauma Foundation
January 2010.

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A study such as this could not be accomplished without the enthusiastic and knowledgeable support, comments and suggestions of many others. Not only the various people I spoke with during the course of the study, but also the published and unpublished papers and books have been very informative and inspiring, and certainly helped the study on its way.

The study included the input of a few local NGOs, operating in this field. The visits to eleven NGOs, in various parts of the world, have been stirring and significant for his study. It was a remarkable opportunity to hear, see and weigh the successes, efforts and hurdles on the pathway to good quality and sustainable mental health care or psychosocial support. It also made it possible to compare hypothetical assumptions and ideas from both the literature and my own experiences to the realities and practices in very diverse settings and circumstances. These visits have contributed largely to the analyses and conclusions, as can be found in this report. It is impossible to mention the many people by name that were so kind to offer me some of their time, to show me around, answer my inquiries, and give me their vision on their daily efforts in this field. I will therefore confine myself to mentioning the names of the organisations that have been included in this study. They are: Dostezhenia, Vladikavkaz, North-Ossetia; Hope Flowers School, Bethlehem, West Bank; Shade, Vavuniya, Sri Lanka; TPO Nepal, Kathmandu, Nepal; ICMC, Jakarta, Indonesia; Network Colombe, that consists of some local NGOs or CBOs from both Burundi and from the Democratic Republic of Congo; Osmieh, Cracanica, Bosnia and Herzegovina; TPO Uganda, Kampala, Uganda; HealthNetTPO Burundi; Bujumbura, Burundi; Society for Psychosocial Assistance, Zagreb, Croatia; and TPO Cambodia, Phnom Penh, Cambodia.

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Appreciation is due to the members of the support committee of this study, even though some of them could only participate in it for a shorter period of time. They are: Peter Ventevogel, HealthNet TPO and current Editor in chief of the journal *Intervention*; Hans Stolk, MSF; Herbert Seevinck, director Mijksenaar; Guus van der Veer, former Editor in chief of *Intervention*; Willem Helmich, Dutch Ministry of Health; Gemma Claessen, former employee of WTF, Tineke Pronk, WTF and Leslie Snider, WTF. Their support and critical or encouraging comments have been very valuable.

And last, not least, I thank the War Trauma Foundation for their initiative to take on such a fundamental but complicated issue as the sustainability of mental health care and psychosocial support in low and middle income countries, and the Dutch Ministry of Health for their financial contribution to this study. I thank both for enabling me to embark on this venture.

Petra Aarts, January 2010

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Introduction

Presently and in the foreseeable future, tens of millions of people suffer the consequences of deprivation and violence, sometimes beyond our imagination: men, women and children alike. The vast majority of them live in low and middle income countries. The origins of their suffering may be manifold, usually interrelate, enhance each other, and hamper recovery. Exploitation, poverty, bad or insufficient governance and policies, both national and international, deficient health care and education, adverse historical, cultural and religious idiosyncrasies, shortages of food and clean dinking water, violence, discrimination, violations of human rights, (sexual) abuse and suppression in past and present, may all be part of the entwinement between cause and effect.

Humanitarian aid, essentially from much wealthier parts of the world, strives to better the living conditions of affected populations. Recently, in the past two decades, psychosocial and mental health care have become part of this effort, though, as we will see, not an *integral* part yet. The current credo of helping people help themselves, in earlier days expressed in the proverb *don't give fish, but give a fishing net*, has been widely embraced. This principle applies to mental health care and psychosocial support as well. The adagio expresses the intention to empower the people concerned, helping them to develop and attain required supplies or services themselves. Indirectly, it also expresses the intention to strive for sustainable assistance. In practice, however, sustainability of humanitarian assistance, in particular mental health care and psychosocial support, is rarely achieved.

Faced with a reality, where worldwide the people concerned count up to tens of millions, it may seem an impossible enterprise to improve their wellbeing and living conditions. Fortunately, where humanitarian assistance is concerned, solidarity and compassion prevail over cynicism and passivity.

Sustainability

This study focuses on sustainability, in particular the sustainability of current mental health care and psychosocial support in resource poor countries. Directly connected to that keyword is the word 'quality'. Obviously, sustainability lacks meaning if it does not refer to sufficiently effective or appropriate services. A comprehensive definition of sustainability, however, is rather complicated. It depends on the particularities of each separate venture, the specific needs of target populations, external conditions, (pre) existing infrastructures, the set of goals of the services, and so on. For the purpose of this study, the definition of sustainability is kept concise and general: it refers to the potentials of good quality assistance, to develop, adjust and last as long as the assistance is needed, and finally evolve into an integrated part of the local societies or communities.

This brief description of what is meant by sustainability in this study is, however, not sufficient to clarify what exactly is expected to be sustainable. In a chapter of the publication of the World Health Organisation: *Promoting Mental Health*, it is stated that policies should support that one of programmes develop into longer-term solutions. The denotation of sustainability generally refers to continuation and durability of effect. The authors, however, point out that there is an important distinction to be made between sustainability of *effect* and that of *effort* (Howe, Ghali & Riley, 2005; see also: Jackson et al. 2005). The authors further state that sustainability of effect refers to two components: namely whether the effects on the beneficiaries are maintained over time and, second, whether effects are transferred to subsequent cohorts of people. If there appears to be no sustainability of effects in one or both senses of the word, one of the causes may be that standards of quality are not met, or, and here we get to the importance of sustainability of effort, effects may be diminishing or disappearing as a consequence of *lack of effort* to maintain and enhance positive effects.

In line with the abovementioned authors this study therefore links the sustainability of programmes to the general fields of capacity building, ecology and organisational development. But it needs to be underlined that the sustainability of programmes or projects themselves is not an aim in itself. The sustainability of good enough care is the ultimate goal. Capacity building, sound local organisations or to embed in pre-existing local infrastructures (ecology) may secure opportunities for the sustainability of effort that permits the sustainability of effects.

Mental health care and psychosocial support

Next to sustainability, psychosocial and mental health care, are keywords in this report. Current mental health care and psychosocial support concentrate largely on strengthening or restoring a new social balance and on individual wellbeing. It is not only important for the condition and health of individuals or groups of individuals; by way of spin-off, it may also provide opportunities for social, economic and political stabilisation. Focussing on the psychological wellbeing of people, both terms in practice may well overlap. For instance, in the abovementioned document of the WHO from 2005, many common psychosocial problems, interventions and goals are described under the term mental health.

Starting from the premise that human life and wellbeing are essentially determined by the interplay of biological, social and psychological dynamics, the WHO, at the turn of the century, has redefined their definition of mental health. Thereby, it parted from the previous definitions that did not take these dynamics into consideration and where health, including mental health, was considered as "not merely the absence of disease". In its new definition the WHO defined mental health as follows:

… A state of wellbeing in which the individual realises his or her own abilities, can cope with the normal stresses of life, can work productively and fruitfully, and is able to make a contribution to his or her community.

(WHO, 2001, p.1).

Next to the recognition of the bio/psycho/social model, this definition also allows for nuances. It considers health and disease as merely the beginning and the end of a more realistic continuum that allows for a coexistence of healthy aspects and partial illness in any proportion in one and the same individual or group of individuals. Furthermore, the WHO is convinced that despite existing differences in values and perceptions across cultures, gender and socioeconomic classes, this definition possesses universal, cross cultural validity.

Apart from its recognition of the multi-factor nature of (mental) health and the identification of a continuum, the new definition also bridges the traditional gap between physical health and mental health, as separate conditions or entities. This smoothes the positioning of mental health more strongly in current public health policies, also in low and middle income regions. Furthermore it illustrates why in many instances the descriptions of mental health and psychosocial care so often overlap.

However, for the purposes of clarity, a distinction between the two terms can be made. *Mental health care* could refer to the care or cure of psychiatric and related disorders. In principle, a wide array of interventions is possible, from the distribution of drugs, psychotherapies, counselling and psycho-education of both the patient and his or her relations. An important reason for overlap in present common practice is the usual absence in low income countries of appropriate or sufficient mental health care facilities, such as hospitals, psychiatrists, neurologists, drugs, diagnostic instruments, therapists, and so on. The care of mental patients and their families, if at all, is mostly in the hands of providers of psychosocial support.

Currently, *psychosocial care* focuses on the empowerment of communities. The mobilization, strengthening and supporting of (pre) existing resources, such as healers and leadership, are important in this. But also rituals, customs and beliefs may enhance the often torn social fabric, and help communities to cope. The empowerment of communities or groups of individuals, by connecting and enforcing innate resilience in both communities and individuals, are thus the nucleus in present humanitarian psychosocial care. It deals with a broad range of psychosocial problems on individual, group and community levels, and the prevention thereof. They may be phenomena of depression, physical complaints, hopelessness, apathy, domestic or sexual abuse, aggression, substance abuse, truancy, hunger, unemployment, or any mix of these.

The quest for adequate and sustainable mental health care and psychosocial support is necessarily interdisciplinary. Psychology, sociology, anthropology, medicine, nursing and management are all, and not exclusively, relevant disciplines. Various backgrounds and convictions in this field, in past and present, have led to divergent views on the nature and interventions of both mental health care and psychosocial support. Undoubtedly points of view will continue to diverge and conflict. In some instances these differing ideas may lead to the development of better practices. There is, however, plenty consensus that a restoration of self-esteem, of hope and of social bonds within communities yield results, both in terms of psychosocial wellbeing as in mental health (Hobfoll et al. 2007).

The commitment of a community to improve their own situation by means of psychosocial interventions may well enhance their dedication and involvement in other area's of humanitarian aid as well. Where coping and mutual involvement and responsibility are growing, the restoration or building and maintenance of, for instance, water for drinking and irrigation, the production of food, vocational- and income generating activities, may well improve as a consequence of enhanced mental of psychosocial well-being. This is one of the reasons why, even in emergency settings, the full package of humanitarian assistance helps best. They support and strengthen each other. The growth of hope, of awareness, of self-esteem, of regaining control and independence promote the sustainability of suitable and fitting humanitarian aid.

IASC Guidelines

This study aspires to connect to the *Guidelines on Mental Health Care and Psychosocial Support in Emergency Settings*, published and distributed by the Inter-Agency Standing Committee (IASC) in 2007. Based on current best practices and current consensus the *IASC Guidelines* promote collaboration and fine-tuning between the more conventional humanitarian assistance and the relatively new branch on the tree of psychosocial and mental health care. Their guidelines put it as follows: "A significant gap had been the absence of a multisectoral, inter-agency framework that enables effective coordination, identifies useful practices and flags potentially harmful practices, and clarifies how different approaches to mental health and psychosocial support complement each other" (p.1). In line with the IASC stance of mutual consultancy and collaboration, De Jong (2002) already argued that it is fairly impossible to mobilise resources to help people cope without a thorough understanding of the context of both their problems and their strength's.

The *IASC Guidelines* thus offer essential recommendations on the facilitation of an integrated approach to deal with the most urgent mental health and psychosocial issues in emergency situations. Joining forces and supplying a wide variety of services to a community, as the *IASC Guidelines* so fiercely promote, will enlarge the positive effects of each particular kind of intervention. Raising awareness, strengthening and awakening local human resources and resilience, restoring hope and social relations, commitment and solidarity, augment the potential effects of traditional humanitarian projects and programmes and vice versa. However, where competition, differing affiliations are present, and where policies and strategies vary as they do in many instances, this collaboration may need time to grow. Working together, fine-tuning, combining forces is not easy. But when it boils down to it, we foremost need the political will to do it.

The abovementioned guidelines specifically refer to emergency situations, where a host of international or supranational agencies endeavour to help a suffering populace. The present study, however, exceeds the emergency phases, and advocates that mental health care and psychosocial support plays a role in post emergency settings and in structural humanitarian or developmental aid as well. The recommendations and standards of quality of the *IASC Guidelines*, by and large, are fitting and leading beyond emergency settings.

The rationale of sustainable and sufficiently appropriate mental health care and psychosocial support is evidently not only a matter of human ethics. The neglect of adverse psychological and social conditions of the target population may well increase the economic, educational and political costs to a large extent. It reduces the potential of human resources. This loss of capacity and ability can even be expressed in economic and financial terms. Moreover, practically half of the loss of human resources as a consequence of disease is attributed to psychological problems (see De Jong, 2002; 8).

The study

This study on sustainability is explorative in nature. Its objective is the identification of indicators that, in current practices of mental health care and psychosocial support, either hinder or help the development of good quality and sustainable care. Its ambition is the formulation of conclusions and recommendations that will stimulate this development.

At present there is sufficient consensus that implementing psychosocial and mental health care is needed over longer periods of time, and exceeds emergency phases. The need for sustainable programmes is, therefore, generally felt. But, as has been stated above, a definition of sustainability is troublesome. It may well depend on each separate programme, its specific context, and set of activities and goals. These may, in practise, be highly variable. The quality of capacity building, such as training, is indissolubly related to sustainability. But next to this, the strategies, characteristics of the target populations, donor's or implement-

ing organisations (exit) policies, assessments and evaluations, networking, collaboration and fundraising, local acceptance and appreciation, opportunities of rooting in local (pre) existent infrastructures of policy, care and education, are equally important. In addition, despite the present growth of indicators for best practise and the many lessons learned, the field is still in an experimental stage.

Changes for clear indications of past and present psychosocial and mental care programmes are surveys of surviving and disappeared programmes or projects worldwide over the latest decennia[1]. However, the mere survival of a local or international NGO over a longer period of time may well be an *indication* of sustainability, but it is not necessarily a guarantee of good enough practise and (sustainable) proper training and care for target populations. In other words, there may well exist local NGOs and international programmes that know how to maintain themselves and survive over a length of time, but don't supply good enough services. Nor does the untimely ending of programmes signify that all or even most components of the NGOs programmes proved inadequate. Furthermore, knowing how many, or which programmes survived or vanished, does not indicate the factors that underlie this. It would not bring the identification and understanding of these factors any further.

As has been stated above, the main target of this study is to identify factors within the entire range of relevant perspectives, that either contribute or hinder the processes of becoming good enough quality and sustainable support structures and systems. Its methods are explorative in nature. Analysing, comparing, and relating findings are important ingredients in this study. The objective is to discern sufficiently valid and general conclusions. The conclusions express the present best strategies to promote the sustainability of the kind of humanitarian projects in question. The tools in this particular study are a study of literature (guidelines, reports and evaluations included), and interviewing key persons in field programmes (eleven in total) that bear sufficient promise for standards of good quality and sustainability.

Literature

Over the years, many journal articles and books, as well as unpublished reports and evaluations on mental health care and psychosocial support have been prepared and/or distributed. The amount of relevant contributions is rapidly growing. The authors are often experienced implementers, trainers, project leaders, and so on. In general they describe, contemplate, analyse and weigh the processes and results of particular psychosocial and mental health programmes. Most of them refer to the experiences and lessons learned in specific programmes in different regions of the world and with a variety of target populations. Other, more general contributions describe the (im) possibilities of diagnostics, assessments, cultural obstacles and opportunities, research possibilities and results, the suitability of various kinds of interventions, etc.

Studies and reports on the treatment of refugees and asylum seekers in western countries are also relevant. They can educate on the nature of the problems and the characteristics and opportunities of treatments and support. However, the nature of psychosocial problems in these populations cannot be applied as blue prints for interventions in and support of populations outside the western world. Comparisons between these groups are only valid to a limited extent. Subsequently, over the years many guidelines and manuals on (training) psychosocial and mental health care have been developed. They contain the lessons learned and past and present states of the art in this field of international humanitarian assistance.

Most of the studies and reports deal with one or more specific programmes or challenges. Sustainability is rarely explicitly included in the analyses. However, descriptions, evaluations and scrutiny of implementations and its results, allow opportunities for identification of factors that may either contribute or hinder processes toward sustainability. These findings from the literature were one of the fundaments of the choice of the visited projects and the enquiries of programme staff, fieldworkers, trainees and primary beneficiaries. A selection of basic relevant literature and studies has been added to this manual for further and more detailed reading.

[1] By the turn of the millennium, the conflict in East Timor, between Muslims and Christians, escalated violently. This resulted in a chaotic run of large numbers of psychosocial initiatives from abroad. After a brief period of approximately two years, only a handful of projects were still going on. The surveyors found the quality of services and policies generally flawed.
Laughry, M. & Kostelny, K. (2002). *Mapping psychosocial interventions in East Timor.*

Projects

An important element of this study was the visit of projects that, according to evaluations and informants have proven to be, or to become, quite sustainable. Eleven projects, programmes or organisations have been selected [2]. The quality of both trainings and provisions, herein, was imperative. Because of the small number of projects visited, they can by no means be representative for the entire field. Nor are they necessarily the best examples. Next to the quality of each projects activities and assumed sustainability, there have been some other selection criteria:

- Projects were preferably exemplary of the most regular psychosocial or mental health care provisions, such as the dissemination of expertise and the nature of interventions;
- Comparability of common projects, such as the training of schoolteachers, services in refugee or IDP camps or settlements, disrupted communities, etc., was similarly important. For this comparison two, in this respect, comparable projects in dissimilar regions and circumstances were chosen, and
- Finally, geographical spreading and varying cultures, was a leading principle in the selection of projects.

The main objective of this part of the study was the indications they could give about both opportunities and obstacles to becoming sufficiently high quality and sustainable programmes. From the results of the visits on location, generalised conclusions with regards to these indicators have been formulated. These conclusions have been compared to findings in the literature.

The reading of information on the projects in questions, and the interviews with relevant representatives from within and outside the projects, were instruments to attain this information. Questions have been prepared prior to the interviews, but where for a large part free floating. Standardised questionnaires to allow for comparisons have not been developed as a consequence of the great variety of projects, regions, goals, planning and, of course, the divergent positions and tasks of the interviewees. Depending on the nature and characteristics of each project, these representatives were project leaders, and managers, trainers, trainees, fieldworkers, primary beneficiaries and, when appropriate and possible, key persons and authorities from within the community. Depending on the interviewee in question, the interviews covered various relevant items, such as the nature and condition of the target populations, evaluation of the appropriateness of both trainings and interventions, relations with external relevant organisations, collaboration, possible spin-off, policy and strategies with respect to sustainability, and so on.

Target audience

This study and its conclusions are meant for all agencies involved in humanitarian assistance, in particular in mental health care and psychosocial support. Like the IASC Guidelines, they are not limited to individual organisations or projects. The quest for sustainable care and support entails collaboration among divergent humanitarian agents. This does not only mean a fine-tuning and working together with other mental health care or psychosocial projects or programmes, educational systems, governments, but also with organisations that provide or facilitate, food, shelter, medical care, water, education, income generation, management, etc.

The study is particularly targeted to the workers and managements of (implementing) NGOs, whether local or international, to various relevant branches of the United Nations and other supranational organisations, governments and to donor organisations that are directly or indirectly involved with the psychological and social wellbeing of the many millions of people in distress in (post) conflict or disaster regions.

Overview of the study

The first chapter of this report concerns the nature and practice of present mental health care and psychosocial support. This is, after all, next to sustainability the topic of this study. Its contents are general of character, but lean as far as possible on current overall consensus and best practice. For some of the targeted audience the chapter can give some insight in motivations, considerations, dilemma's and do's and don'ts of this particular kind of humanitarian assistance. In the list of references that concludes this report, readers will find a selection of books and articles that deal with the various subjects in much greater detail. The same counts for the following chapters as well.

[2] The projects included are mentioned in the acknowledgements of this report.

This chapter begins with contemplating why governments and organisations embark on psychosocial and mental health care. It further illustrates the conditions under which target populations survive and describes the nature of, and what is known about the effects of atrocities on their physical and mental integrity. Other paragraphs of the chapter deal with common practices and dilemmas of mental health care and of psychosocial support. Relevant items such as possible interventions of both mental health care and psychosocial support, and cultural discrepancies and challenges conclude this chapter.

The second chapter deals with one of the main instruments of promoting sustainable services to primary beneficiaries: training. Training, included the training of trainers (ToT), is one important means of capacity building in affected regions and countries. It's a manifestation of the common axiom *to help people help themselves*. To give some indications of what, who and how, according to present best practice, training should mean, this chapter deals with various relevant issues. Such items are: the importance of preceding and continuous assessments, both on the needs of the target population, the progress of the trainees, and the appropriateness of trained interventions, of avoiding top-down or single training, of care for caregivers, supervision, and cultural sensitivity and suitability.

The chapter further offers a brief, but to the point overview of lessons learned in the past and of differing standpoints amongst colleagues with respect to mental health and psychosocial care in general and on common practices of training in particular. A reflection of the current debate concerning counselling also finds a place in this chapter. The chapter further deals with the pursuit for experimental and scientific (evidence based) fundaments of trained contents and interventions. A paragraph on the training of trainers ends the chapter.

Where the first two chapters mainly address the subject matter of sustainability of effect, the third chapter concerns the just as important sustainability of effort. The development and consolidation of local NGOs, or the support of community based organisations is instrumental herein. Although not all projects or programmes in the field under scrutiny are necessarily supported or initiated by local organisations, many do. In fact, a policy of the international community to assist in the establishment of local NGOs, community based organisations, health care facilities, or even governments, is an important step towards sustainable mental health care and psychosocial support. In practice, however, local organisations in most cases do not survive the initial funding period(s). This chapter stresses the importance of aspiring and supporting local organisations to improve their functioning and continuation. However, in contrast to self-organisations in the West, their own governments will rarely support self organisations in low income countries. Self-reliance therefore depends largely on financial and initially also organisational support from abroad.

Becoming an independent and well functioning NGO is not easily accomplished. Community based organisations, and young NGOs, await a multitude of challenges and tasks. They concern a workable organisational structure; recruiting, training, supervision and taking care of personnel; communicate with third parties, networking, assessing, fundraising, evaluating, administrating, planning, adapting, and so on. This chapter summarises these tasks, and stresses the importance of assisting local organisations and NGOs to develop into sufficiently functioning institutions, as an important pathway to more or less sustainable care and support.

Chapter four deals with donor organisations, by which, where applicable, also international implementing or host organisations are positioned. Donor organisations play a significant role in the sustainability of both the effects and the efforts of local care and support. This chapter describes and aspires to analyse the position in the field of donor organisations. Although donors and local organisations share a common objective, their interests do not always follow parallel lines. Combined with some uncertainty and lack of experience in this relatively new branch of humanitarian assistance, such divergent concerns may cause strain in the relation between the fieldwork and their facilitators. This innate tension may lead to a constructive development of both expertise and good practice, but it may also become an impediment.

In order to explicate the main causes and mechanisms of these tensions, the position of donor organisations and their ranks and files are described. These ranks and files may be governments with their own political agenda's, business corporations, private donations, (state) lotteries, or any combination of these. Just like local implementing organisations, donor organisations are accountable for their expenditure. An exception herein may well be the charity of churches. Their funding is not earmarked for particular ventures and it is not necessarily limited in time. Other relevant

topics in this chapter are the facilitation and financing of good quality evaluations, research, cost efficiency and exit strategies.

Chapter five contains the conclusions of this study with respect to the endeavours to enhance sustainable care and support. Some of these conclusions may seem obvious, clichés maybe, in the sense that many people in and outside the field could foresee them. However, putting the conclusions in a context of political, economic, educational, scientific, managerial and socio-cultural perspectives, as is the intention of this chapter, may well explain why in practice these 'clichés' are so rarely followed through. Therefore, the conclusions are presented in a narrative way. This makes it possible to illustrate the complexity and inter-relatedness of various relevant topics. The conclusions are necessarily general in nature, and will have to be translated and adapted to each particular venture.

To attain a broader effort to enhance the sustainability of mental health care and psychosocial support, by and large a change of outlook, policy and mentality of all agents active in the field of humanitarian assistance may well be required. Despite the many attempts to improve mental and psychosocial problems in great numbers of people, closer scrutiny reveals that only a very small proportion of care and support outlast their initial funding periods. An awareness of possibilities and obstacles as presented in this report may be a vehicle in the development of more sustainable mental health care and psychosocial support, in both its effects and efforts.

Chapter 1

Psychosocial support and mental health care

Modern day conflicts and wars, unfortunately, are frequent. Disasters, due to natures' whimsies, like floods and earthquakes are equally common. In combination with current social and political misgovernment, corruption, inadequate policies, climate changes, pollution, erosion, often the most urgent in the poorest regions in the world, people suffer from famines, crop failures, infectious diseases, displacement, poverty, hopelessness, violence and so on.

Traditional humanitarian aid has tried to tackle some of the causes and ill effects of human suffering as a consequence of such adversities. And lately, especially since the mid-nineties of the past century, psychosocial support and mental health care projects have been launched to alleviate the mental suffering of the affected population. But from the beginning the doctrine of humanitarian aid has been under debate. This dispute by far exceeded the issue whether humanitarian assistance should be given at all, or how much money and effort should be spent on it. The argumentation especially concerns the creation of dependency, its morality, half-heartedness, efficiency, effectiveness, its quantity, strategy and direction in both theory and practice. The axiom of all humanitarian aid was to do 'good', whatever that may mean, and 'do no harm'. In practice, however, erroneous projects, a lack of efficiency, of discernable effects and of appropriateness, or even paradoxical effects has been recognized in many instances. This debate also touches on the principles of mental health and psychosocial care.

This report concerns first of all the opportunities of supporting the build of good enough quality and sustainable mental health care and psychosocial support in affected regions and countries. A review of the many disputes concerning the nature and course of humanitarian assistance in general is not relevant here. Hence, although in this report the question of *how to* is the main issue, the topic of *why* we should at all, is also of significance to the subject matter of this report and its conclusions. In the various paragraphs of this chapter possible answers to this question will be explored, as it relates to many different topics of this chapter.

In the introduction of this report a broad brush distinction has been made between psychosocial support and mental health care, where mental health care refers to people with pre-existing or reactive psychiatric or related disorders, and psychosocial support signifies support and care for lighter nonpathological reactions and prevention of adverse psychological or behavioural reactions. Both of them are targeted on individual and communal levels. In reality, as has been explained in the introduction, there is an overlap.[3] This may well be a reason why many organisations apply their own definitions for mental health care and psychosocial support. This overlap and it's meaning for projects or programmes, will be further illustrated below

In this chapter, in line with the *IASC Guidelines*, also the meaning and dilemmas of both psychosocial support and mental health care will be further examined in various paragraphs. Relevant items, next to the definition and nature of current mental health care and psychosocial support, are the meaning of culture versus the individual with regard to mental health care and psychosocial support, possible strategies and interventions, the meaning and importance of empowerment and capacity building, and working with and within already existing or emerging (grassroots) support structures. This chapter, however, will begin with a narration and consideration of the very people it is all about. Many of the reasons why we should indeed bother at all with psychological and psychosocial support will be addressed in this paragraph.

Beneficiaries

Many books and papers on the subject of mental health care and psychosocial support in (post) conflict regions, and especially project proposals begin with a portrayal of the predicament of any specific target population. This is not only done to inform or convince third parties of the necessity of support, but also to remind others and ourselves of who are the main actors, the principle subjects and agents in the undertaking of mental health care and psychosocial support in (post) conflict areas.

[3] To acknowledge this overlap in practice, the *IASC Guidelines* apply the composite term of 'mental health care and psychosocial support'.

Lack of mental health is the result of the interplay of constitutional, individual and group life experiences, social interaction, societal and political structures and resources and cultural particularities (Lahtinen, et al., 1999). Loss characterises the predicament of large groups of violated and uprooted people. This does not only refer to the loss of livelihood, shelter, education, health and income, but also of family members, friends and social cohesion. Moreover, there is also loss of dignity, trust and safety; of a positive self-image and of a perspective of a future (Aarts, 2000). As a consequence of eruptions of violence or disaster, the pre-existing social fabric is often torn. Inter-human relations are disrupted, which otherwise could provide mutual support. The losses further impede the potential to restore a mental equilibrium following and during shocking or stressful experiences. And in many cases there is an ongoing threat to the lives and wellbeing.

The problems of the affected population are manifold. And so are the causes of their suffering. National and international politics, corruption, the unfairness of the world trades, poverty, lack of basic public health and education, social and economic disintegration, etc. play a role in the sources of the hardship. It concerns not only the deficiency of the bare necessities of live and livelihood, but also the violation of human rights. The complexities of the causes of human suffering also play a role in the challenges of effective humanitarian aid; mental health care and psychosocial support included. Many of these factors are beyond the control of willing governments and humanitarian organisations. Despite the fact that the world's imperfections can not be easily overcome, on a smaller scale help for individuals, groups of individuals and communities, appears feasible, and worth our while.

There are many millions of refugees and internally displaced people in the world. The exact figures, presently estimated at some 35 million, do not really matter. They change all the time as a consequence of the precariousness of political and military circumstances, and the incidences of violent outbursts. However, it is important to acknowledge that the burden of hosting refugees and IDPs is taken on by poorest and most unstable countries in the world, whereas the richer countries keep their borders as closed as they can; that is: as closed as is more or less acceptable to their own inhabitants (voters) and to the international communities. The hosting of great numbers of refugees, however, is a true burden to low income countries. One of the reasons is that refugees often have to live amidst an indigenous populace that also suffers from repression, shortages and violent outbursts. Often serious tensions develop between refugees and natives that threaten stability even further and drain available resources. It frequently occurs that international aid is given to the refugees (food, shelter, drinking water, medical care) while the indigenous people are excluded of such support. Of course, this too does not improve the relation between the two groups.

The above is only one of many examples where international policies and strategies prove counterproductive in the quest for stable and resourceful communities. This counter productivity is usually not deliberate or intentional. However, it illustrates the necessity of careful consideration, collaboration and fine-tuning between relevant agencies and sectors that the *IASC Guidelines* and others so fiercely advocate. It requires multidisciplinary approaches, the involvement and collaboration of relevant agencies and institutions and a willingness to respond to atrocities in a durable way and to *remember* lessons learned, and not only a short-lived or half-hearted answer to a western publics' outcry as a reaction to what they see and read in the media, until that outcry withers or is redirected to yet another atrocity or disaster elsewhere.

For the people it concerns - the primary beneficiaries of humanitarian aid - long term exposure to the violation of their rights, is a fierce attack on their physical and mental integrity. It may well have a negative impact on their ability to cope, on their behaviour and functionality. Loss is a word that signifies their present condition and challenges. This does not only mean the loss of their homes, incomes, status, of family members and friends, of health or social cohesion, but also of trust, hope, dignity, safety, control, independence, direction and self-esteem.

In the first years of psychosocial support emphasis was laid on adverse or pathological individual reactions. Especially Posttraumatic Stress Disorder (PTSD), then a newly defined diagnostic classification in the west, was expected to be the prevalent reaction. However, field experience and epidemiological studies revealed that, fortunately, the majority of exposed people appear to be quite resilient (for an overview see De Jong, 2002). However, severe and prolonged stress and trauma can be overwhelming and cause a large number of maladaptive psychological reactions, including behavioural responses. The prevalence of lifetime PTSD in various methodologically comparable studies proved highly variable. It ranged from

around three to fifty percent, depending on the severity of the stressors, the region, and the presence or absence of specific risk or protective factors (see later in this chapter). The prevalence of depression exceeds these figures; the percentages vary between fifteen and seventy.

Like in the west, PTSD in (post) conflict regions is rarely an isolated disorder. Co-morbidity with for instance depression, other anxiety disorders, substance abuse and personality disorders often coincide (Hobfoll et al. 2007). In many instances, PTSD is not present at all or does not meet cut-off scores, while other pathological reactions, such as the abovementioned, are present. On the other hand, PTSD can be a co-morbid disorder of, for instance, major depression. On a more phenomenological level, hope and helplessness, guilt feelings, shame, changes in the perception of the surrounding world or of cognitions, and affect deregulations can be discerned. Like the pathological reactions, they have an influence on the individual's wellbeing and on their relations and functioning with and amongst others; family or community. People can feel estranged and isolated, withdrawn in themselves. It may interfere with parenting capacities, thereby depriving their children of good enough care, love and protection.

Individual reactions to stressors and trauma may influence the community. Many share much of the hassles and experiences, and it may well impair the communal capacities to cope with past and present stress and damage the social fabric. Both individual and group psychological or behavioural reactions to atrocities and trauma are varied. They are by and large determined by cultural characteristics, like customs, idiosyncrasies and common beliefs; by personal predispositions and by factual circumstances, such as the availability and common lenience of substance abuse. It is the complexity of all these circumstances and maladaptive reactions that need to be addressed in current mental health care and psychosocial support.

Humanitarian assistance is aimed at people who have faced, and still face, often extreme predicaments. Threats to their physical health as a consequence of starvation, torture, (sexual) abuse, mutilation, infectious diseases and maltreatment, also threaten their psychological integrity, their strength and coping capabilities.
Their experiences include the witnessing of cruelties, or murder of their loved-ones, combat, deficient nutrition, loss of shelter and livelihood, the disruption of social networks and family ties, living in a unfamiliar or hostile environment, and so on. Children are especially vulnerable. Not only do they face the same hassles as the grown-ups, but they are also often deprived of proper education; of a better future. Their strength is not matured, nor are their cognitive faculties and moral judgments. Their coping capacities are strongly dependent on the coping or lack thereof of their caregivers.

Women too, are an acknowledged vulnerable group. Apart from the ordeals mentioned above, they have to face the threat or reality of sexual violence. In times of adversity the incidence of domestic violence and sexual violations tends to increase. Often the women are left as the sole parent of their children and the only person to do the chores, work on the land and to provide food or money. Husbands may be missing, engaged in combat, or they are idle or drunk. In many parts of the world the position of women is traditionally precarious, they are generally often considered as providers of sex and other services for males. Their own will and wishes, will only be honoured if they don't go against those of the males and the community. Obedience, virginity, chastity, fertility and servility are highly regarded female 'values'. The punishment for not being able to live up to these standards can be harsh. It does not matter whether the woman or girl had any choice in disregarding the 'rules'.

In the eyes of present humanitarian assistance the population clearly suffers from the hardships and cruelties of contemporary warfare, violence and oppression. The consequences may be long and short term and varied. These experiences, however, are not unrelated or apart from people's pasts, even in a multi-generational sense of the word. In earlier days too, life never was a rose garden. Historically similar experiences, including the more contemporary individual biographies, play a role that may well be of equal importance to communal and personal reactions, positive and negative, in more recent psychological and physical stresses. Psychosocial workers, whether expatriate or local, should be aware that rape, premature death, grief, hunger, pain and illness, cruelty, repression, group pressure, discrimination and abuse, but also inner strength, resourcefulness, coping, compassion, laughter, joy and love are part of times gone by as well.
An awareness and understanding of the association of previous and recent experiences, makes it easier for mental health care and psychosocial workers to assess the impact of specific cultural phenomena, and of both

communal and individual psychological reactions to fear, stress and trauma. It may well help to connect mental health care and psychosocial support to (pre) existing resilience, coping strategies, communal support systems, beliefs and customs. This wealth of earlier experiences and capacities can not be understood apart from the current reactions to adversities. With respect to sufficiently high quality and sustainable mental health and psychosocial care, this understanding is vital.

The rationale of mental health care and psychosocial support

There are compelling motives to improve the mental health and wellbeing of large proportions of the world population. While confronted with the sometimes intense suffering, in conditions of a seemingly neverending lack of even the barest necessities of life, emotional responses are quite common. Empathy for others and a sense of commitment and responsibility, cause people do their bit or support those who do. These emotions, however ethically valid, are not the only motivation to try and soften the suffering of millions. One of the costs of the mental consequences of violence, disasters, extreme poverty and repression, is the loss of human resources. This loss causes considerable economic depletion. According to the World Bank and the WHO currently some estimated 15% of the total Global Burden of Disease[4] is caused by neuropsychiatric or psychological disorders (Murray and Lopez, 1996). In low and middle income countries this percentage is considerably higher than in high income countries (De Jong, 2002). Especially in times of adversity as a consequence of violence, the disruption of communities, mass migration, climate changes, economic crises and the combination of these, as it is often the case in the poorer regions of the world, this loss of human resources obstructs recovery, adaptation, development and innovation.

Another reason to take on the challenge of psychosocial support and mental health care is the growth of an emerging awareness of human rights and illegitimacy of its violations. This awareness may well facilitate a gradual development or transition into more civic societies and promote the participation in public life. Furthermore, psychosocial support underscores the importance of education and economic participation in its programmes. This will also facilitate the broader involvement in or stabilisation of political and civil life, and the emergence of a more general respect of universal human rights.

The rationale of humanitarian aid, mental health care and psychosocial support included can de summarised as follows:

- There are sound ethical reasons to lighten the distress of affected communities and populations and to divide the burden of adversity more evenly, as currently the bulk of this burden rests on the shoulders of the poorest regions of the world.
- There are also firm economical reasons to reduce the loss of human capacity as a consequence of attacks on people's physical and psychological integrity and coping capacities.
- Furthermore, the empowerment and capacity building of a population may well stimulate social, civic and political commitment and participation.

Mental health care

The care and, if possible, cure of mental disorders in low income countries is profoundly hindered by a general lack of adequate medical provisions in primary, secondary and public health care. Furthermore, the financing and health insurance in many instances is highly insufficient. The existing infrastructures are often insufficient, badly equipped, or shattered. In many so-called third world countries, the majority of the population is totally dependent on foreign, i.e. humanitarian medical aid and supplies. Medication is expensive, of poor quality or scantily distributed. Proper administration and follow-up of drugs can be flawed.

Mental health care provisions often are even worse than the care for physical ailments. In many countries the number of psychiatrists can be counted on the fingers of only one hand. If they are there, they usually reside in the richer urban regions. In times of prolonged instability, shortages, oppression and violence, the higher educated parts of a society may take the opportunity to flee the country. This so-called brain drain can be devastating for present and future prospects. Mental health care, however, was and still is often neglected; the mentally ill and disabled being ignored, deprived of care, or shielded away from the community. At its best, mental disorders are addressed by traditional healers.

Many 'common' mental disorders are present, such as retardation, psychoses, affective and anxiety disorders, dementia, etc.; their causes often, less or more, part nature, part nurture. And, of course, there is the intertwinement of physical illness with mental com-

[4] The Global Burden of Disease is an instrument that measures the health status of any given population.

plaints, such as posttraumatic reactions after physical trauma or psychosomatic and somatoform phenomena. The astonishingly high prevalence of epilepsy, for instance, in many poor countries, appears to correlate with long term deficiencies of essential nutrients, especially during childhood. However, the occurrences of disabling depression, anxiety, posttraumatic complaints, prolonged grief or psychoses can be significantly increased by living under extreme and long lasting duress. As has been mentioned in the introduction, it has been estimated that almost half of the loss of human resources, is rooted in psychological problems. Yet, it must be stated that the incidence of stressors and psychological reactions may vary widely, depending on the region or ethnic background.

With the given high rates of disabling mental and neurological disorders and the current huge deficiencies of sufficient public and mental health care, strategies to at least alleviate some of the needs in a potentially durable way have been developed over time. However, in order to succeed to some extent, it requires an interdisciplinary and inter-agency approach. A present promising approach is psychoeducation. With respect to mental disease this means the enlightenment of families who take care of mentally ill or retarded kin. A comprehensible explanation of the causes of any particular disease is often necessary, because in many deprived communities the ideas about the nature and causes of mental disorders can be quite peculiar and based on superstitions. Feelings of shame, guilt or aggression and ignorance of caregivers often cause additional suffering in patients and in families.

Furthermore, education about possible treatment or approaches, and pointing out the possible potentials of handicapped or diseased people may well lead to more adequate and humane conduct. It is not only the obvious mental disorders, such as psychoses, neurological afflictions and retardation that are often misinterpreted by others. Also depression, behavioural problems, posttraumatic phenomena and prolonged grief are often not understood in their nature, and courses. Adequate handling of those affected, therefore, can be mostly absent within the family, the schools and in communities at large.

Next to psycho-education of the population, the instruction of the local medical professions is another probable promising practise. Often initially supported by western mental experts such as psychiatrists, neurologists or psychologists, local medical doctors and nurses are trained to understand predisposed and reactive mental disorders. These trainings include diagnostics, treatments, and the biological and psychosocial components and consequences. In the absence of ample clinics and relevant medical specialists, the local nursing staffs are often targeted for training. They are acquainted with the local conditions, with vulnerable groups within, and with local thought, customs and traditions. In addition, coming from the same community, they are often trusted by the population. Next to their work in the clinic or field offices, they are encouraged to perform out-reach tasks in the communities. They often carry out psycho-education on behalf of the target population and support the care for the mentally diseased.

The training, involvement and commitment of local key persons in the community are one very important pillar in the pursuit of sustainable mental health care in (post) conflict areas. Next to nurses, also midwives, traditional healers and community leaders can be educated to help alleviate the suffering of the mentally ill and their family members, and to respond to it with compassion, care and support. They can be informed about behavioural misconduct, substance abuse, and domestic violence – also the domain of psychosocial care - and learn to prevent or react to it in a constructive manner. The training contents and the psychoeducation can be valued and adjusted by local caregivers over time and according to the circumstances, needs and cultural characteristics. The chances of becoming locally accepted and durable will enhance when these interventions become more fitted in local particularities. The typical further advantages and obstacles of this policy will be elaborated in following chapters of this report.

Part of the policy to allow for the development of sustainable mental health care is the promotion of human rights. An awareness of the universal rights of men, women and children, empowers a population and has the potential to make them more prepared to withstand breaches of these rights. It may also serve as a (re) development of moral standards. Local and national governments should, if possible, not be excluded from the education concerning human rights. Encouragement of adequate mental health care can also be directed at governments. Yet another measure to promote the sustainability of mental health care services and psychosocial support is the involvement of the local (educational) care infrastructures. The basic principles of mental health care, including psychosocial support, could be added to the curricula

of medical schools and other relevant academic or vocational training schools and institutes (see action sheet 6.1 of the *IASC Guidelines*).

As has been stated in the previous paragraph, in many low income countries, there is an accumulation of adverse influences on both people's physical and mental integrity. The causes may be (contagious) infectious diseases such as malaria and HIV/Aids; they may be caused by prolonged malnourishment, personal predisposition, and by combat exposure, torture, abuse, living under crowded conditions, loss of family members, and so on. In most of the mental disorders or diseases the possible causes cannot be discerned, they interrelate and are known to potentially exacerbate the complaints. This may well be a reason why in reality mental health care and psychosocial care do overlap. For instance, where in children or adolescents behavioural problems and developmental disturbances exist, next to other interventions the reunion of these children with their parents or families, may well improve their condition. Indeed, in practice mental health care and psychosocial support need to coexist.

Psychosocial support

In times of violent outbursts, disaster, starvation, or mass displacement, the pre existing social fabric or even the sheer survival of communities are threatened. Current psychosocial care seeks a restoration of some social coherence and mutual trust. Psychoeducation, the promotion of human rights, empowerment and self-organisation are important means. On a more individual or group basis psychosocial care provides basic counselling techniques and other kinds of interventions. The *IASC Guidelines* (pages 2 and 3) distinguish between problems that are more social and more psychological in nature. Poverty, oppression, discrimination and such, belong to the realm of social problems, whereas depression, prolonged grief, PTSD, or substance abuse are more psychological. In reality the two very often overlap. In practice, therefore, psychosocial support addresses both kinds of problems in relation to each other. It is a matter of course that psychosocial measures meet the needs, and fit the culture(s). The main characteristics of psychosocial interventions will be described in the next paragraph of this chapter.

Prevention of dysfunctional mental conditions is one of the main components of psychosocial care. Preventive measures are targeted on both social and the more individual psychological levels: the promotion of the wellbeing of the community and the individual are its objective. Behavioural problems, delinquency, affective disorders, apathy, loss of (self) interest and dignity, substance abuse, learning problems and motivation, are a few of the problems that can seriously harm a community, and cause considerable distress in individuals. The motivation of such prevention may be clear: it prevents additional human suffering, and reduces the enormity of socio-economic losses.

In the introduction of the *IASC Guidelines* factors to help identify people at increased risks are summed up (see also: De Jong 2002, 6, 7). It is a long list and it concerns:

- Women, e.g. pregnant, (single) mothers, widows or unmarried women and teenage girls;
- Men, e.g. ex-combatants, idle or unemployed men, who have lost their capability to provide for their families, or young men at risk of detention, abduction or violence;
- Children and adolescents, e.g. separated, orphaned, abused, trafficked, recruited in gangs or armed forces, delinquent or in forced labour, undernourished and under stimulated and under educated.
- Elderly people, especially when they have lost family members or other care providers;
- Extremely poor people;
- Refugees and internally displaced persons or migrants;
- People who have been exposed to, or witnessed stressful events or trauma;
- People with pre existing mental or physical disorders or disabilities;
- People in institutions, such as orphans and retarded, prisoners or the elderly;
- People experiencing social stigma, e.g. untouchables/dalit, prostitutes, retarded persons, rape victims;
- People of specific risk of human right violations, e.g. political activists, religious, lingual or ethnic group.

Although an awareness of specific vulnerable groups of people is helpful in the direction and provision of care and support, it is important not further stigmatise and marginalise people as victims per se. Differences within and among each so-called risk group may be profound. Furthermore, there may well be individual and social resourcefulness, resilience and problem solving capacities.

There are several realistic objections to naming the affected populace *victims*, as was formerly quite common. The word underlines vulnerability and helplessness, and denies people their capacity the cope and adept and (re) take control over their lives; it denies them innate resilience. The word victim felt to many, as if the people were not even partially masters of their own lives and fate. Furthermore objections have been made against a previous focus on psychopathology, in particular PTSD [5], disregarding the fact that it is a normal reaction to abnormal circumstances, and discounting a more suitable psychosocial approach. The present emphasis on resilience and empowerment among experts has evolved since. Although this emphasis should not lead us to close our eyes to suffering and become blinded to adverse psychological reactions; the problem people endure is not *resilience*, but the lack or limitations thereof in face of extreme hardship.

Next to the identification of the most common vulnerable groups it is also helpful to be aware of so-called protective factors. De Jong (2002: 7) lists them as follows:

- The presence of a social network, including a nuclear or extended family;
- Social support and self-help groups for empowerment and sharing;
- Employment or other possibilities for income generation;
- Access to human right organisations;
- Recreation and other leisure activities;
- The possibility to perform culturally prescribed rituals and ceremonies;
- Political and religious inspiration or comfort, meaning and a perspective for the future;
- Camps with a limited size;
- Coping skills, intelligence and a sense of humour.

It may be clear that many of the more external protective factors, such as the presence of supporting family members, employment, income, a supportive social fabric, access to human rights organisation or health care facilities, recreation, inspiration and, for refugees or IDPs living under less crammed conditions in camps or settlements, are not commonly at hand, especially not in emergency settings. However, coping skills, intelligence, humour, constructive beliefs and hope, may well be. In terms of psychosocial support, these human resources are the foundations on which interventions are built. They are aimed at the rallying and mobilisation of these internal forces on which self-esteem, dignity, compassion and initiative can grow. An awareness and advocacy of universal human rights, including the rights of women and children, are important in this empowerment of people.

The *IASC Guidelines* strongly recommend, where ever feasible, the combination of many relevant kinds of support to affected people such as basic safety, sanitary provisions, food, water, (mental) health care and psychosocial support, etc. (See the appendix: Example 1). The combination of these activities enforces the potentials of each hitherto separate undertaking. The opportunities of psychosocial support are clearly enhanced in combination with vocational training, income generating activities, micro credit and the referral of people with more severe psychological problems to mental health care providers, and vice versa. Many of these non psychosocial or mental health humanitarian initiatives are beyond the scope of this report. In the next paragraph on interventions, however, it will be made clear how current psychosocial support and mental health care are hooked in to other initiatives and indeed reinforce each other. The very principles of inter-agency community based programmes and the strengthening and guidance of human resources and coping skills, are part of the distinctive features in humanitarian assistance that promote sustainability.

Interventions

Psychosocial support, as the word already shows, is directed at both social and psychological domains. In practice the two are largely connected, and co-dependent. The range of psychosocial support is quite broad. It concerns psycho-education, empowerment, encouragement and support of communal functioning, of mutual responsibility and compassion, of self-initiative and self-help, of independence, individual and group counselling[6], and so on. Just as the more traditional kinds of humanitarian assistance psychosocial support and mental health care are subject to some basic principles, such as don't harm, don't stigmatise or isolate. It also stipulates the maximisation of the participation of the target population (coverage); the pertinence of interventions to the needs; a continuous provision of support for as long as it is needed; the effectiveness of the interventions; equal access for the members of target groups (equity), and the support should strengthen and utilise the local capacity.

Reality proves that these basic principles are by no means always met. Causes of breaches of these principles may be ignorance or inexperience of some

[5] For more details and some elaboration of this issue: see chapter 2; p. 39-40.

implementing organisations, private enterprises and donor organisations. Furthermore, there is a lack of collaboration or fine-tuning, and a set of personal goals, irrespective of the needs of the target population and of generally endorsed parameters for good practice. It may be clear that ignoring such guidelines and principles seriously threaten the potential sustainability of psychosocial support and mental health care. Present day guidelines, such as those of the IASC, take the principles of best practice into account, and as such they are crucial to the pursuit of high quality and sustainable support and care.

In the remainder of this chapter, community based and psychological interventions will be further scrutinised in the light of the abovementioned basic principles and according to current best practice. The inherent overlap of the more social, community based interventions, and psychological support or mental health care, will be clear. Issues of cultural peculiarities, the importance of psycho-education and advocacy, empowerment and the support of grass root organisations in this perspective, will also be addressed.

Community based interventions

As has been stated before, the fundamentals of community based interventions are to be found in the potentials it generates towards empowerment, self-support, and awareness and in the reduction or alleviation of suffering. The range of possible interventions is quite broad, and each separate intervention does by no means exclude others. In the contrary, they are known to reinforce each other. To the realm of community based interventions belongs psycho-education. Psycho-education concerns various possible items and prospects that should in each region be adjusted according to the specific circumstances and needs. In practice, psycho-education addresses basic but attainable hygienic and preventive living standards, such as the consequences of substance abuse or about the use of prophylactics to avoid sexually transmittable and other infectious diseases. Items of causes and consequences of (domestic) violence, sexual violations and rape may well be of relevance.

Furthermore, psycho-education promotes the awareness of the spectrum of adverse psychological reactions to prolonged stress and traumatic experiences. It may help people understand their inner painful condition and its implications for their wellbeing and coping capacities. Knowing they are not alone in this; that it is a basically 'normal' reaction that can be expressed and shared, and that healing to some extent is possible. It potentially reduces shame, isolation, prolonged grief, guilt feelings, apathy, and negative behavioural reactions or acting out. It may also decrease psychosomatic or somatoform complaints. This is one aspect where the preventive characteristics, with regards to mental health issues, of psychosocial support becomes clear.

In communities, psycho-education may enhance mutual understanding and support (See the appendix: Example 2). It facilitates the identification of vulnerable groups or individuals in the community that may benefit from special care. Awareness raising, in a broader sense of the word, is yet another of its possible functions. And gradually, when activities of psycho-education are made available to a community at large, by means of journal articles, leaflets, and broadcasting, in susceptive individuals, key persons or institutions, a change of mentality, policies and conduct may grow. This 'going public' may also reach more people in the target groups who might well benefit from specific psychosocial interventions.

Psycho-education is usually part of other interventions too, such as community dialogues or any other organised communal activity such as play-acting, drama, singing, and storytelling [7]. Such activities need not be dramatic or over-concentrated on problems; humour, joy and sharing can be powerful ingredients to ameliorate feelings of hope, mutual commitment, coping abilities and overall wellbeing, thus empowerment. Community based activities can also be vocational training, education, and income generating or leisure activities. These too, give hope, perspective and build self-esteem. An inherent side-effect is that it gives people who share the same predicaments an opportunity to talk to each other about their situation and feelings, without the sometimes too heavy burden of counselling.

In temporary settlements or in regions where infrastructures are destroyed or malfunctioning, primary education for children can be organised. This will give them at least some opportunities and structure in their daily lives. It may especially be important to engage adolescents in some structured activities and prefera-

[6] Current theoretical and practical controversies concerning counselling are addressed in chapter 2, page 44-49.

[7] In activities that are set up to involve and express, the participants and public are commonly given the opportunity to choose topics and define problems themselves and come up with possible causes and solutions. Psychosocial or community workers, in a respectful manner, may offer alternatives. This approach enhances both the commitment and effects.

bly encourage them to take part in common activities in the community. Adolescents, especially boys, tend to isolate themselves from the community at-large and hang out in peer groups. They are then in danger of engaging in substance abuse, sexual violations, and other delinquent actions, which in the end is not only an additional burden to the community, but also hampers their own wellbeing, morality, and development into responsible and stable adults. The organisation of volunteer work for the community, such as building or restoring houses and sanitary facilities, will give them (self) respect, positive contact with peers and ample things to do. And so does helping and supporting other people in the community.

Children and teenagers may fare well when they are invited to take part in organised leisure activities. They can be sports, competitions, theatre, games, painting, drawing, embroidery, and so on. The potential impact on their wellbeing and sense of belonging can hardly be overestimated. It may bring back joy, laughter and self-confidence. Moreover, it lessens the burden on parents and caregivers.

In all community based activities it is important to engage and commit the target groups, community members and leaders as much as possible in the planning and implementation. They know their own needs and ways the best. Their involvement and commitment is essential to mastering, initiative, empowerment and, thus, to more durable positive effects.

Psychological interventions

As has been described earlier in this chapter, some persons suffer from psychological sequels that hinder their capacity to cope and adapt. Those individuals, generally, may not benefit sufficiently from community activities as explained above. Mood and anxiety disorders, including posttraumatic symptoms, are the most prevailing psychological reactions. These 'some' individuals may, in particularly affected communities, count up to the majority of the community in question. In the absence of even *basic* health care facilities, let alone mental health care, psychosocial support also has to respond to the needs of persons that suffer from a, to various extents, disabling set of complaints. The ultimate aim is to improve their coping skills and wellbeing and to empower them to participate in communal activities, vocational training, voluntarism, etc.

The usual psychosocial interventions such as counselling, drama, dialogues, are insufficient measures to improve the situation of individuals with severe mental afflictions. It is, therefore, part of current best practices to create, or to offer access to care for those who suffer from serious mental or neurological conditions. It is fitting to a multi-sectoral approach to connect with existing care facilities or to train relevant personnel of such facilities to respond to the needs of those seriously in need. However, in reality, this can be quite impossible in regions that lack fairly all common public health care infrastructures. Sometimes psychosocial workers are left no choice but to do their utmost under extremely difficult conditions.

As has been stated above, depression even major depression, more than PTSD, can be the most prevalent disorder that can be found in affected communities. For several reasons drugs as a treatment are not generally available. Practical causes, such as limited or nonexistent availability, flawed distribution, expense, and difficulties with a proper understanding of its working, doses, side-effects and follow-up, may be the most common ones. Furthermore, special and suitable drugs for PTSD have not yet been developed. The normal drugs available for PTSD patients in the west are anti-depressant or, sometimes, anxiety reducing medication. However, benzodiazepines are counter-indicated for the treatment of PTSD. There are even other reasons why drug treatments for these ailments can be considered problematic in low income regions. In the west, first choice treatments are a combination of psychoactive drugs and psychotherapy. The effectiveness of anti-depressants in especially sub clinical depression is presently questioned. Activation, particularly in the physical meaning of the word, seems to work just as well or even better: negative side-effects being absent.

Depression, in what ever form, is characterised by inactivity, apathy, guilt feelings; whether rooted in real events or in neurotic reactions, ruminating, shame, but may-be the most painful and damaging: despairing hopelessness. Depression, as has been mentioned before, is also a rather common co-morbid condition of PTSD. In the absence of adequate mental health care facilities and infrastructures and medication, psychologically oriented psychosocial support must address these conditions. Stimulation of physical, mental, and social activity and restoring hope by empowerment may well be quite effective measures to reduce the suffering of these people. Sharing, verbalising and scrutinising emotions and cognitions may be helpful in the reduction of symptoms. Well tried psychosocial interventions are basic counselling tech-

niques or nonverbal approaches. However, most interventions offer a mix of both verbal and nonverbal components.

In psychologically oriented interventions, the expression and sharing of pain, suffering or especially burdensome memories are a chief beneficial or healing goal. This can be accomplished in either individual or group counselling sessions, and in creative expression such as narrative theatre[8], drama, drawing, dancing, and so on. However, individual preferences and choices need to be respected. Some individuals withstand and avoid any demand of reflection on their beliefs and emotions, based on their personal constitution and biography. Sometimes they are too young to benefit from counselling, although children and younger adolescents may well profit from creative expression through, dance, drawing and play acting. Other, less psychologically oriented psychosocial interventions are also measures to reduce isolation, low self-esteem, apathy, and delinquency and improve commitment, hope and sense of a future worth living for, in adults and children alike.

In Western psychotherapeutic approaches, the verbal component of the expression of emotions and reasoning is crucial. The availability of a willing and receptive audience, however limited it sometimes may be, and a suitable vocabulary, are not so commonly present in non-western cultures (see later in this paragraph). Psychosocial supportive interventions need to take this into account and adapt programmes and services accordingly. Furthermore, there is a clear dynamic between social, psychological, physical cognitive or spiritual facets of each individual. Offering a full package of psychosocial services, that cover these and other facets, are considered to be best suited.

Especially children and women are generally acknowledged vulnerable groups. They usually lack either the maturity and/or the position to choose for themselves, and are generally dependent on the goodwill of others; e.g. parents, care givers, husbands or male relatives. Psychosocial or psychological support to these groups call for specific caution. First of all, it needs to be understood that both women and children belong in their communities even when the conditions are not favourable for their present wellbeing. Treating them regardless of their surroundings, relations and culture may cause them harm. The isolation of such so-called vulnerable groups from the community may well endanger their wellbeing and future opportunities even further. Second, isolation of individuals or groups of individuals may lead to stigmatisation. Third, for interventions with women and children to be successful it may be necessary to try and change the conduct and mentality of their kin or relations. Psycho-education, community dialogues may be important measures to achieve understanding and respect for specially wounded individuals.

An important means to reach children in need of special care or support is to work within schools or similar institutions, like orphanages and boarding schools. Bearing in mind the adage of humanitarian assistance of helping people help themselves, school directors, teachers, pedagogues, psychologists can be educated on the cognitive, behavioural and emotional consequences of trauma and stress and about the 'normal' developmental stages of children and youngsters. The can also learn to identify children or adolescents in need of psychological support and to supply support (some basic counselling techniques) themselves. They can be made aware of the existence of psychosocial programmes or mental health facilities in the vicinity, organise outdoor leisure activities, stimulate the formation of children's or adolescent's groups with similar interests, and so on. Schools, however, must be dealt with in many aspects. There is for instance little use of bringing child-friendly counselling techniques to a school if the climate and common didactics are predominantly restrictive, humiliating and punitive. An overall approach is, therefore, recommendable. The understanding of the fact that people are bio-psycho-social entities, despite cultural particularities, warrants a holistic and systemic approach. For the psychosocial support or mental health care of children this means that parents and caregivers of children will need to be involved and supported in their care for and understanding of their children.

Issues of culture

In many instances, it is stipulated that interventions much fit the culture. Disregarding particular traditions, beliefs and customs will prove to be ineffective and may even be harmful and tear a fragile social fabric even more. This is not to say that cultural idiosyncrasies are beyond criticism. It may well be customary to kill daughters or wives when they violated, willingly or unwillingly, the families honour, and it may well be 'normal' to ostracise or punish raped or violated girls or women, or hurt young men in rituals, or mutilate a girls genitals: these conducts can be care-

[8] Sliep, Y. & A. Meyer-Weitz (2003). Strengthening social fabric through narrative theatre. Intervention. International Journal of mental health, psychosocial work and counselling in areas of armed conflict. 1:3: 45-56.

fully addressed during psycho-education and awareness raising of universal human rights. It would be highly unrealistic for implementing organisations to expect to be able to change these often deep-rooted traditions and beliefs. However, they can be cautiously challenged and opposed.

Another issue that is related to local cultural phenomena is religion. A shared belief system and related rituals can hold together a community and be a basis of strength, hope and trust. Interfering with religious beliefs of target populations is presently not understood as part of humanitarian aid. It may be a wish or even conviction of religiously inspired humanitarian organisations that their own religion and beliefs will be helpful to *any* target population, evangelicalism within communities that hold other convictions is not considered good practice; its consequences may well be harmful to the often fragile communities that are the recipients of our support. The same reasoning applies to strong political convictions in humanitarian organisations. The ultimate aim of western support should be to allow people to follow their own, but informed, directions.

Expatriate humanitarian workers have to be aware that, not only the target population, but they too are ingrained in their own cultural idiosyncrasies. It may seem obvious, but the conviction that western cultures set universal standards is sometimes deep-rooted. The awareness of the relativity of some of our beliefs stimulates a more respectful attitude towards other culturally determined convictions and behaviours and enhances the capacity for flexibility, tolerance and a perspective of relativity. For instance, teenage mothers are seen as problematic in many western countries, but they are experienced as 'normal' in many other parts of the world, where girls tend to marry young and where an extended family normally shares the responsibility for babies and children. An advocacy to prevent the marriage of sexually ripe youngsters or oppose sexual activities in teenagers at all may not be understood and welcomed by the recipient community. However, where human rights are violated by common practice and traditions, setting an example and psycho-education may be the intervention of choice.

Community based psychosocial support has to take specific culturally determined views and conduct into consideration. Working in an affected community where hierarchy and segregation are innate, will have to be done cautiously. Where community's key persons, elders, chiefs or healers, are left out or ignored, tensions and opposition may emerge. Traditional support systems or healing practises may go underground or sabotage the psychosocial programme. Ignoring the cast system, as it is known in some Asian countries, too may demand specially organised and guided interventions (Jordans, et al. 2003). Jordans c.s. (page 32) further state 'the cultural gap (…), in terms of counselling skills and concepts, should not be exaggerated. Basic communication skills and emotional support, though in different terminology, are not incompatible with existing forms of interpersonal relationships and problem management.'

The main difference between various cultures can be perceived as predominantly externalising emotions (overt, aggressive, expansive) or internalising (guilt, grieve and shame). This may not only apply to negative emotions, but also to feelings of joy and happiness. For example, some experts believe that in many low and middle income countries, people are unwilling to talk about shocking experiences, and that the 'talking cure' is a western creation, related to their typical culture of (religious) catharsis, penance and confession. Although 'wanting to forget the past' are frequently expressed outside, but also inside the western world, as a means of coping, evidence indicates that the expression and the sharing of distress is universally experienced as a relief. It is also functional in repairing or establishing social coherence and empowerment (De Jong, 2002: 38-39). In line with Jordans c.s., it can be asserted that these cultural differences too, do not necessarily hinder psychosocial interventions. It may require some adaptations that can be guided by informants stemming from the communities. It must, however, be kept in mind that in each culture the individual differences can be enormous (See the appendix: Example 3). In psychosocial support and mental health care the psychosocial workers, and maybe especially foreign ones, have to be aware that he or she is not facilitating help for a *culture* but for a multifaceted group of individuals.

Cultural practices can also be of help in attaining a specific set of goals of a support programme or project. Traditional rituals, in particular cleansing rituals, can be helpful with the improvement of the wellbeing of the beneficiaries. These rituals are perceived and experienced by the recipients as a means to undo negative effects of hatred, combat experiences, (sexual) abuse, rape, etc. By means of cleansing rituals freed child soldiers and ex sex-slave girls have become acceptable again to their families and community. However, any uncritical embrace of traditional healing

practises or rituals by psychosocial workers is not recommended. Such practices can sometimes be harmful and contribute to the distress.

The (re) creation of a social fabric, the care for vulnerable people and preventive support systems, especially where it concerns ten of millions of people, living mostly under unimaginably harsh conditions in a great variety of regions world wide, is by no means an easy task. Strategies to help people help themselves have been developed. Some of them still have to prove themselves. The dissemination of know-how in all its details and domains is crucial in this undertaking. Training, therefore, is the subject matter of the next chapter.

Chapter 2

Training psychosocial support and mental health care

Helping-people-help-themselves is the device of all current development aid. Hence, the same holds for attempts to provide psychosocial and mental health care. Education and training of local (future) care givers are, therefore, at the very core of this modern kind of humanitarian support. The premise is mainstream and largely undisputed. But from this starting point, many things cease to be simple or straightforward. Despite the union, questions like how, what, where and when or who needs to be trained or educated, long remained in the open. These issues have been and still are open to controversy, doubt, mistakes, apparent failures, and fortunately some successes as well. Furthermore, these questions can only be properly addressed within the contexts of varying and specific circumstances, values, beliefs, socio-economic opportunities, (pre) existing care systems or traditions, and last, not least, of the real needs of the primary beneficiaries.

These topics, their contexts included, are the subject matter of this chapter. The quality of psychosocial and mental health care programmes largely depends on the answers. The sophistication and appropriateness of our responses may not be the only, but certainly are *crucial* elements in the quest for sustainable care. Of course, the responses to these issues are not fixed; over time they must and will be adapted and changed according to altering views, growing insights, and to evident worse or best practices.

The chapter begins with an overview of the relatively brief but intense experiences from the first decade. It concerns the training of local people to act as care providers within their communities or to adjust the available care to current demands. There have been essential lessons learned from this recent past, such as community based approaches, and the (in) appropriateness of mainstream classifications, and lessons yet to be learned. In order to underline that training local people is not a goal in itself, but that, ultimately, the aim is to facilitate support and care for troubled and vulnerable people, notice will be given to the necessity of preceding assessments, including relevant issues such as cultural sensitivity.

Next, the topics of what, where, when, how and who of training will be addressed. The experimental or scientific basis of various kinds of interventions, etc., finds a place within these paragraphs. The chapter finishes with attention to the training of trainers (ToT), as a pathway to sustainability per se. It is a matter of course that all these issues merit much further elaboration and deliberation than can be given in this report. Therefore, as in the previous and next chapters, a list of references can be consulted for further reading.

The Balkan wars: The 'primordial soup' of psychosocial care

It were especially the wars in former Yugoslavia (1992-1995)[9] that marked the beginning of a new kind of humanitarian assistance, that soon came to be known as psychosocial support. Images and accounts of the wounding, raping and killing of innocent people, of the nearly starved and tortured bodies of concentration camp inmates, and indications of so-called ethnic cleansing, shocked the world, in which hitherto many people believed that there would never be an 'Auschwitz' again; at least not in a nearby country, with 'white' and 'rather civilised' inhabitants.

The Balkan wars coincided in time with an emerging professional interest in the effects of psychological traumatisation. In the third edition of the *Diagnostic and Statistical Manual of Mental Disorders (DSM III)* of 1985, published by the American Psychiatric Association, a new classification was published. The so called Posttraumatic Stress Disorder (PTSD), in the otherwise strictly etiologically neutral DSM, referred to a number of complaints that might well be a consequence of external shocking events (trauma).

The notion of posttraumatic misery itself, overlapped with a recently grown awareness in some societies of

[9] In other parts of the world, such as in Rwanda and other African and Eastern countries were also initiatives to alleviate the mental suffering of the population. However, these projects did not provoke so much attention and commotion as it did in former Yugoslavia.

the reality of violence, suppression, maltreatment and (sexual) abuse within the intimacy of human relations. These items were previously and generally subject to public denial and professional negligence. Evidence of the potential of sometimes long lasting and severe psychological damage as a consequence of these phenomena, was given in the DSM and the many clinical and epidemiological studies that emerged after its first publication.

Leaning on the experience of a relatively small number of therapists with the treatment of survivors of persecution of the Nazi's during the second world war, the idea settled that 'working through' traumatic experiences was the key to mastering posttraumatic symptoms. The guided exposure to individual traumatic memories, within a safe and supportive therapeutic environment, would facilitate this process of working through. This premise of exposure still is central to current mainstream treatment and theory. However, PTSD and the practises of its treatment also inspired fierce scepticism and criticism from within and outside mental health professional circles.

Balkan reality and lessons learned

The situation in former Yugoslavia confronted mental health experts with vast amounts refugees and survivors, in the absence of readily available resources to address their suffering. It immediately became apparent that the multiple problems of the population could only be attended to in a multidisciplinary way. But in the early stages of giving support to people in the urgent stress of violence and warfare on the one hand, and the brief (by and large untested) experience with the treatment of posttraumatic complaints, especially in divergent cultures, on the other hand, errors were made. However, the axiom to-help-people-help-themselves was immediately understood. Training local people was the focal point. The problem was what, how, who and to what purpose to train.

Notorious mistakes were, for instance, the so-called 'flying in' for a couple of days of mental health experts who lectured about the psychological effects of traumatisation, mainly limited to PTSD, to a generally layman audience. As for the support to the population, they often had not much more at hand than the 'talking cure'; after which they 'flew out' again. Yet another infamous example is the rapid development and testing of various questionnaires to assess posttraumatic psychological complaints in relation to actual traumatic experiences. Although these questionnaires could in potential lead to an important growth of knowledge and a useful assessment of the condition and needs of a populace, this practise soon became not only scientifically, but especially ethically disputable. The main objection to handing out questionnaires to a suffering population consisted of the likelihood of traumatising people again, without offering them any, or at least good enough, support.

Another area where much went wrong was the mutual cooperation of NGOs, both foreign and local, and the fine-tuning of their activities. Despite the efforts of larger international NGOs, during and in the aftermath of the wars, it proved hard if not impossible to make collaboration and tuning a common practise. This humanitarian field too, has the characteristics of a market economy, wherein competition may well cause a lack of openness to differing opinions and practises. Where NGOs need to fish in the same ponds to obtain the necessary funding to finance their organisation and activities, it is hard to imagine that this reluctance to combine their strength with competing organisations can be overcome by them. In the chapters concerning local organisations and donor organisations, this issue will be further scrutinised. For it bears significant importance to the stimulation of sustainable psychosocial and mental health care in (post) war regions.

A summary of the main 'lessons learned' is listed below. Many of them have since become best practise within the field in question. They are the result of early insights and analyses and, of course, of trial and error. Quite a number of them will return and be elaborated in forthcoming paragraphs and chapters.

- **Community based care**. Armed conflict and warfare may cause vast amounts of people to suffer many kinds of hardship. In many instances they also lose resources, materially and mentally to help themselves sufficiently. Moreover, in many instances traditional and local care systems are disrupted, absent or not equipped to give psychosocial or mental health care. The training of people within communities (grassroots) to teach them to understand and respond to psychosocial problems could facilitate the growth of resources to help-people-help-themselves and build or restore relations of mutual responsibility and support.
- **Follow-up training**. A one-time 'fly in' of trainers with some theoretical and therapeutic baggage at hand concerning trauma, soon proved to be dysfunctional. There are several convincing reasons to

train local care givers more regularly and over an extended period of time. A relationship of mutual trust and learning needs time to build; skills and attitude need to be exercised and evaluated; trainers need time to respond to what they themselves learn and understand from the trainees and their experiences in the field: insight into the nature and complexity of psychosocial and mental health problems need time to develop, and the appropriateness of community, group and individual interventions need to be evaluated and monitored, to mention just a few. This so-called one-time fly in training, also set a bad example of top-down training sessions, where mutuality and building shared insights and experiences is quite impossible.

- **Fitting the local culture**. How and what is trained should be relatively close to the way trainees and of course the primary beneficiaries think, reason, and feel. Existing traditions and beliefs will have to be respected by trainers and become mutually assessed with respect to their usefulness within the processes of learning and helping. The skills and attitudes of local psychosocial workers need to relate to the world and experience of the primary beneficiaries. However, in a relation of mutual trust, beliefs and traditions can also be subjected to comment. Respect does not preclude criticism.

- **Monitoring, evaluation and research**. The art of supporting vulnerable people in low and middle income communities is not ready made. The vast quantity, the complexity and interconnectedness of problems in war stricken regions meant that new approaches had to be developed by trainers and organisations. The monitoring and evaluation of these processes proved to be indispensable. But proper techniques of both monitoring and evaluation need to be adapted to the set of goals of each (training) project. The most essential is the evaluation of the effects of (trained) interventions. But it is also the most difficult and costly one. Scientific research, whether epidemiological or evaluative, also demands high skills and budgets. Furthermore, questions of ethics need careful consideration.

- **(Self) Care for psychosocial workers and local trainers**. Volunteers and helping professionals are not uncommonly confronted with the same hardships as the populace they want to help. Symptoms of stress and the psychological consequences of traumatic experiences may well surface during training courses and during their work in the community. These phenomena need to be encountered and largely overcome during the training courses. In as such they may become an integral part of training for it demonstrates the trainees exactly the nature of these problems and the resources and interventions that help to overcome them. Trainees also learn to share, build mutual trust, and to give and receive compassion. Their own developed coping skills and resources may become essential tools for their work. It also demonstrates to them the meaning and necessity of supervision and the prevention of vicarious traumatisation.

- **Nongovernmental organisations**. Psychosocial and mental healthcare workers are mostly organised in the legal status of an NGO, with an official registration and by laws. Local initiatives may also be legally represented or supported by (inter) national implementing organisations. Donor organisations demand this structure first of all because they need an 'address' to communicate about the goals, activities and evaluations and, of course, about the allocation and audits of budgets and expenditure of a legal NGO. But it has many more advantages. As an organisation it becomes easier to organise training courses, fieldwork, provide a good environment and opportunities for supervision for the care givers, fundraising, differentiation of tasks, and to develop strategies to improve the care both in quality and quantity. Furthermore, it facilitates contact and collaboration with other relevant NGOs or regular institutions, such as hospitals, schools, vocational schools, public authorities, universities, etc. It also provides possibilities to probation, i.e. learning on the job in other organisations, specialisation and division of tasks or work. Hence, the relation with other institutions increases the potential spin-off of a project by embedding it in local infrastructures, mutual referral systems, psycho-education and influencing existing curricula of educational institutions (See the appendix: Example 4). The importance of a well functioning organisation can hardly be overestimated. It is, therefore, worth the effort to support local NGOs to organise themselves in a way that may well enhance their potentials.

Another lesson learned is that psychosocial support can not be considered as yet another kind of (short term) emergency aid. The training of fieldworkers,

laymen and professionals alike, takes time; serious time. Moreover, the adverse consequences of living under severe stress, anxiety, threat, and trauma are not short lived. There is sufficient evidence that the consequences of trauma can be long lasting and highly variable (alternating periods of latency and exacerbation, or late onset) in their life-time courses (Aarts & Op den Velde, 1996). And finally, the development of care providing organisations, networking, referral systems, collaboration and communication with relevant other organisations and the development of adequate interventions, demand effort. It goes almost without saying that psychosocial and mental health care should be considered as structural humanitarian assistance. Moreover, sufficient nutrition, housing, economic opportunities, health, education and safety are basic to efforts to ameliorate the mental and psychosocial condition of any target group. As the *IASC Guidelines* advocate, humanitarian agencies need to collaborate to ensure that the most fundamental necessities of livelihood are addressed along with community based psychosocial support and mental health care.

Lessons learned, unfortunately, does not mean to say that errors and malpractices no longer occur. Many avoidable mistakes, errors, misconceptions and malpractices still take place (Wessels & Van Ommeren, 2008). Apparently, lessons sometimes need to be learned all over again and again...

Trauma critics

From the mid nineties, critical sounds were voiced on the basic principles and practises of psychosocial and mental health care. Not only in former Yugoslavia, but also elsewhere (Summerfield, 1997, 1999; Young 1995). The critique was quite fundamental. It concerned the very concept of trauma and all the supposed misconceptions and malpractices that followed from this 'false' concept. Young, for instance, claimed that the current rise of interest in trauma and especially in posttraumatic stress disorder, was a construction from a 'Western psychiatry' that was affected by a general spirit of time that translated normal adversity of life into an illness, and allowed people the gains, financial or otherwise, of 'victimisation'. In other words, the concept of psychological trauma fulfilled a societal tendency or need, but lacked sufficient scientific foundation. According to Young and those who agreed with him, psychotraumatology was merely fashionable, and knew too many uncritical followers.

Summerfield c.i. generally endorsed Young's vision on trauma. But he took it a step further in emphasising that trauma and especially PTSD were concepts that held no bearing to the psychological realities in other cultures. Individual or group therapies, focussed on the 'working through' of traumatic memories of individuals were totally inadequate. Not only because of the impracticality of giving huge amounts of people time consuming and expensive treatments, based on insufficiently founded and culturally biased principles, but even more so because the reality of the problems people lived in, was complex and manifold; the supposed suffering of bad memories being only one of them. The mistakes that Summerfield c.s saw or foresaw that followed from these fallacies were that:

- Basically normal human reactions to stress, repression and warfare were described and approached in pathological terms, thereby stigmatising and not helping the people in question;
- A focus on symptoms and complaints denies the inner strength, resources and coping skills of people;
- Mainstream theories and practise are based on a culture that differs from many other cultures;
- Addressing only trauma and psychological suffering instead of the full package of material, medical and psychosocial needs is counterproductive and therefore potentially harming;
- The role of local traditional healing and coping, and of spiritual and community leaders were neglected, instead of used as a significant source of help.

This basic critique was not smoothly voiced, but quite loud indeed. It definitely influenced the mainstream of psychosocial and mental health care in (post) war or disaster areas in a positive way (see under lessons learned in this chapter). Although, unfortunately, there still are ample examples of less well considered projects. But, as is often the case with reactive critique, it was also extreme and polarising. The word trauma became a taboo for a while. Only uttering the T-word meant that one became guilty by association; guilty of medicalising, stigmatising, ignoring psychosocial opportunities and obstacles, and overall malpractice. Furthermore, many of the critical analyses of Summerfield c.s. had already been understood from within. Trauma and especially PTSD, by then, was and still is subject to crucial assessments. And although the expression, interpretations and even awareness of posttraumatic symptoms may vary under the influence of cultural determinants, human pain and suffer-

ing are universal.
Nevertheless, the present emphasis on resilience and coping in trauma research and thought may well be inspired by these critiques. It may lead to a shift away from a too narrow focus on dysfunction and pathology in favour of individual and communal inner strength and coping capacities. In Beech (2006) this is formulated as a shift in focus from a deficit model (symptoms) to a wellness model. However, when negative emotions and behavioural responses, fear and anxiety, hinder the ability and resources of coping and adaptation, these feelings and unfavourable adjustments, still need to be addressed. As is quite common in the aftermath of a fierce debate, the position of only-this-and-not-that evolves into a more common sense *best practise* of both-this-and-that.

Assessments

It is the purpose of this chapter to underline the importance of training local people to help others in the community to help themselves. Learning the kind of support and care, for whom this help is needed, and in what way it can best be designed and delivered, should precede training as part of any project. The meaning of proper assessments as a foundation for adequate psychosocial and mental health (training) projects can hardly be overestimated. It is significant too, for the potential sustainability of these projects. Furthermore, assessments are not a one-time activity foregoing the beginnings of a (training) project, but especially in longer lasting projects, assessments need to be (partially) repeated. Situations can change, previous findings and their interpretations can prove to be unsuitable, and errors can be made. Appropriate and timely reassessments or evaluations facilitate the adaptation to possible changes in needs and circumstances. This paragraph deals with the various items that may have to be assessed and, briefly, some basic techniques. Of course, both assessment items and techniques vary according to specific circumstances and regions. The statements and opinions in this paragraph are inevitably general and may acquire adaptations and elaborations in each concrete assessment. Furthermore, it makes sense to distinguish the assessment of needs and services in general from the assessment of required knowledge and skills in training courses. However, both kinds of assessments are important.

For training courses it is essential to learn about the nature and extent of psychosocial or mental health problems within a specific community and what kinds of help, and thus training, are likely to be most suited to address these problems. This does not, of course, need to be done when reliable estimations are already available from other institutions or organisations. Next, it is worth every effort to select trainees from the community, who are sufficiently motivated and talented, and likely to be acceptable care providers within (a part of) a given populace. This selection and the spectrum of trainable interventions are subject matter of the next paragraph. In practice training courses are part of broader projects of NGOs. Assessments are the responsibility of these NGOs and they encompass more than the abovementioned.

The identification of vulnerable groups and individuals in a community, who are the primary beneficiaries of most (training) projects, is a first step. They can be widow (er)s, victims of (sexual) abuse, torture and neglect, women, children, orphans, ex soldiers, invalids, (mentally) ill, and so on. It is also recommended to get a well informed overview of the daily living conditions of a population and the measures that have been or are planned to be taken for improvements. It concerns shelter, the (un) availability of food and drinking water, hygiene, health care, education, and finally an estimation of the safety of the people in question. These urgent material needs do have an impact on the lives of survivors: it is hard to talk about your depressed feelings, when you also worry about your hungry children.

Adequate assessments are not only focussed on the demand side, but also on the available supplies, both from within the community as from outside. International, local or supranational NGOs may provide relevant activities to improve living conditions in the region. Getting an overview of their activities is important for fine-tuning activities, preventing overlap and double efforts, and for mutual collaboration. Equally important is the help such an assessment can give the primary beneficiaries with finding income generating opportunities, vocational trainings, education, micro credit, (mental) health care and so on. The assessment should also take into consideration the communities own institutions, cultural activities, schools, rituals, spiritual and healing traditions, and the present state of a social fabric.

It has already been underlined that psychosocial assistance and mental health care projects need to be aware of and sensitive to traditional sets of beliefs, values and conduct, here summarised as culture. However, awareness and sensitivity does not mean that also

'negative' traditional beliefs, values and behaviours, such as repression, exclusion or battering of women, have to be excused or ignored as part of an innate culturally determined system beyond the criticism of other cultures. Cultural sensitivity, in this respect, may well mean that equilibrium between universal human (children's included) rights, and traditional values will have to be found.

It is, however, crucial that training and interventions of psychosocial workers relate to their culturally determined perspectives. An assessment of cultural characteristics, therefore, is a *conditio sine qua non*. Awareness and identification of local obstacles and resources alike, contribute to tailor-made training courses. Where a restoration of people's wellbeing and health is concerned, insight into existing cleansing rituals, coping strategies, religious beliefs, history and the social structures, is important. This includes not only an understanding of leadership, traditional position of elders and healers, but also of the weight of common taboos or feelings like shame, or the significance of the individual as opposed to the extended family, clan or community.

The particularities of specific cultures are not easy to assess. There are no ready made 'manuals' that weigh each specific culture against the background of psychosocial and mental health care in (post) war or disaster area's. More general studies, however, on local cultural phenomena are available. And together with the sharing of information and experiences with other NGOs and local key persons, like school teachers, spiritual leaders, midwives and traditional healers in the region, they are valuable assessment tools. Though, it will need to be taken into consideration that cultures are not static. Internal diversities and individual varieties within a given culture may well be manifold. Furthermore, the capacities to change and adapt are intrinsic human traits.

Important to all psychosocial training and work of local care providers is the availability of literature, and opportunities to share and to learn from the experiences of more or less comparable projects. It helps psychosocial and mental health care workers to compare and relate their experiences and opinions to those of others. Furthermore, it may diminish the sometimes felt isolation. The facilitation of mutual networking and meetings, and the distribution of relevant written reports, studies and analyses[10] , may well contribute to the quality of individual caregivers and of projects as a whole.

In conclusion, and focussed exclusively on the contents of training courses, is the assessment of the specific skills, tools and insights that local (future) caregivers may need in order to provide good quality support and care for the primary beneficiaries and communities. Next to insights into the living conditions and mental problems in the population in general, the appraisal of present skills, values, knowledge, and conduct of trainees is important. Training courses need to be adapted to what is already available and what may be required in trainees. Such assessments need to be repeated before each follow-up training. Proper evaluations of training courses, including the sharing of field experiences and role plays, may give trainers an opportunity to assess both the improvements and shortages of the trainees, and the relevance and quality of his or her own training.

Community Based Training

This paragraph, in general, describes the so far best practise of psychosocial training. This best practise will be held against its various contexts and its critics. For training courses to be successful and durable it requires awareness and sensitivity to historic and cultural particularities, socio-economic and public health circumstances and of the many threats people may face in their daily existence, as has been described before. This may seem a matter of course, but in too many instances they appear to be forgotten or are not given sufficient consideration. On the other hand, in many instances adverse circumstances and threats, may be overwhelming and blur the vision to opportunities. But still, in the face of the seeming impossibility to change the overall daily lives and wellbeing of so many people for the better, opportunities may well be there.

Criteria for psychosocial and mental health care in (post) disaster and conflict areas are described (Aarts, 2000) and for the most part they are also relevant criteria for training courses. These criteria are:

- The goals must be pertinent to the needs of the beneficiaries;
- The aid must reach the greatest possible number of beneficiaries;
- The aid must be provided on a continuous basis for as long as it is needed;
- The theory and (trained) interventions must be suitable and effective;

[10] Since 2002 a specialised peer-reviewed journal (quarterly) is available: *Intervention. International journal of mental health, psychosocial work and counselling in areas of armed conflict*. It contains theoretical and practical, general and specific contributions on many relevant issues. Contributions are from international experts. It is an important forum for all involved in psychosocial and mental health care.

- There must be equal access for all members of the target group; and
- The aid must strengthen and utilise the local capacity.

Returning to the fundamental opposition of Summerfield c.s. to the emphasis on trauma recovery programmes for people who live under the duress of multiple and often urgent problems that threaten their very existence, training local care givers to provide psychosocial assistance in the community, should again be considered. First of all, where urgent needs to survive, such as food, drink, sanitary facilities, shelter and some basic health are lacking, psychosocial or mental health training should not be given priority. However, according to the *IASC Guidelines*, it often proves beneficial to combine mental health care and psychosocial support with the emergency aid, in this sense that it may well enhance the positive effects of both kinds of support. Second, when training is opportune, empowerment of the target groups to (re) create a social fabric and reinforce their own capacities and autonomy, should be the ultimate objective. In other words, people should be supported to deal with their often multiple problems on their own accord. People experience these problems as intertwined and not as isolated; posttraumatic complaints being only one of them.

Furthermore, according to critics, mainstream kinds of training would not correspond with many cultural characteristics elsewhere in the world. Talking about emotions, expressing and sharing feelings and doubts, handling conflicts, reasoning, giving true biographical accounts, are seen as typically western values or attributes. And as important tools and goals in psychosocial training, they may not relate at all with local peculiarities. This appraisal, however, needs some nuance. The abovementioned cultural or socio-historic characteristics may be less inflexible than is assumed. Many of them are not inborn. They may well be a result of political repression, or the suppression of women by men, of men by elders, or children by parents, and so on. In the safety of a trusting and private relation, where the pressure of conforming may fade, sharing and talking about feelings and problems, often prove feasible. And not only feasible, but also desired and consoling. In an estimation of various training courses on counselling in countries like Cambodia and Sri Lanka (Van de Put, et al., 1998; Van der Veer & Van de Put, 2000) confirm the prospects of 'western' counselling in such cultures.[11]

Trained psychosocial interventions, nevertheless, must fit a culture or traditions and adapt to the particular problems, coping strategies and needs of (groups of) individuals within a community. In worldwide practise, the range of psychosocial interventions is quite wide. Dancing, relaxation, shared activities such as sport, music and play, etc. all belong to the arsenal. Creative arts forms, story telling and narrative theatre complement them. It falls outside the scope of this manual to describe them in any more detail. However, neither of these interventions is just done for the shear pleasure of it, albeit of importance. The activities commonly share a theme that bears importance to and is implicitly or explicitly chosen by the participants. These themes may vary from political repression, hunger, fear and threat, hatred, to domestic violence. They are an outlet and a means of understanding, sharing and learning how to cope. For children and adults too, nonverbal activities may be the only way they can express their pain and worries, so that they can be identified and as much as possible dealt with. Counselling principles and skills, however, are relevant to all these interventions. Therefore the training and nature of counselling are somewhat elaborated below.

Training counselling techniques: controversies and practice

In previous days counselling was understood as an important component of psychosocial and mental health care, also within the context of a community based approach. Basic counselling techniques provide skills, attitudes and understanding of psychosocial problems in trainees, whether they are more modern professionals, like nurses, medical doctors and psychologists, or key persons in the community, such as leaders, healers and teachers. These basic skills are considered pivotal to any kind of psychosocial intervention by care providers. However, the term counselling also refers to support in the sense that individuals or groups of individuals are supported to solve or cope with psychosocial, economic or mental problems. It is especially this last form of counselling that is currently quite controversial.
The main objection to the training and practice of counselling is that its techniques and traditions are

[11] The African local counsellor and project leader Prudence Ntamutumba told the author in a private conversation that talking about domestic violence with Sudanese refugees in Uganda was only possible when moral judgments were left out. After all, it was generally accepted that men had the right to 'discipline' their wives or children. Domestic violence could only be spoken of in terms of it *feeling* bad and hurting, and not in *being* bad.

quite specific and therefore not inherently suitable and adaptable to other cultures. However, there is no consensus in the field that this was the case. Others (Jordans, et al. 2003; van de Put, van der Veer 2005) have experienced that the basics of counselling as a respectful way of mutual support are quite universal and despite the need for cultural adaptations, as is the case with *every* type of humanitarian assistance, works well in the practice of local support systems.

Another common objection to counselling – and this refers especially, but not exclusively to counselling beyond the training of its basic techniques - is that it has a connotation with *therapy*. Besides the already questioned cultural appropriateness, such kinds of counselling demand much more advanced knowledge and understanding. Examples of harmful practices with counselling understood as a kind of psychotherapy or psychological (trauma) debriefing indeed exist. However, with proper and continued training, education, supervision and thorough selection of trainees, such malpractices can be avoided and fill the void in care and support for people that suffer from apathy, hopelessness, substance abuse, posttraumatic complaints, depression and so on; symptoms and behaviour that make it unlikely that they can profit from other less intensive kinds of psychosocial support. A last objection to the counselling of individuals or groups of individuals mentioned here, are its financial costs. Counselling is a quite lengthy and intensive intervention, both in its training and its practice, and therefore comparatively expensive.

In the guidelines of the IASC the *term* counselling is not mentioned. In action sheet 6.1 basic counselling techniques (as meant in this report) are recommended. On page 116 it is described al follows:

General health care providers frequently encounter survivors' emotional issues in treating diseases and injuries, especially in treating the health consequences of human rights violations such as torture and rape. Some forms of psychosocial support (i.e. very basic psychological first aid) for people in acute psychological distress do not require advanced knowledge and can easily be taught to workers who have no previous training in mental health.

The qualities of such interventions are further elaborated under point 5 of action sheet 6.1. and referred to as psychological first aid. In this report, though, the term counselling is still used, because in everyday practice it is still a common word. From the descriptions in the IASC and other guidelines, reports and publications it appears that the current controversies mainly refer to its association with Western traditions, in other words cultural appropriateness, and to the odds of harmful practices. Sufficient adaptation and proper training, however, could ensure to a high extent that both sound objections are avoided. The question of cost efficiency will be addressed in a later chapter.

The psychological condition of survivors of atrocities is often depicted as a pyramid, of which the two slopes portray the continuum of stress-related mental or psychosocial problems. Depending on the severity of past and present circumstances, the majority at the base of this pyramid would benefit from improvements in their living conditions (basic services and security), the second section would be helped with community and family support, the third would need targeted, but non-specialised support, and a minority, at the top of the pyramid, would require specialised support (*IASC Guidelines*, 2007, p. 12). Depriving the third layer of nonspecialised care, such as counselling, could well be understood as unethical. Furthermore, the impact of their impairments and maladaptive responses even of a minority, influence the community at large.

The basics of counselling or psychological first aid indeed underlie most, if not all psychosocial and mental health care activities, whether vocational training, support groups for special groups, or assistance for children in or outside the schools. The principles of counselling also bear significance for healing or supportive recreational activities, art therapy, drama, and narrative theatre (Sliep & Meyer-Weitz, 2003). Despite the urgency and complexity of psychosocial problems, the basics of counselling appear relatively easy to acquire. This is important, because local 'candidate' psychosocial workers and counsellors are in most cases laymen. In many countries in this world there are only very few, if at all, professionals such as psychiatrists, psychologists, paramedics and social workers. If there are, they mostly live in the bigger cities and not in more rural or suburban settings, where much of the fighting takes place; where communities, the social ecology, and the means of sustenance are disrupted or destroyed, and where refugees and internally displaced persons most often can be found.

The reason for this relative simplicity of counselling principles is that the skills are close to the fundamental social supportive skills many people acquire naturally. A basic understanding of the possible effects of atrocities, whether manmade or natural, can be transferred

by introducing a small set of theoretical concepts (Van der Veer, 2003). This 'simplicity' does not only facilitate the learning process of the counsellors, but also of their clients. 'It is mostly aimed at making them clients aware of knowledge and skills they already possess' (van der Veer, 2003, p.17). Van der Veer further stresses that counselling should not be exclusively focussed on trauma recovery, but on support for all kind of problems. Despite this relative simplicity, this does not mean that one time trainings or the handing out of training manuals suffice. Acquiring, improving, and adapting counselling skills take time. The importance of repeated training courses and learning on the job, can not be overestimated.

Who to train depends on the circumstances, opportunities, goals and problems of each psychosocial and mental health care programme. They can vary accordingly, such as the population of a camp for refugees or displaced persons, single persons in a community (victims of torture, members of a minority group), or people fighting for a daily existence in the rudiments of a community. Trainees will be selected from interested, willing and suitable representatives from these populations. They can be people working within existing, educational, social, religious or health infrastructures. They can be community leaders, nurses, students, religious leaders, healers, midwifes, or medical doctors.

Counselling skills encompass active listening, it being understood as emphatic summarising and structuring what the client both tells in words, what is not being mentioned, and by body language. The counsellor mirrors and contains both the clients' thoughts, feelings and facial or bodily expressions. 'Making choices' is not a matter of following the counsellor's analysis and advice. It is a mutual discovery process and scrutiny, including the client's own wishes and possibilities. Next to this, an attitude of respect and understanding of the client's fears, anxieties and resistances, needs to be developed in counsellors in order to help the clients overcome these. Learning to build a relation of mutual trust and respect are pivotal in counselling.

The way these basic counselling skills and attitudes can be trained is by using didactic tools such as drama, relaxation exercises, role play and the such (Van der Veer, 2003). What was at first understood as a special problem in training local counsellors, in practise turned out to be a potentially favourable condition. The trainees, in most cases, are members from the very same communities as their (future) clients. They suffer(ed) the same ordeals, they share or are aware of common values and beliefs, but they also personally know the pain, the grief and other psychological effects of stressful and traumatic experiences. These effects will have to be addressed during the training, because they might interfere with their possibilities of becoming adequate help providers. However, the very same effects and experiences appear to facilitate the learning process.

Addressing the psychological and somatoform reactions and adaptations of the trainees to their personal hardships, assists not only their understanding and valuation of the theoretical knowledge, but also the experience of the potentials of counselling processes. By addressing their own predicaments during the training process, the trainees sense the positive meaning of verbalising or otherwise expressing emotions and thoughts, of sharing, of mutual trust, and problem solving, coping strategies, etc. They also experience in themselves or amongst themselves the presence of shame, defensive mechanisms and resistance to both their problems and the counselling process itself. It can make them better counsellors themselves.

Didactic tools like psycho-education, drama, and role play are important in this process. Not only because the trainees themselves experience the hindrances and potentials of counselling, but also because it demonstrates intrinsic important values and attitudes, like mutual trust and learning, confidentiality, honesty and respect. In many cultures, however, these values and attitudes are not a matter of course. The trainer will have to demonstrate them, by his or her own openness, honesty, confidentiality, neutrality, respect and mutual learning. In short, the adverse experiences of trainees and their psychological reactions to them can be overcome as obstacles and be used as valuable tools in both their learning processes and their actual (counselling) work in the field. Theory and practical examples can relate to the own experiences of trainees, and are therefore potentially better understood (Van der Veer, 2006).

Supervision, in particular clinical supervision of counsellors is critical. Like training in general a one-off clinical supervision is by no means sufficient. The supervision should be an ongoing process. Its goals are to keep counsellors focussed and equipped for their often difficult work, and to facilitate progressive learning and the further acquisition or refinement of skills, attitude and insight. It warrants the sustainabil-

ity and efficacy of their interventions. However, the need for ongoing clinical supervision harbours practical problems. Clinical supervisors need to be experienced and skilled supervisors. These skills and experience, though, are mostly not readily available and especially in the first years it will have to be imported. Another problem is the limitation of funding periods that may strain the need for ongoing clinical supervision. The last problem, mentioned here, are the relatively high costs of continuous and regular clinical supervision, especially where local capacity to provide the supervision is still absent or insufficient (See the appendix: Example 5).

All training, albeit counselling or its basic techniques, art therapy, narrative theatre or drama, needs to be adapted to specific circumstances and socio-historic backgrounds. An example of such an adaptation may be the training of schoolteachers. Educating teachers to understand and assist their pupils, who may show a variety of adverse emotional and behavioural reactions to the stresses of their daily lives and to the weight of their memories, their fears and nightmares, can be effective. The teachers can learn to support these children and, when necessary, refer them to local counsellors or mental health care providers. However, there are regions where the dominant educational culture is authoritarian, punitive, and hierarchical. Training psychosocial assistance to vulnerable children and youth will have to be preceded and accompanied by the acquisition of more democratic, interactive and respectful didactics and attitudes towards children and their parents. Furthermore, some basic knowledge on the physical and psychological development of children and adolescents often needs to be attained. The true need for psychosocial support of children has to be felt and understood by teachers. Only in such a climate the support for vulnerable children and youth can grow and thrive. Here too, experiencing the meaning and value of such principles themselves in the course of their trainings, facilitates the necessary changes in perspective and attitudes of the teachers (See the appendix: Example 6).

Part of every training should be the prevention of practically or emotionally over-burdening of the (future) psychosocial workers. Several so called 'psycho hygienic' measures, like relaxation, sharing with colleagues and supervision can be helpful in both the prevention and the resolution of possible negative consequences of supporting people with sometimes heartbreaking problems. It can hardly be stressed enough that counsellors and other psychosocial workers need to be supported by an organisation that can provide or stimulate these measures and looks after the psychological health and wellbeing of their staff. Clinical supervision, however, it not a measure against vicarious traumatisation and burn-out, but specifically an important tool to enhance the professional capacities of psychosocial workers. It may keep them sharp and self-critical.

It has become a good practise to have training courses of several days or weeks in a safe place, away from the trainees' daily routines and burdens. This facilitates the concentration and learning processes. It also provides room for trainees to get to know their colleagues from their own and from similar organisations. Exchanging ideas and experiences can prove to be fruitful. Furthermore, a network of acquainted psychosocial workers, may pave the way of mutual fine-tuning, collaboration, specialisation and referral. However, the fact that all rules know their exceptions is illustrated in the example 7 in the appendix.

The evaluation of trainings is an important tool in assessing the results and impacts of training courses. It, of course, includes the qualities of the trainers and the trainees, and their relation. It also includes the value of various didactic tools and the appropriateness of the trained theories and interventions for the work in the field. Proper evaluations may lead to better or more suitable training and fieldwork.
The evaluation of training courses usually is done by both the answers and reactions of trainees to evaluative questions or written questionnaires, and the reports of trainers themselves. In follow-ups trainings, which should be common practise, progress of trainees and the training process can be observed, and obstacles and blind spots can be identified and addressed. The evaluation of training courses should be considered as an ongoing process. In which the reactions and (lack of) progress of trainees and the observations and reports of trainers, are important next to the analyses of experiences of the trainees in the field. (The evaluation of psychosocial or mental health care projects as a whole, are elaborated elsewhere in this manual)

Over the years some manuals on the training of local psychosocial and mental health care workers and teachers have been published by experienced trainers (Mikuš-Kos, 2005; Van der Veer, 2003; Baidoun, 2006). These and other manuals can function worldwide as good quality starting points for training courses and follow-ups. The contents and didactics

are sufficiently general and universal. It may prove to be worthwhile to adapt the manuals to specific backgrounds and circumstances. The publication of additional manuals for such specific conditions may well be recommended. Finally, the availability of manuals facilitates the quest for efficiency and sustainability.

The evidence base of interventions

The ultimate aim of training local caregivers is, of course that they can support, care for, or cure (parts of) the target population. Hence, the ultimate test of the success of (training) projects is to see if the implemented and trained assistance, indeed improves the psychological wellbeing, resilience, or mental health of the primary beneficiaries. There is currently some pressure to implement or train 'scientifically proven' effective programmes or interventions. In other words, interventions of trained local care givers should be evidently effective, in order to avoid potential harm to the beneficiaries and the waste of effort and public finances. The proof of effectiveness should be based on scientific evidence. There is an apparent rationale for the demand for evidence based interventions.[12] It is, however, easier said than done.

There are several reasons, part of them scientific and financial, why evidence based interventions presently may well be a bridge too far. The regularly vast amounts of people that may need psychosocial or mental health care, the complexity of psychological problems, and the interrelatedness of physical, psychosocial and material conditions, are often overwhelming. Where should meaningful research start? If it is scientifically possible under these circumstances to 'prove' a decrease of, let's say, general wellbeing or posttraumatic symptoms how do we know that this improvement is caused by the psychosocial interventions under examination and not by, for instance, more food or safety?

Furthermore, there are important ethical considerations. For instance, the scientific study of the effects of specific interventions needs to be controlled. The call for a well matched control group causes ethical problems, for it means that a group of people are not receiving assistance in order to be 'used' as a comparison group. Only the very choice to allocate time, effort and money to scientific studies in the place of factual support, contains ethical considerations. It is not to say that ethical questions can not be overcome. In all research, ethics are considered, and *have* to be considered in each single study, and adapted to minimise harm and unethical actions.

A next step in research is that measures are chosen or developed. But measures of what? As has been said before, problems in the target population may be complex. Questionnaires on for instance posttraumatic symptoms[13] or depression, however reliable, valid or culturally sensitive, may well miss the essentials of people's suffering. Suffering from symptoms of any disorder, without meeting cut-off scores, produces false negatives. Moreover, measures based on mainstream diagnostic classifications may well not be adequate outside the cultures in which they were developed. In the complexity of their lives many determinants exist that influence the wellbeing and functioning of people. This indicates that special measures will have to be developed to suit the condition and situation of the target population.

The interpretation of findings is yet another issue. If, for instance, one finds that, of the measures used, there is a significant improvement before and after the intervention, and there is no such improvement in the controls, this does not necessarily indicate that the nature of the intervention (f.i. art therapy or counselling) is effective. It only warrants the conclusion that doing an intervention and hence paying attention to people and activate them, may improve their conditions. To make it even worse, if there are three groups studied, two groups that each receive different interventions and one control group, and their statistical analysis shows that one intervention renders better results, this still does not mean that this one intervention is evidently better as compared to the others. It may reflect that the caregivers implementing this particular intervention are better professionals, have better skills, personalities or are more experienced. It is a good scientific rule that *one* result is *no* result. Only repeated studies are capable of ruling out such possi-

[12] In current (mental) health care in the richer parts of the world, evidence based treatment has become common practise. However, besides the evident advantages, evidence based medicine is also criticised. What is especially attacked are the 'protocolised' treatments, based on the rarely existing 'average' patient. Every deviation of the protocol demands bureaucratic fuss, and in still inexperienced care givers it may kill the 'clinical eye' (Altman & Bland, 1995; Straus & McAlister, 2000).

[13] In the west so far, there are only two 'evidence based' treatments of choice for PTSD. They are cognitive-behavioural therapy and Eye-movement Desensitisation and Reprocessing (EMDR). Their effectiveness is especially tested for clear cut PTSD. Their use for more complex and co-morbid conditions, as we often see in our target populations, is yet to be proven. Furthermore, these therapies are done by experienced and specially trained psychotherapists and not by laymen. (Foa, et al. 2000).

ble confounders.
Scientific research after the effectiveness of specific interventions, furthermore, needs a team of well schooled and highly educated multi-disciplinary researchers. The assessments, measures, tools, and data analyses take time and are costly. It should also be taken into consideration that regular follow-up studies are required to confirm effectiveness over a longer stretch of time. The needed sophistication of research measures, tools and personnel, along with the required financial resources and ethical considerations, currently make a quest for evidence based interventions fairly impractical; a bridge too far.[14]
Though not really evidence based as we understand it, there are fortunately alternative ways to indicate the potentials of particular sets of interventions (Bolton, Tol & Bass, 2009). Properly adjusted and skilled programme evaluations can be important indicators of the appropriateness of training courses and interventions. Such evaluations should in fact be examined and calculated in the costs and other resources of psychosocial and mental health care projects. In projects, for instance, where schoolchildren are the primary beneficiaries, subjective reports on the decrease of aggressive behaviour and bullying, or the increase of concentration, sociable behaviour, parents' involvement etc., may be important signifiers. More objectively, school marks and data on truancy may complete indications of the (in) effectiveness of interventions. The analyses of the results of evaluations may well guide improvements and adjustments of (trained) interventions.

Training of trainers

The axiom helping-people-help-themselves refers to both the stimulation of resilience and coping in the primary target population, and to the capacity of local caregivers to help the target population in getting there. The training of local caregivers to train volunteers or (semi) professionals to become colleague caregivers, is an important means of empowerment. The training of training (ToT) is therefore considered as a vital tool for both empowerment and sustainability. Its so called cascading qualities (Baron, Jensen & De Jong, 2002) refer to yet another important advantage. By ToT the number of trainees and the amount of people that can benefit from interventions, can grow exponentially. Furthermore, the principles of proper care and empowerment and insights into the consequences of adversities and continuous stress can slowly become more embedded in communities. It presently is good practise to include a ToT in psychosocial and mental health care (training) projects. However, this quite common sense policy is not as simple as it meets the eye.

Years of experience with the training of trainers in many parts of the world have shown that ToT is as feasible and sensible as was commonly thought, but that it may require much more effort and investment than was previously foreseen. The selection of trainees that can be included in a ToT, needs to be done carefully. Baron (2006, p. 111) sums up the qualities that she feels need to be present in suitable (local) trainers. 'These include a personality that is outgoing, confident, well organised, mature, compassionate, insightful, constructively critical, responsible, flexible, sensitive to time, self-motivated, quick, intelligent, creative, with a sense of humour, physically healthy, emotionally stable and sensitive towards psychosocial and/or mental health issues.' Maybe this grade of perfection is a bit hard to reach. But many of these qualities, indeed, should be at least partially present in aspirant trainers. In the previous paragraph on the training of counselling, the importance of the personality of a trainer for building a relation of mutual trust and respect, just like the trainees will have to do with their clients, has already been stressed.

Another prerequisite is that the trained future trainer is in possession of sufficient and appropriate know-how, insight and skills. In short, they need to be well trained themselves. Unfortunately, there are ample examples that this is not always the case. The trainee to become trainers themselves should also have sufficient field experience that can be related to the training contents. Next to the academic contents a contact oriented approach is of equal importance (Van der Veer, 2006). In various studies after the effects of particular therapeutic interventions, it proved that the significance of therapeutic techniques may be less important than the quality of the supportive, trusting and meaningful relation with the therapist/psychosocial worker as a person. These skills, therefore, need to be made aware and taught so that they can be acquired by their own future trainees.

Like in all training courses, follow-ups and supervision over longer periods of time, monitoring and evaluation are also necessary in ToT. More detailed recommendations with respect to ToT can be found in Baron (2006). The set of goals of psychosocial and mental health care (training) projects, including ToT, should perhaps better be process driven, instead of the usual project driven products (Wickramage, 2006).

[14] Allden, c.s. (2009) describes various considerations with respect to opportunities of research and, hence, the development of an evidence base of psychosocial interventions. Working Group 6 of the Inter-Agency Standing Committee.

Chapter 3

Local nongovernmental organisations

The quality of services provided is of great importance for sustainability. This includes, of course, the suitability of such services to address and adapt to the needs of a target population. Yet the functionality of organisations that provide such services may well be of equal importance. As has been stated in the introduction of this report, the effects of psychosocial support and mental health care may well fade away without the efforts to ensure its continuance, adaptation and quality. This chapter, therefore, describes the meaning of such organisations and the efforts to promote their performance.

The words 'nongovernmental organisation' (NGO) in this chapter refers to a multitude of organisations involved in the promotion of mental health care and psychosocial support. It includes community based organisations, health care facilities, training schools, universities and even relevant local governments. Supra- and international organisations play their part as donors or implementers. Donor organisations, whether governmental, from the UN or nongovernmental, will be the subject matter of the next chapter. Their potential to promote sustainable mental health care or psychosocial support cannot easily be overstated. This chapter, however, is mainly reserved for *local* organisations, whether officially registered as NGOs or not, because they appear quintessential in the quest for sustainable services.

International support is naturally limited in time. The need for care for the social and mental wellbeing of a population living under duress, however, is known to outlast many funding periods. Although capacity building has become a common international strategy in the quest for efficiency, sustainability and spin-off, this is mainly reserved for the dissemination and development of know-how. Unfortunately, in practice many programmes or projects die an untimely death. It seems it is not yet sufficiently understood that well functioning local organisations are pivotal to embed sustainable services. The empowerment of local NGOs has long been second to training or the provision of direct services to a population. In this chapter it is advocated that a more general strategy to help build well adapted and functional local organisations may well prove to be essential with respect to sustainable care.

In common humanitarian and developmental assistance it has long been a general policy to encourage, at least in words, the building of capacity in the form of supporting the growth of local NGOs or community based organisations. There are both practical and more political reasons for this. A practical reason is that donors logically prefer to find local partnership in accountable organisations. But it is also considered as an instrument in a policy that promotes, on the long term, more civic and matured societies. However, in many low or middle income countries, even in those that have general elections, self-organisations of the population often are foreign bodies. There hardly exists a 'middle field' between official governments and the population, as is so familiar in the west. In many low and middle income countries and regions, governments are wary of potentially critical and committed self-organisations. Many current governments only tolerate these 'foreign bodies' in their midst because they bring in currencies, or in exchange for (economic) support from the international communities. Nevertheless, the encouragement of nongovernmental organisations in middle and low income countries may well ease such favourable societal changes in the end, but they certainly increase opportunities of sustainable care and support.

In current practice, mental health care and psychosocial support are usually carried out, or even initiated by local organisations. The local organisations are commonly founded just for the cause. Implementing or host organisations, whether working with or through local organisations, usually react in the direct aftermath of emergency situations. The necessity for lasting care and support for the population, though, is apparent. Both local and international staff often state they feel frustrated, when after the funding periods their projects or programmes are terminated prematurely. This general 'untimely' ending of needed support and care, as a consequence of lack of funding, is felt as one of the main problems that hinder sustainable developments.

However frustrating, the provision of foreign money and effort inevitably are limited in time and quantity: hence, the importance of strategies and policies to work around these limitations. Enhancing opportunities for sustainable care can be endorsed by policies of capacity building, concentrated on both effect and effort. Training and assisting local psychosocial workers and (mental) health care personnel, as has been described in the previous chapter, is such an effort to build local capacity. Yet another, somewhat less general strategy of capacity building is the education and stimulation of awareness in local relevant institutions, such as universities, health ministries, (para) medical personnel, teachers, vocational training schools and, if they exist, social welfare facilities. This last policy to enhance local capacity, by creating awareness, know-how and skills, however, requires a lengthy endeavour. It can best be performed and negotiated by local community based organisations and NGOs (See the appendix: Example 8).

Depending on the goals of any psychosocial intervention, leaving behind at the end of a funding period a local organisation that has a fair change of functioning and survival without the finances and support of the initial implementing organisations or donors would certainly help to attain the required sustainability of care and support. Therefore, this chapter addresses the advantages of sufficiently functioning NGOs in the field of psychosocial support and mental health care. Of course, donor organisations play a role in this, but their significance in the process will be described in the next chapter. This chapter focuses on the wide variety of tasks and functions, both internally and externally, that need to be developed and consolidated in order to fulfil their capacity to help and assist a population that has to cope with suffering and survival challenges, often beyond the imagination of luckier people in wealthier and less violent parts of the world. When local NGOs are considered to be of importance for the provision of sustainable and good quality care and support, assisting them to structure and organise their performance may well be worth the attempt.

Local NGOs

Local organisations, whether officially registered or not, that consider psychosocial support or mental health care as their commitment, are founded for various reasons. First, they can be the result of a local initiative, and second, they can be initiated according to the policy of implementing or donor organisations. The local initiatives are often the result of the enthusiasm and commitment of volunteers that want to somehow alleviate the suffering of their countrymen. These volunteers can be laymen, but they can just as well be (semi) professionals, such as doctors, social workers, nurses and psychologists. The locally initiated organisations need to find financial support form abroad. Most official donors, however, demand their local partners to officially register as an NGO and, thus become a responsible partner. This young NGO further seeks training to direct or enhance their 'helping' strategies and methods.

All NGOs, whether rooted in local or international initiatives, need to develop and consolidate their capacity. This is not an easy task, and it should best be understood as a process, that may exceed the funding period. Assistance and attention for this process should not be underestimated. Both may well be needed even after the NGO has become an independent organisation. The required competence roughly concern the following fields.

- Structuring the organisation, and clarity of the mission (mission statement);
- Managerial skills and tasks;
- Human resources;
- Public Relations, including networking (see the appendix: example 9), collaboration and coordination, and
- Financial resources, such as fundraising, bookkeeping, allocation, income generation.

Organisation structures

The structuring of an organisation usually follows common paths. The required by-laws when an aspirant organisation officially registers, normally stipulate a board, a general director or group of directors, team leaders, and team workers, that communicate and work together on agreed upon and clear proceedings and missions. How exactly an NGO is structured, may not be of too much importance. It is, however essential that the structure sufficiently fits local cultural peculiarities, and allows for efficient and good quality functioning on all levels. Furthermore, the by-laws should guide policies and measures that can help dissolve friction and disagreement that may threaten the functionality and even survival of the organisation. Especially, since in many low or middle income countries, there is no formal experience with personal responsibilities, friction, working in teams, and so on, the capacity to resolve or live with interper-

sonal problems and differences of opinion within an organisation are not yet rooted.

Structuring an organisation that has grown out of local initiative may well be quite difficult. The initiators are often a group of colleagues, friends, family members even, that found each other in a shared idea or mission and a joint enthusiasm. In the beginning they are usually all partners in decision making processes. Differences of opinion that may find its origin in smaller and bigger issues may hinder the functionality and even threaten the very existence of such a group. When funding is found and a formal NGO is registered, the responsibilities that come along with it will make the need felt for a well functioning organisation that is both accountable and performing according to standards. Forming a hierarchical structure with a division of tasks and responsibilities, may offer the means to improve and grow as an organisation. The need for a formal structure will be felt by many within the organisation, but will at the same time meet with resistance and internal tensions. Dealing with this reluctance and tension is part and parcel of any reorganisation. The process has to be guided, given ample time, and support. External assistance, by means of consultancy and training, would be recommended in many cases. This, naturally also applies to local NGOs that are initiated by international organisations.

Because international efforts are confined in time and money, the development of proper exit strategies, that give local psychosocial support or mental health care a fair chance to survive and develop, is essential. However, exit strategies commonly only refer to guide staff in a final evaluation of a project and in the administrative aspects of exiting. There are no general guidelines or policies of how support to a suffering population can be sustained after the projects official terms. This may well be one of the biggest causes for frustration in both ex-pat and local staff. Exit strategies ideally go further than this and should comprise strategies that include a movement towards future independence of a local organisation. Training and consultancy of local NGO staff on management and performance is essential in this.

Consultancy and training is not limited to the design and establishment of a formal structure. The capacity and tradition of all the processes involved, especially in countries or regions where the vast majority of people lack experience with working within an organisation and carrying some responsibility for one own functioning or that of others, need to be developed and understood by the people concerned. Topics that frequently need guidance and time to develop are processes of:

- Decision making and transparency;
- Dealing with internal or external disagreements and conflicts;
- Meetings, deliberation;
- Divisions of tasks;
- Personal responsibilities;
- Mutual responsibilities;
- Internal and external communication;
- Managerial techniques and responsibilities, and
- Monitoring.

The main thing that binds an organisation and prescribes a structuring of human resources and tasks is the assignment: the main mission of an organisation. Unity and clarity of a mission, whether put down in an official mission statement or not, is important in this. Such a shared mission may help as an anchorage in times of disagreement or conflict regarding the directions of the organisations in question. However, it may be best if a mission statement is sufficiently general or at least not too specific. It should allow for adaptation and change as an appropriate reaction to alterations in the nature or incidence of problems in the target population or as a reaction to renewed assessments or intervention methods. In practice many organisations that primarily responded to the consequences of political repression or organised violence, expanded their efforts to for instance domestic, gender, or sexual violence. In many instances the activities developed as well, such as producing written materials and broadcasting as a means to educate, create awareness, and such. Political action and trying to influence the judicial system, broadening the networks, may also be useful activities that may emerge over time.
Next, when local NGOs become established, income generated activities can become feasible. Training other NGOs or institutions may well be the most evident of income generating activities.

NGO management

Managing an NGO implies a diversity of activities. These activities are complex and are often interconnected. It takes skill, know-how and a good sense of direction of managers, middle management, and fieldworkers. A proper communication and transparency is imperative. The functioning and position of a

board, whether on distance or more closely involved, would be described and defined in the by-laws. The tasks of the management are both internal and external. A division of responsibilities often facilitates streamlining, tuning and execution. However, when an organisation starts from scratch, the skills, know-how, and sense of direction and communication structures still need to be developed and adjusted. The tasks of the management are manifold and can be summarised as human resources, administration, monitoring, finances, evaluation, networking, public relations, training, assessments and, of course, organising support and care for the target populations, both in quantity and in quality. In fact, many of those tasks have been depicted in various action sheets of the *IASC Guidelines*. Because of the here postulated importance of organisation consultancy and training regarding opportunities for sustainable care and support, some of the task are further illustrated below.

Human resources

The '*code of good practice*', compiled by People in Aid (2003) describes the objective of recruitment of staff and volunteers as 'to get the right people to the right place at the right time.' Though this is certainly a challenge, this code, and also the guidelines of Oxfam (2004), direct and assist the processes of recruitment of personnel. Recruitment does not only refer to psychosocial workers, but also to local NGO managers, group leaders (middle management), directors and board members. Training staff and personnel to become the 'right people' for the job, including personnel occupied with the fieldwork, is a prerequisite. Training in resource management includes relevant items such as selection, safety, prevention of burnout or vicarious trauma, training, and supervision.

The selection of suitable field personnel does not only refer to motivation, qualification, prior experience, personality, but also to diversity regarding ethnic/religious/age groups and gender. Insights into local conditions, cultures and traditions, fluency in the language, and understanding of the psychological, social and cultural responses to stressors, are of equal importance. Furthermore, the management of an NGO should keep tracks on the functioning and need of further training of psychosocial workers. Fieldwork, especially in emergency situations, not rarely goes hand in hand with threats to the safety of the staff. Protection and preventive measures belong to the responsibilities of the management. Such a demonstration of care for their health, wellbeing and safety furthermore enhances the staffs' bonding and motivation.

Particular difficulties in personnel management are problems with keeping them. One of the causes of losing staff is that most of the work has to be done without salaries, especially after a funding-period. There commonly is, however, reimbursement of expenses. When people find a paid job, they naturally leave the NGO in question. This sometimes, in case that a staff member found a job in a different branch, is a loss of investments in recruiting and training. It may also cause stress or tension in teams. Working with volunteers requires additional strategies and policies. Selecting, directing, guiding, training and last, not least motivating volunteers, is a true challenge. Losing staff, however, is inevitable. The management needs to deal with it in a mature way and consider it as a given that changes of personnel take place, whether they are board members, managers or field workers. Acceptance, preparedness and adaptation are keywords in this.

In every organisation it is crucial to keep track of both individual and team performances. Next to keeping track of accomplishments and weaknesses of their personnel, it gives the staff or board an opportunity to reflect not only on the needs and conditions of the field or office workers themselves, but also those of the target population. The presence of security breaches, burnout, health hazards, a lack of guidance and incentive, not only of their own personnel, but also of key persons in the community, can be revealed by regular performance appraisals. This can be followed-up by preventive or renovating measures and policies. Individual performance appraisals could benefit from accurate job descriptions. It enhances the awareness of one's responsibilities and can be described according to a given persons capabilities, personality and wishes. In sometimes chaotic situations it may give people a handhold, and may thus prevent the loss of commitment and motivation.

Keeping track of the performances of personnel also facilitates the awareness of need for (further) training and supervision. The need for further training should be measured in relation to the requirements and quality of the fieldworkers or community workers and the assessments of the needs of the target population(s). Also new and promising interventions can be trained to broaden the range and scale of support and care. Organising training and follow-ups is one of the tasks of an organisations staff. Finding funding and the

right trainers herein is the main challenge. In practice training, including follow-up training is sometimes offered by international organisations. In many cases the training, including the travel and accommodation expenses of the personnel, are compensated. It may be tempting for an NGO to accept such offers. However, for the good of the actual care and support, it is imperative to thoroughly evaluate if the training contents fit the overall policy and mission of the NGO, and mostly the needs of the primary beneficiaries. Furthermore, the possibility that fieldworkers, community workers and the target population get confused by frequent changes in approach and techniques should be carefully considered.

A final task of the management is to keep a solid administration, both with regards to donor organisations, but also for the local organisation itself. Donor organisations request an overview and liable administering of the funding, human resources, interventions, other resources such as vehicles, computers buildings, and so on.

Monitoring and evaluation

Both monitoring (systematic observing or supervising) and evaluation (appraisal), just like proper and regular assessments, are of great importance to the development and practice of good enough mental health care and psychosocial support. Its potential is to reveal if targets are met in numbers, methods or approaches, and to disclose if particular interventions are sufficiently suitable and correspond with the actual needs and problems of the target populations, whether they be trainees or primary beneficiaries. Logically, donor organisations request monitoring and evaluation of the facilities and interventions they facilitate or pay for. Monitoring and evaluations belong to the responsibilities of the local organisations' management, even when as most often is the case the evaluation is performed by external consultants.[15] However, depending on what has been agreed upon to monitor and/or evaluate, various difficulties may surface in the process. These difficulties may be of practical nature or evolve as a consequence of the complicated character of the relation between local (implementing) organisations and their donors.

To start with the latter: in name local NGOs and their mostly international donor organisations are partners. They would share overall aspirations and objectives. However, in practice there is a certain tension between donors[16] and local organisations. This tension is mainly a consequence of the fact that 'donors' ultimately allocate the efforts (finances included), and the local workers are the recipients. Negotiating these innate tensions is part of the tasks of local organisations' management, especially when differences of opinion or misunderstandings arise about the efficacy of the local organisation in question, or the quality or appropriateness of their assessments and interventions. Ideas about policy, attainability, suitability, and quality, may well differ where mutual interests diverge and where hard evidence lacks about the effects of interventions. These differences may lead to bothersome conflicts or inappropriate measures but, if openly and effectively discussed, can also lead to improved policies.[17]

In practice we can distinguish between various kinds of evaluations. The most common evaluations that take place are the midterm and so-called end evaluations (at the end of a funding period), are *project* or *process* evaluations. They should reveal whether the described goals of a project are met and if the overall policies and management of a project or programme are sufficiently appropriate. For instance, training can be evaluated by questionnaires filled out by trainees and by reports of trainers at certain points after training. The success (outcome according to the goals) of training can best be evaluated where sequential trainings are arranged, especially when follow-up trainings are given by the same trainers. Next to the trainees' questionnaires, the trainers can estimate if the trainees are indeed improving, and assess the need for further or more specific training. Process evaluations (management and policy) are relatively easy to perform. Project evaluations usually include the number of beneficiaries reached or trainings given, cultural sensitivity, outreach activities, assessments, collaboration with other organisations, and so on, in the light of the previously described goals of the project.

The most challenging form of evaluation, however, is the evaluation of the effects of the programme on the primary beneficiaries. It is the most challenging because it is the most costly and most complicated kind of evaluation to perform. Various kinds of diffi-

[15] The IASC Guidelines (2007) describe standards of good practice for external evaluators of assessment, evaluation, and monitoring. According to Tol and Jordans (2008), however these standards in practice are rarely met.

[16] The perspectives of donor organisations herein are described in the next chapter of this report.

[17] By publishing the proceedings of an expert meeting held in Slovenia in 2007 the journal 'Intervention' in March 2008, dedicated a special issue to the potentials and possible problems in the evaluation of community based psychosocial programmes.

culties of a scientific, ethical and financial nature, as sketched in the previous chapter need to be mastered. However, reliable results of such evaluations are essential to the development of good enough and more evidence based interventions and policies. It takes; first of all, the development of proper outcome indicators that take into account the many confounders that may bias the results of evaluation instruments. There are, fortunately, key documents that may be helpful with the design, practice and interpretation of effect evaluations (Bolton, 2002, UNICEF, 2007, Jensen, et al., 2005). Its importance with respect to sustainability is in the promotion of quality of effect. It may be clear that it takes effort to develop, warrant and improve this quality.

As has been stated before, the results of monitoring and particularly of evaluations may well lead to alterations in the implemented programmes, its methodologies or overall approach. Suggested alterations as indicated by the results of monitoring and evaluation, however, need to be communicated and negotiated between the donors and the NGOs. Monitoring and evaluation may also reveal the quality or functionality of networking, additional fundraising, training, organising the fieldwork, research, statuses, all administration, bookkeeping, public relations, internal and external communication, etc. If improvements in any of these seem to be required, they can be designed and performed in deliberation between the donors and their local partners.

Fundraising

Finding funding for new or prolonged activities of an NGO is an important venture of the management of local organisations. Without funding or other income, the NGO cannot or no longer continue, sustain and develop care and support. However, fund raising, for many reasons, is a rather sophisticated endeavour. An endeavour that in many instances needs to be performed multiple times, since funding periods only last for a certain number of years (mostly two or three) and because local organisations often have to find additional funding for separate or additional activities. The first difficulty is that most donor organisations have their own particular format for applications. This requires more often than not a considerable investment of time. Filling out the proposals, furthermore, requires a fluency in English or French that is not always easily available[18]. And last, the management and staff must be acquainted with a particular vocabulary that appeals to and lives up to the standards of donor organisations.

In the previous chapter it has already been mentioned that even this form of humanitarian assistance by and large functions like a market. Inevitable competition for funding from many other organisations, whether local or international, means that the identity of the organisation has to be established and clear. This can be done by a policy of proper public relations, by providing good enough services and interventions, publishing, networking and by liaisons with relevant local or (inter) national or local institutions and ministries. Enhancing the credibility of a local organisation not only promotes opportunities for funding, but also the development of a well functioning organisation providing quality care and support.

[18] An inability to read and speak English has further disadvantages: it hinders the possibility to read available documents and literature, and diminishes the opportunities to take part in international networks.

Chapter 4

Donor organisations

The effort to promote sustainable psychosocial support and mental health care is a joint venture of both local organisations and donor organisations. For the sake of clarity the distinction between these two kinds of organisations is made, whereas in reality the field of players is more complicated. (Inter) national implementing organisations, for instance, can operate as both donors and organise the fieldwork and trainings themselves. They may operate as go betweens between donors and local communities or NGOs. Notwithstanding these complexities, the influence of donors on the efficacy, sustainability included, of care and support can hardly be underestimated.

Donor organisations come in all sizes. Some are small; some are highly organised and involve a great number of personnel. Most of them have only recently added psychosocial support and mental health care to their humanitarian activities. Donor organisations can be founded by private initiatives. They may dispose of their own capital or raise funds elsewhere. Others are supranational, such as various UN organisations and the International Red Cross, others are national non-governmental organisations or they are a venture of national governments. Whether great or small, rich or poor, donor organisations are held accountable, not only for the tax payers' or public donors' money, but also for the efficacy of their endeavours and overall policy. This puts donor organisations in a potentially precarious position between the organisations they support (the actual fieldwork) on the one hand, and their own funding relations on the other hand.

This relation may well have an impact on the policies of donor organisations with respect to their activities and policies regarding opportunities of more sustainable mental health care and psychosocial support. Many donor organisations know a long history of more traditional humanitarian assistance, but are relatively inexperienced with psychosocial and mental health interventions. This chapter therefore begins to describe the position of donor organisations, and the consequence of taking part in what we could call a 'funding market' in a relatively new field. Furthermore, the policies, or lack thereof, with respect to some special issues that appear to be of importance for the quest for sustainability, are described. They are exit strategies, evaluation and research, and cost efficiency.

Donor organisations and their ranks and files

The accountability of donors on the expenditure and otherwise efficacy of their activities in low income countries means that they may be less free in their policies as one may expect. In some cases governments are financing humanitarian assistance. They may give a budget to donor organisations to implement programmes, usually with local partners. It is a matter of course that governments have their own agenda's. Their wishes with respect to humanitarian aid are commonly also led by other interests than strictly humanitarian ones, such as national or international more general economic or foreign policies. It would perhaps go too far to state that governments dictate the policies of their donor organisations to a great extent, but some influence of official foreign policies on the attribution and allocation of humanitarian assistance cannot be denied. This influence may become clear in the choice in which countries or regions humanitarian aid is implemented and how much resources may be spent.

Another influence on the policies of donor organisations that cannot be neglected is the publics' voice. It does not matter whether the donors are semi-governmental organisations or nongovernmental. Modern media reports on humanitarian crises and their audiences are moved to donate in an effort to be of some help. However, there is selectivity in the attention of the mass media too, depending mostly on the availability of moving, hence saleable footage. The power of a public outcry was best demonstrated after the media covered tsunami that hit Asian and African coasts in 2006. It brought about a huge wave of emergency aid, mental health care and psychosocial support included, financed by governments and the public. Millions were spent on smaller and bigger projects. However, there was insufficient time for reflection on the most effective ways to adjust the 'help' in the context of culturally, politically and practically fitting interventions; let alone time for mutual collaboration

and fine-tuning. Unfortunately, the results, as observed later, appeared to be disappointing in relation to the invested money and effort.

Donor organisations are to some extent bound to react to governmental policies and the publics' (corporative or private included) wishes. Just like local or implementing organisations they are dependent on the availability of generally scarce external funding and, therefore, operate within a market. This means donors generally will feel inclined to react to the wishes of overall policies and the publics'. They will, furthermore, need to distinguish themselves from 'rival' donor organisations, by developing a 'corporate identity' and by flagging their projects. There are two important potentially adverse consequences of this market situation. First of all mutual competitiveness and striving for a distinguishable identity as opposed to other similar donor organisations, may well stand in the way of collaboration and fine-tuning which, as has been stated before, is a prerequisite for the quest for sustainable care and support. Second, usually the public is not tempted to donate for complicated operations and analyses. They expect preferably immediate results and directly, depicted effects of their donations. In order to get funding, donor organisations may feel inclined to 'show' such immediate results and activities in their annual reports.

This situation of relative dependence on media attention, (inter) national policies and the publics' demands, cannot easily be altered. It is a reality in which most donor organisations need to operate. However, clarity and awareness of the markets' mechanisms may create some resistance to and prevention of its negative consequences such a quick unsustainable interventions and reluctance to collaboration. Donor organisations may well develop a policy to educate both media and the public to some extent. They could explain the objectives of mutual collaboration and the objectives of psychosocial support and mental health care and the complicated processes involved in delivering suitable and sustainable psychosocial support and mental health care. There should be a general awareness that proper evaluations and even research are inevitable to develop sufficiently effective care and that it also pays to help build local capacity in both effects and efforts to make a difference in the long run. This awareness would withstand the tendency to donate only for immediate and direct results.

Evaluation and research

The incentive of donor organisations, in line with humanitarian assistance in general, is to alleviate the agonies of people living under duress as a consequence of violence, repression or any other kind of natural or manmade adversity. Capacity building and empowerment are crucial in this. Evaluation and research are the eminent means to assess if previously determined objectives are met. As has been described in the preceding chapter, evaluations are commonly limited to project or process evaluations that may give indications of the number of people reached, if the programme has been completed as planned, if a manual is written and distributed, how many training sessions have taken place, and so on. These evaluations are relatively inexpensive and easy to be done and they are usually built in the projects' design in the first place. However, such evaluations in general do not give sufficient insights into the nature and quality of the effects of certain interventions on target populations, whereas the efficacy of interventions, both in terms of effects and investments, is essential.

As has been stated before, experiences with psychosocial and mental health care exist only during the past few decades. By promoting evaluations that preferably demonstrate results from their efforts, donor organisations want to show their capabilities. Indisputable evidence of its effects, however, is still slim. This lack of hard proof, however, does not necessarily indicate that positive results are limited, or even nonexistent. The study of effects is scientifically complicated, as has been further elaborated elsewhere in this report, and requires many resources, both financial, human and in capability. This current lack of scientific proof, however, does not mean there is no anecdotal evidence at all. It only means that there is insufficient *scientific* evidence. However, the many existing evaluations, the educated estimations of trainers and psychosocial workers, and reports of or about beneficiaries may well give indications of both ineffectiveness or effectiveness of interventions and strategies.

Proper evaluations can indeed reveal or indicate if the ultimate goals of sustainable mental health care and psychosocial support for the primary beneficiaries are met. It can also reveal that certain policies, strategies or interventions do not deliver the required results. Especially midterm evaluations that may well point out that previously agreed approaches or goals best could be changed, allow for opportunities for alterations that in turn can be evaluated in later stages.

This means that donor or implementing organisation may best permit for such changes, if convincingly motivated by their expat or local partners. However, the current lack of scientific evidence potentially puts all organisations involved into the defensive. This defensive position in donor organisations might lead them to invest little in further development of the field, by on the one hand economise on effect evaluations and research, while on the other hand preferring interventions and policies that thus far seem to be the most popular or effective, thereby leaving little room for essential further developments. It is currently too early, the evidence is too slim and too tentative, yet, to trust on 'evidence based' interventions.

The evaluation of effects of single programmes and projects, however costly, is a prerequisite for the future development of good enough interventions. In many cases, though, insufficient effort has been made to implement such evaluations. Donor and implementing organisations could well promote and stimulate the development of indicators to get some insight into the true efficacy of their programmes and strategies. Despite the difficulties involved, it is obviously worth our while to build further on the already existing efforts in this. (Williams, et al. 2008 prepared a list of recommendations concerning the evaluation of psychosocial programmes, see also UNICEF, 2007).

Next to the evaluation of effects, research[19] is also an important tool that facilitates the further development of efficacy of programmes. There are several obstacles, though, that make appropriate research quite scarce. Some of them, the required sophistication of skills, and technical and ethical difficulties have already been considered elsewhere in this report. The 'just' allocation of scarce resources is yet another hindrance. The latter also has ethical implications. One commonly expressed objection to research is that money that should be spent on actual care and support would be allocated to costly (in effort, time and money) research. This ethical objection, however, can be avoided by using earmarked funding for research. Collaboration with institutions such as universities, whether local or not, governments, the international community could provide for special funding and other required resources.

The advantages of proper evaluation and research are abundant. It may give better insights into the conditions, social structures, historical and cultural idiosyncrasies, resilience and problems of target populations. In combination with assessments of the services of other humanitarian organisations, strategies can be developed to deliver a wider variety of support to the target groups by means of collaboration and fine-tuning. Moreover, it can specify what kind of community based interventions, training or collaboration shows the best or most promising results. Hindrances to proper effect evaluations and research could well be overcome.

Cost efficiency

The inherent scarcity of financial resources and the accountability of donor organisations towards their own donators, are an important source of careful considerations of donors on where and how to allocate their financial support. As has been said above, the rank and file of donor organisations themselves too, play a pivotal role in this. They usually demand swift action in regions that are at that particular time in the focus of the media, or follow the interests of dominant policies with respect to not only human rights, but also of diplomacy and commerce. There is, however, guidance from the World Bank and United Nations about the amount of money in dollars that can be spent per capita per year. These amounts should secure some equal distribution and affordability and are related to the availability of financial resources reserved for humanitarian assistance. This does not mean that the hands of donor organisations are completely tied, but more or less tied they are. And it does not go without consequences for general policies and the actual fieldwork. Furthermore, a lack of sufficiently allocated financial resources may well pose an immediate threat to the sustainability of current projects and programmes.

There is a generally and rightfully felt repugnance to allocated money and effort going to waste. Indeed, there are ample examples of relatively high overhead costs and money sticking to the fingers of those it was not meant for. This may be a cause of the reluctance of donor organisations to pay salaries to local personnel, especially to local management. However, the work of local managements is a *conditio sine qua non*. In the quest for ongoing efforts to develop, adapt and sustain capacity to provide care and support, the management of local organisations cannot be missed. And although donor organisations may find it difficult to convince in particular their public donors, the support, also financial of local organisations employees is imperative.

[19] An artificial distinction between effect evaluation and research has been made here while, naturally, scientific methods and tools can be applied in effect evaluations. Research, in this instance, is reserved for the study of phenomena beyond an individual programme.

There are yet two other consequences of the endeavour for cost efficiency. The first is the difficulty and reluctance to finance proper effect evaluations and research, as has been explained above. The second concerns the nature of implementations. At present, community based approaches are the most popular, because they appear to be the most efficient, successful and cost effective, and lean on appraisals of resilience in the populations in question. However, to ameliorate the suffering of individuals or groups of individuals suffering, additional measures may be required. In the last decades techniques of counselling groups and individuals have been trained. These more sophisticated trainings, and the need for continuous supervision, are costly. Combined with the debate in the field concerning the appropriateness of the notion of counselling, the lack of scientific evidence concerning its effects, and the relative high costs, donor organisations are presently less inclined to grant budgets for (the training of) counselling.

Exit strategies

It is a matter of course that individual donor organisations can only do so much. In practice, projects or programmes are financed and supported for limited periods of time, usually for a period of two or three years; in emergency settings, sometimes for much shorter periods of time. Unfortunately it is not rare that there is no time for sufficient considerations on the need for prior and proper assessments, the quality and the ultimate aims of interventions. Although it is presently generally recognised that mental health care and psychosocial support can only be sustained if there is sufficient local or other capacity, in practice, many projects or programmes do not survive their initial funding periods. And if they survive, it is commonly only with huge effort and little potential. For this reason it is necessary that donors develop proper exit strategies that go further than debriefing and withdrawing their expat personnel and other resources. Proper exit strategies include policies developed to take into account that a particular funding period may be limited, but that the efficacy of interventions may need further development and the efforts to sustain a programme should continue.

For the continuation of mental health care and psychosocial support programmes two common policies may be developed, which do not exclude each other. One of them lies in the empowerment of the local partner(s). In the previous chapter the required skills for local organisations to prepare and accomplish their various tasks, have been summarised. Donor organisations do best if they support local organisations to attain the skills and know-how to continue and develop their organisation and work in the days to come. Donor organisations may use their own networks to facilitate further fund raising and their positioning in the regional or national field. In some cases local organisations have been quite successful in the development into a powerful and independent organisation. The support, by means of timely and well prepared exit strategies of the initial donor or implementing organisation, proved to have been crucial in this.

Another way to position a local partner in the region or country is to connect with relevant pre-existing institutions. They may be medical schools, universities, vocational training schools, and so on. This policy has two advantages, the first being that it may empower and connect local partners of donor organisations in a way that may strengthen their position, the second that an awareness is created, outside the regular NGO world, of the fact that violations of human rights, are a hazard to a given populations health and wellbeing. But more important, the awareness too that negative consequences can be opposed by powerful measures that take into account both the communities and people's resilience and their weaknesses.

Unfortunately, the practice of the past decennia demonstrates that such exit strategies of donor organisations are quite rare indeed. One of the reasons may well be that their own funders demand swift actions and their focus follows the lead of where media attention is most present (See the appendix: Example 10). There is hardly time for proper evaluations and considerations. Nevertheless, other donor organisations have demonstrated that good exit strategies allow them to withdraw their resources and allocate them elsewhere, while at the same time leaving local organisations sufficiently empowered to continue and develop their work for the good of the people it concerns.

Chapter 5

Conclusions

The main objective of this study, as has been stated in the introduction of this report, is the identification of critical factors that might either contribute to or hinder the (further) development of sufficiently adequate, and especially sustainable, mental health care and psychosocial support in low and middle income countries. At the heart of this question lies the aspiration to alleviate the psychological suffering of millions of people as a consequence of often complicated and intense adversity, and empowering and capacitating them to regain more control over their wellbeing and living conditions. Yet another reason, based on current consensus, is that such empowerment and the enhancement of mental wellbeing potentially enhance the efficacy, sustainability included, of other nonpsychological terrains of current humanitarian assistance.

In the introduction of this report sustainability of mental health care and psychosocial support is described as the potential of good quality assistance to develop, adjust and last as long as the assistance is needed, and to finally evolve into an integrated part of local societies or communities. Furthermore, a distinction has been made between sustainability of *effect* and sustainability of *effort* (Jackson et al. 2005; Howe, Ghali & Riley 2005). The sustainability of effects depicts both the efficacy of care and support on the primary target populations, and its potential to reach other cohorts. Whereas the sustainability of effort signifies the importance of the endeavour to maintain and develop the effects over time. It may be a first and foremost conclusion of this chapter that both the quality of effects *and* of effort are equally crucial in the quest for sufficient and sustainable mental health care and psychosocial support. In order to attain or maximise sustainability both, in combination, need to be addressed.

This report and its conclusions are based on written materials and on discussions with a variety of respondents from the local NGOs that were visited for the purpose of this study. These conversations did not only reflect on the nature and potential sustainability of effects and effort of their own interventions and organisations an relations, but also on their experiences and considerations of the overall endeavour of humanitarian assistance; mental health care and psychosocial support in particular. These conversations were enlightening and sometimes quite intense. Respondents generally proved to be knowledgeable and skilled and ready to adapt their programmes and strategies where needed. Next to providing, and developing interventions, all of the visited organisations have taken on the quest of capacity building in their own regions or elsewhere in the world. They do that by training other NGOs, community based organisations and (governmental) institutions, by offering their services, publishing their findings, producing manuals, and by collaborating and tuning with (inter) national organisations and institutions on behalf of the target populations.

Both pillars of this report - literature and respondents - underscore the importance of capacity building as an instrument of first choice to attain sustainable mental health care and psychosocial support. As is reflected in various chapters of this report, capacity building is since decennia a consensus based standard in present humanitarian aid. Training included the training of trainers, psycho-education, awareness raising and advocacy sum up the main capacity building elements. The contents of what is being trained and educated in this field, of course, has evolved over time and is likely to continue to do so. In various parts of the first two chapters of this report the ongoing evolution and main issues of past and present controversy have been portrayed and argued. This internal evolution, and even its controversies, can in itself not be understood as obstacles to sustainability. On the contrary, they potentially stimulate the development of understanding concerning the needs and requirements of target populations on the one hand, and of good enough interventions on the other hand. Notwithstanding the above, current basic consensus as reflected in the *IASC Guidelines*, supports the prevention of potentially harmful or ineffective interventions and approaches, and enhances the expansion of best practice. Most of the respondents of this study underline the importance of such adequate and suitable guidelines, but also recognise that these guidelines too are subject of further development and adaptation.

Based on both the experiences and opinions of the respondents and the literature, some major areas can be identified that contain obstacles with respect to the potential sustainability of mental health care and psychosocial support. The first obstacle is the innate difficulty to the workings and effects concrete, including the ensuing lack of solid evidence, of such kinds of support and care. The second, may well be a failing of adequate collaboration and networking of *all* organisations or stakeholders involved. A third would be the need for realistic goals, and good quality and affordable interventions. And finally, a lack of adequate exit strategies that focus on sustainability of projects and programmes of some donor organisations can be discerned. On the other hand, the recognition and acknowledgement of such obstacles may well lead to the development of consensus on policies and strategies of sustainable mental health care and psychosocial support. The above identified obstacles are further described below.

Before going deeper into this, however, some obstacles of sustainable mental health care and psychosocial support that are shared with any other branch of humanitarian assistance need to be recognised. Disregarding the exact nature of humanitarian supports various circumstances pose an immediate challenge to sustainability, and therefore, for as far as possible, need to be taken into account in the planning, design and exit strategies of help and support. Bad governance, the absence of sufficient infrastructures and facilities; the erratic reality of scarcity of (financial) means[20] and resources, the vast amount of affected populations, the recurring hazards of natural or economic disasters, violent outbreaks, and political repression, can destroy the (re) built capacity and infrastructures in a blink.

Furthermore, political (international geopolitics[21]) and the publics' agenda's may well influence their policies and strategies. The dependence on external capital may lead, not only to mutual competition for restrained resources and for public attention, but also to the choice of where mental health care and psychosocial support are to be implemented. In many cases these will be regions that are front page news as a consequence of emergencies or crises. The result may well be too rapidly implemented and too uncoordinated interventions that in most cases last for a far too limited period of time. Efficacy, leave alone sustainability, are a far cry from there.

Internal obstacles to sustainable care and support

There are some identifiable internal obstacles that potentially impede the quest for sustainable mental health care and psychosocial support. Many of them have been quite successfully addressed in various publications, manuals and guidelines such as those of the IASC. Others still await a generally acceptable consideration. The interviews with various respondents for this study show that, indeed, there is an emerging consensus concerning the underlying principles of mental health care and psychosocial support. There is a general acknowledgement of the fact that care and support demand an interdisciplinary approach.[22] Furthermore, the potential meaning of mental health care and psychosocial support as an integral part of other interventions and policies to enhance the overall wellbeing of the beneficiaries is widely recognised. Moreover, there appears to be a firm consensus amongst the respondents of this study that addressing the mental wellbeing of the recipients should be part of *structural* developmental aid, and that shared efforts are needed to embed such care in local institutions and (health care) infrastructures.

Another example of current consensus based, best practice is that a narrow focus on posttraumatic stress disorder or other pathological reactions and their presentations is essentially criticised. Such a focus neglects the wider social context in which symptoms and their presentation are formed (Tol, 2009). This context may be shaped by any combination and severity of strained resources, lack of social cohesion and integration. However, epidemiological studies (for an overview see: De Jong, 2002) reveal that these pathological reactions are a reality in a smaller or larger part of the target population, and as such should also be addressed. Communities form the natural environment in which people can function and thrive. In addition, a well established community can provide crucial protective factors that may be of influence to the

[20] In chapter 4 of this report some paragraphs have been reserved for the important issue of cost efficiency. The planning of interventions and strategies that do not take into account the reality of scarcity of financial resources form a direct threat to sustainability. It should, however, be considered too that the fixed number of dollars that is allocated to be spent per year per head, rests on human-made priorities and decisions.

[21] The subject of psychological and social care and support in the light of humanitarian assistance in general and in particular the strenuous relation of humanitarian aid with economically motivated geopolitics, falls outside the scope of this report. However, especially the latter, may well constitute the quintessential hurdle for sustainable developmental support, mental health care and psychosocial support included.

[22] See the chapters 1 and 2.

course and severity of adverse responses to harsh conditions. As such communal life is pivotal to the mental health and overall wellbeing of its members. Therefore, psychosocial support and mental health care contain strategies to re (establish) healing and protective potentials in affected communities.

Furthermore, it is considered imperative that interventions fit local cultural idiosyncrasies, both by mainstream literature and the respondents. Suitable interventions should take into account that there exists a dynamic between social, psychological, cultural, physical, spiritual and cognitive factors. Interventions need to be adapted to such interactions and of local values, rituals and traditions. However, the awareness and flexibility should be present that cultures and their expressions are not static and leave space for individual diversions and deviations. Furthermore, a critical appraisal is required of the potentially supportive and unfavourable elements in cultural manifestations and beliefs. According to respondents, however, respect for cultural idiosyncrasies is not limitless. Harmful[23] beliefs and practices can be probed and carefully questioned. The underlying principle of many community based interventions and counselling is that the verbalisation, expression and sharing of painful memories, circumstances and emotions (exposure) is important for coping, healing and building mutual trust and support. According to many relevant respondents of this study there is no obvious indication that the expression of emotions and cognitions would not be fitting the cultures in many low and middle income regions. It can be considered as a universal human trait. But it takes effort and ample consideration to build in such universal principles in culturally suitable interventions. Insufficient consideration and adaptation of local conditions and particularities may constitute an internal obstacle.

Apart from the abovementioned general agreement amongst the involved (inter) national organisations on the underlying principles of mental health care and psychosocial support, there are other internal characteristics or qualities that may hinder the sustainability of mental health care and psychosocial support. As compared to many other branches of humanitarian or developmental assistance, the area of mental health care and psychosocial support lacks a tangible basis. Some of the relevant stakeholders question the workings or even the necessity of mental health care and psychosocial support. According to many respondents, primary beneficiaries too may well be sceptical to commit themselves to services that yield no tangible or immediate result. Psycho-education, advocacy and awareness raising, collaboration with other more concrete kinds of humanitarian services, are generally applied instruments to commit beneficiaries, local institutions, such as schools and health care facilities and relevant governments and donors.

More and more there is a demand for scientific evidence that interventions attain sufficient positive effect on the primary beneficiaries. To date, however, this 'evidence' lacks and it is highly questionable if there will be any in the near future (Patel, et al. 2007, Hobfoll, et al. 2007). There are several reasons for this shortage and future prognosis. They are somewhat more explicit in the second chapter of this report. The required high standards of research expertise, methodological problems and the, in comparison, excessive costs of researching the effects of psychosocial interventions are but two of them. However, this by no means signifies that there would be no alternative and reliable indications that psychosocial support and mental health care could be effective. The current emphasis on the development of indicators could be considered as a first step in this.

Nevertheless, closer scrutiny of evaluation reports, studies and the literature support the positive workings of psychosocial interventions. Despite the generally acknowledged absence of scientific evidence, there appears to be sufficient anecdotal or empirical evidence. However, Hobfoll and colleagues (2007) recognise that although there is currently no sufficient evidence, scientific or otherwise, to recommend specific intervention models, it is certainly feasible to formulate general foci and criteria that guide and underlie good enough psychosocial interventions and strategies. The complexity and diversity of a great many factors that may to a large extent determine the condition and (scarcity of) opportunities of primary beneficiaries, make it necessary that adaptation and flexibility will always be required. The development of standard and detailed intervention models is therefore quite unlikely. The authors, however, conclude that based on 'informed evidence' some five intervention principles can be discerned that should be guiding the outline of individual intervention models. They are the promotion and stimulation of: a sense of safety, calming, a sense of self- and community efficacy, connectedness and hope.

Just as is the case with content and methods of training, the efficacy of interventions will grow with the help of proper evaluations or research, and with the

[23] As opposed to human rights

further development, adaptation and improvement of manuals and guidelines. In as such, these manuals and guidelines are important factors in the quest for sustainable care and support. Furthermore, it can be concluded that treatments and interventions that aim at the strengthening of local help seeking behaviour and coping strategies are likely more sustainable, e.g. they are to be expected to continue after the initial funding periods (Tol, 2009).

In summary, the following potential internal obstacles of sustainable mental health care and psychosocial support can be discerned:

- Lack of sufficient regard for cultural particularities;
- Lack of adequate evaluation and research opportunities concerning the needs of the target populations and the efficacy of interventions;
- A one-dimensional instead of a multi-disciplinary approach of care and support that takes into account the multi-facetted and complexity of problems, behavioural maladaptations and pathology of the target populations;
- Insufficient acknowledgement of the developmental character of mental health care and psychosocial support;
- Interventions that are not suitable for the needs of target populations, and
- Lack of acknowledgement for a possible need for flexibility and adaptation of current mainstream standards.

In conclusion, the provision of opportunities for an ongoing development or adaptation of instruments or indicators to evaluate the efficacy and suitability of specific interventions would allow the field to grow even further.

Collaboration, fine-tuning and networking

The importance of inter-sectoral collaboration, on behalf of target populations, has been underscored by the IASC Guidelines. The underlying idea that psychosocial support and mental health care can be more beneficial and effective when other aspects that threaten the wellbeing and resources of target populations are also addressed and vice versa, is a common and shared notion in the literature and of the various respondents of this study. Next to inter-sectoral collaboration, the need for collaboration between organisations that provide mental health care and psychosocial support in particular regions is also recognised. This is especially the case in emergency settings, where various, mostly foreign initiatives try to play their part without proper assessment of the conditions and needs of the target populations and their surroundings. Fine-tuning and collaboration are generally considered imperative. In some cases, especially in emergency settings, larger supra- or international humanitarian organisations take the efforts to unite scattered initiatives. However, despite the sometimes regular stakeholder meetings, successful collaboration rarely seems to take place. Reasons for this may be, according to the respondents, mutual competition, criticism or disagreements and inexperience. Furthermore, smaller initiatives or organisations may feel overwhelmed and ignored by their more powerful counterparts. These issues are hard to conquer. They can only be overcome when and if timely policies and strategies are present and agreed upon, before everybody has taken in their positions at the sites.

However, collaboration and fine-tuning also imply the working together of donor organisation and implementing organisations on behalf of the primary beneficiaries. By financing projects or by withholding funding, and through the appraisal and evaluation of proposals, donor organisations and implementing organisations work together very closely. However, despite emerging examples of the better, some respondents of this study felt the relationship with some of their donors as strenuous. They find the priorities of donor organisations and their preference of particular kinds of interventions sometimes as too one-sided decisions, to which they feel obliged to comply. The possibly divergent objectives of donors on the one hand and their partners on the other hand, may lead to mutual tension. At its worst it may lead to donor driven interventions instead of need driven interventions.

There are some specific items, according to some respondents, that interfere most commonly with the effort their local organisations can offer to sustain and adapt mental health care and psychosocial support. They concern the processes of fundraising and the length or lack thereof of funding periods. Fundraising is, and in the foreseeable future will remain a necessity. It is unlikely that local organisations will get sufficient resources from their own governments or from their own income generating activities, if such are the case. NGOs, also international NGOs will have to negotiate the nature and period of projects. Furthermore, in many cases, especially smaller donors will only invest in a specific part of a programme.

Finding willing donors and responding to their stipulations, is generally time consuming. On the other hand, though, donors' suggestions concerning the design and contents, monitoring and evaluations can improve the quality and coverage of programmes.

According to some of the respondents, their continuous search for donors makes working within their local organisations especially precarious and restraining. Trained and experienced staff, the management included, is often uncertain if they will find the means to continue their work and get their salaries. Respondents describe special and inventive measures to keep on staff in between funding periods. A number of donor organisations, according to some of the respondents, are only able or willing to fund overhead related to a specific project or programme. This is a source for insecurity about future possibilities of the organisation, the position of personnel involved and the care and support for their beneficiaries. As such it causes an unreasonable strain on management and personnel. 'There is no proper business or corporation in the west that can afford to ignore their human resources and organisational functionality. Yet, it occurs that such support for local organisations in low and middle income countries is neglected.'[24] With respect to the sustainability of their efforts, respondents plead for institutional funding, next to the core funding of particular projects.

In order to attain some financial buffer, the majority of the included NGOs of this study, try to generate some income of their own. Their main objective often is to secure and sustain the overhead of their organisation (institutional funding). Income is derived from either counselling, but more often, from training of third parties. This development, logically, is commonly acclaimed. However, it puts local organisations in a judicial twist. In order to receive funding for their projects, they officially need to be nonprofit organisations. Otherwise they will not be officially exempt of taxes. A possible solution for this problem would be to split up into one commercial, and one nonprofit organisation. Such a split, however, is not considered favourable for young organisations. Furthermore, in badly governed countries, paying taxes can be financially exhausting and politically complicated.

Many of the respondents that have been interviewed for this study feel the lack of true collaboration or partnership, as it sometimes occurs, as an impediment for sustainable care and support. In general, the respondents found that some donor organisations may:

- Offer too little or no time to perform the required adequate assessments;
- Insist on specific interventions without sufficient or convincing arguments;
- Put pressure on applying organisations to meet the terms or priorities of donor organisations, which are not always in accordance with their own estimation and evaluation of what is really needed;
- Impose artificial deadlines that seem to be set for the sake of fixed funding-periods or money allocations, and less for the good of the target populations or the efficacy, sustainability included, of good quality care and support;
- Fix too short funding periods with respect to the agreed upon objectives and the needs of the target population;
- Make it impossibility or extremely difficult for local organisations, as opposed to international NGOs to get funding from larger donor organisations, and
- Sometimes risks a deterioration in the relationship at the end of funding periods in the case proper and clear exit strategies lack.[25]

There is, however, another tension in the relationship between donor organisations in general and NGOs. As a consequence of the underlying structure of humanitarian assistance, implementing organisations - whether local, national or international – need to apply and argue for funding. Of course, in itself the applications and argumentations are by no means a negative influence. But because in most instances the relation with donors is limited in time, new funding will have to be found. According to the respondents of this study far too much of their time and energy has to be spent on the application formats of donor organisations (See the appendix: Example 11). During various interviews respondents expressed the sometime unnecessary bureaucratic demands and the ongoing necessity of proposal writing as a huge burden on their capacity and energy, and experience it as an obstacle to the quality and sustainability of their work.

By supporting some projects and withholding funding of others, donor organisations can also determine to a

[24] Quote from: Abhijit Dasgupta: Senior manager ICMC, Jakarta.

[25] Two of the respondents described the partings of their organisations with a donor at the end of a funding period very evocatively as cold turkey instead of a preferred weaning process, or as a bad divorce versus a decent divorce.

large extent what kind of interventions are to be preferred and implemented. In many cases, the number of potential beneficiaries, their appeal to the public, and cost efficiency of interventions appear to be decisive. However, the decisions of how, what, where and who to support or care for, should be a well informed and negotiated decision between *all* the partners concerned, and not exclusively of donor organisations and their rank and file.

It was generally felt by the respondents of this study that, with respect to sustainability, donor organisations may constitute a fragile pillar. Indeed, their significance for sustainable mental health care and psychosocial support can hardly be exaggerated. Donor organisations, naturally, have their own preferences and priorities, based on their experiences, policies and strategies, networks and position in the field. By granting or withholding resources, they are in the position to determine to a great extent the nature and coverage of interventions. However, this intrinsic power need not necessarily influence the quest for care and support in a negative way. By making informed and balanced decisions, donor organisations can in principle be 'solid' pillars. Some of the current donor organisations already proved that.

There is yet another kind of collaboration that is pivotal to the sustainability of mental health care and psychosocial support. Larger or stronger (inter) national or local NGOs often seek collaboration and tuning with regional or national relevant institutions, such as health care facilities, social institutions, community leaders and care providers, orphanages, schools, universities, and so on. It serves the objectives of local institution building, and of embedding the care and support of target populations in existing infrastructures, including governments or governmental organisations. This embedding into local infrastructures is, by the vast majority of the respondents, considered as crucial for the potential sustainability of mental health care and psychosocial support in the long run. Most of the visited local NGOs for this study include an active policy on this and attempt to reach their goals by a combination of psycho-education, advocacy and awareness raising and by offering psychosocial services to the target populations of relevant institutions. Furthermore, this collaboration is of importance for opportunities for mutual referral of clients or patients.

An identified obstacle to an overall and serious collaboration and fine-tuning in this particular field is the almost inevitable competition for scarce financial resources. In chapters three and four of this report it has been argued that competition and rivalry is not only typical for implementing organisations but also for many donor organisations. The need to be distinctive and flag activities in order to attain a maximum of credit, in both meanings of the word, may well tamper with the willingness of close cooperation to a smaller or larger extent. Its influence on the cause depends on the maturity, commitment and central focus of each particular organisation.

A final topic of this section is networking. The importance of networking between similar or relevant organisations is widely acknowledged by the respondents of this study. Its advantages are identified as an opportunity to grow professionally by exchanging know-how and experiences. It further allows for joint, and thereby more cost efficient trainings, joint effect evaluations or research, stronger advocacy on behalf of target populations, exchange of documentations and skills, for instance on training or research, and other kinds of mutual assistance. It further facilitates learning possibilities for psychosocial workers and offers opportunities of experience with other kinds of interventions, policies, strategies, and primary beneficiaries. Sharing the networks and relations of other organisations, furthermore, may be valuable. Moreover, when it concerns international networks, it offers prospects to practice the English language and get acquainted with the special and constantly changing vocabulary of this field. And finally, networking may well help to prevent isolation of local organisations from the international mainstream. Because of the many advantages of networking the facilitation of such networks by donors is recommended.

Setting realistic goals

A clear-cut threat to sustainability of mental health care and psychosocial projects or programmes, recognised by the respondents, is unrealistic assessments and aspirations. This does not only concern local organisations - whether NGOs or community based organisations - but also larger international NGOs and donor organisations. Unpretentious goals are essential in a field where the problems are so vast, complicated and entwined, and where 'answers' to these problems are still developing and tentative. Most of the respondents underline the importance of clarity and simplicity of goals, especially at the beginning of 'new' projects or programmes. Furthermore, the costs as opposed to the returns need to be taken into

account. Sometimes pilot phases are recommended in combination with proper evaluations. Respondents are of the opinion that a broader understanding could evolve concerning learning processes involved, and for the fact that a true understanding of what is really going-on in people, communities, regions or countries, can only progress slowly and carefully.

Exit strategies

Adequate exit strategies are widely recognised as imperative for the maximising of sustainable mental health care and psychosocial support. According to the respondents, however, current exit strategies are too often limited to the funding period or project, and to the winding-up of the donors financial and personnel involvement with the project. The respondents, supported by the literature, identified several characteristics that exit strategies should imply, in order to maximise opportunities for sustainable mental healthcare and psychosocial support. They will be further described below.

The experiences of some of the NGOs show that it can be concluded that proper exit strategies of donors are best developed at the very beginning of, or even before, any shorter or longer funding period. Preferably, they are planned thoroughly and in deliberation with the local partner(s). Of course, the details of such exit strategies depend largely on specific local characteristics and circumstances. However, some overall recommendations can be formulated. Exit strategies should be concentrated on the processes of sustainable care and support. It is common knowledge that the necessity of mental health care and psychosocial support is by no means restricted to funding periods; it takes time and effort to build capacity and develop effective interventions. A negligence of the involved processes hinders the quest for sustainable care and support. Both in the literature and in the interviews it was often found that the foci of donors are in too many cases project driven instead of process driven.

In chapter four, three areas have been mentioned that appear crucial for proper, process focussed, exit strategies. The first is the recommendation to empower local partner organisations by offering them organisational advice and training on a structural basis, if and where needed. The second is the support of local organisations with the acquirement of additional funding. A last mentioned recommendation would be helping local partners to connect to relevant local organisations or institutions and facilitate them to take part in relevant, also international, networks. These three recommendations can be followed through by utilising and collaborating with other relevant donor organisations.

In this chapter, one final question would still remain, and that is whether mental health care and psychosocial support holds specific characteristics with respect to sustainability, as opposed to other branches of developmental or humanitarian aid. Although this was not an enquiry of this study, it can be approximated that, in general, nothing in this study could pinpoint anything that would be clearly distinctive for this relatively new brand of humanitarian or developmental assistance. Issues such as the multi-facetted problems; the variety of cultural, political and societal strains on resources, but also capacity building, cost efficiency, the opportunities of inter-agency collaboration, institution building, awareness raising and so on, are at the core of any humanitarian venture. Particularities, of course, can be found in the technicalities of this field, but to varying degrees the same goes for agricultural, commercial, livelihood, or any other kind of assistance. Without any doubt, though, the many obstacles to grasp or substantiate the efficacy and validity of current mental health care and psychosocial support as elaborated in this study, pose considerable complexity.

Afterthought

The current consensus on overall procedures, goals and strategies of mental health care and psychosocial support as is reflected in the *IASC Guidelines* of 2007, was the initiative of various larger donor organisations. They clearly recognised and acknowledged the importance of consensus based strategies and collaboration; of an inter-sectoral approach, and of a clear guidance for local and international implementing organisations. In a field were the efficacy of interventions still lacks solid evidence, clarity on current best practice is helpful. Yet another advantage is that it may ease the acceptability of current mental health and psychosocial approaches for governments and other institutions. Furthermore, it provides donor organisations with the tools to appraise and support the potential quality and appropriateness of funding applications. And finally, the fact that possibly required deviations of this consensus will need to be argued, supports the further development of this field.

To help the field to improve its sustainability further,

it may well be recommended that donor organisations attempt to achieve a comparable consensus themselves. Such a consensus would potentially prevent donor driven in favour of need driven interventions, as they now take place especially in emergency settings; it would facilitate collaboration and tuning between donors on behalf of the primary beneficiaries, and support the development and utilisation of exit strategies that take into account the potential sustainability of specific projects, programmes and local organisations. Moreover, it could stimulate a more thorough focus on the (longer term) processes, as opposed to the (short term) funding periods.
The results of this study and this plea could hope to be a starting point for such consensus building and collaboration amongst donors.

References

Aarts, P.G.H. & W. Op den Velde (1996). Prior Traumatisation in the process of aging: Theory and clinical implications. In: B.A. van der Kolk, A.C. McFarlane & L. Weisaeth (Eds.). *Traumatic stress. The effects over overwhelming experience on mind, body and society*. New York: Guilford Press.

Aarts, P.G.H. (2000). *Guidelines for programmes. Psychosocial and mental health care. Assistance in (post) disaster and conflict areas*. Utrecht: International Centre Netherlands Institute for Care and Welfare.

Ager, A. (2006). *Towards a consensus protocol for psychosocial response in complex emergencies*. In: Reyes, G. & G.A. Jacobs (Eds.) *Handbook of international disaster psychology. Fundamentals and overview*. Westport: Praeger Publishers.

Allden, K., Jones, L., Weissbecker, I., Wessells, M., Bolton, P., Betancourt, T.S., Hijazi, Z., Galappatti, A., Yamout, R., Patel, P., Sumathipala, A. (2009). Mental Health and Psychosocial Support in Crisis and Conflict: Report of the Mental Health Working Group. Pre-hospital and disaster medicine: 217-227.

Altman, D.G. & J.M. Bland (1995). Absence of evidence is not evidence of absence. *British Medical Journal*: 311: 485-492.

Baidoun, M. (2007). Training Manual. *Training school counsellors and teachers on supporting traumatized children*. Bethlehem: Hope Flowers School.

Baron, N. (2006). The 'TOT': A global approach for the training of trainers for psychosocial and mental health interventions in countries affected by war, violence and natural disasters. *Intervention. International Journal of mental health, psychosocial work and counselling in areas of armed conflict*. 4:2: 108-125.

Beech, D.R. (2006). Peace-building, culturally responsive means, and ethical practices in humanitarian psychosocial interventions. In: G. Reyes & G.A. Jacobs (Eds.). *Handbook of international Disaster psychology. Volume 1*. Westport, Connecticut, London: Praeger.

Bolton, P. (2001) Cross-cultural validity and reliability testing of a standard psychiatric assessment instrument without a gold-standard. *Journal of Nervous and Mental Diseases*, 189(4), 238-242.

Bolton, P. & Tang, A.M. (2002). An alternative approach to cross-cultural function assessment. *Social Psychiatry and Psychiatric Epidemiology*, 37, 537-542.

Bolton, P., Tol, W.A. & Bass,J. (2009). Combining Qualitative and quantitative research methods to support psychosocial and mental health programmes in complex emergencies. *Intervention*. 7,3: 181-186.

Foa, E.A. , T.M. Keane & M.J. Friedman (Eds.) *Practice guidelines from the International Journal of Traumatic Stress Studies*, New York: Guilford Press.

Hawe, P., Ghali, L. & Reley, T. (2005). Developing sustainable programmes: Theory and practice. In: World Health Organisation (2005). *Promoting mental Health. Concepts, emerging evidence, practice*. Geneva: World Health Organisation.

Hobfoll, S.E., Watson, P., Bell, C.C., Bryant, R.A., Brymer, M.J., Friedman, M.J., Friedman, M., Gersons, B.P.R., Jong, J.T.V.M. de, Layne, C.M., Maguen, S., Neria, Y., Norwood, A.E., Pynoos, R.S., Reissman, D., Ruzek, J.I., Shalev, A.Y., Solomon, Z., Steinberg, A.M. & Ursano, R.J. (2007) Five essential elements of immediate and mid–term mass trauma intervention: Empirical evidence. *Psychiatry*, 70(4); 283- 315.

Inter-Agency Standing Committee (2007).
IASC Guidelines on mental health and psychosocial support in emergency settings. IASC.

Jackson, N. et al. (2004). The challenges of systematically reviewing public health interventions.
Journal of Public Health Medicine, 26: 303-307

Jensen, P.S., Weersing, R., Hoagwood, K.E. & Goldman, E. (2005).
What is the evidence for evidence-based treatment. A hard look at our soft underbelly.
Mental Health Services Research, 7(1), 53-74.

Jong, J.T.V.M. de (Ed.) (2002). *Trauma, war, and violence*. *Public mental health in socio-cultural context*.
New York: Plenum.

Jordans, M.J.D., Tol, W.A., Bhogendra Sharma, Van Ommeren, M. (2003). Training psychosocial counselling in Nepal: content review of a specialised training programme. *Intervention*, 1,2,: 19-35.

Lahtinen, E., Lehtinen, v., Riikonen, E. & J. Atonen (Eds.) (1999). *Framework for promoting mental health in Europe*.
Hamina, (Stakes) National Research and Development Centre for Welfare and Health, Ministry of Social Affairs and Health, Finland.

Laughry, M. & Kostelny, K. (2002). Mapping psychosocial interventions in East Timor.
www.forcedmigration.org/psychosocial. Retrieved April 2008.

Mikuš-Kos, A. (2005). Training teachers in areas of armed conflict: a manual. *Intervention Supplement*, 3:2.

Murray, C., Lopez, A.D. (1996). The global burden of disease. Geneva: World Health Organisation.

Oxfam (2004). Recruitment in humanitarian work.
Retrieved from: http://www.oxfam.org.uk/what_we_do/issues/gender/links/0404humanitarian.htm.

Patel, V., Araya, R., Chatterjee, S. Chisholm, D., Cohen, A. et al. (2007). Treatment and prevention of mental disorders in low-income and middle-income countries. *Lancet* 370; 991-1005.

People in Aid (2003). Code of good practice in the management and support of aid personnel.
http://www.peopleinaid. org/pool/files/code/code-en.pdf

Petevi, M., Revel, J.P. & Jacobs, G.A. (2001). *Tool for rapid assessment of mental health needs in refugees, displaced and other populations affected by conflict and post conflict situations. A community oriented assessment*.
Geneva, Switzerland: World Health Organisation.

Put, W.A.C.M. van de & G. van der Veer (2005). Counselling in Cambodia: cultural competence and contextual costs. *Intervention. International journal of mental health, psychosocial work and counselling in areas of armed conflict*. 3:2: 87-96.

Reyes, G. & G.A. Jacobs (Eds.) (2006)
Handbook of international disaster psychology. Fundamentals and overview. Westport: Praeger Publishers.

Sliep, Y. & A. Meyer-Weitz (2003). Strengthening social fabric through narrative theatre. *Intervention. International journal of mental health, psychosocial work and counselling in areas of armed conflict*. 1:3: 45-56

Special Issue (2008). Evaluation of community based psychosocial programmes. *Intervention. International journal of mental health, psychosocial work and counselling in areas of armed conflict;* 6-1.

Straus S.E. & F.A. McAlister (2000). Evidence-based medicine: a commentary on common criticism. *Canadian Medical Association Journal:* 163, 837-841.

Tol, W.A. & Jordans, M. (2008) Evidence based psychosocial practice in political violence affected settings. *Intervention*, 6(1), 66-69.

Tol, W.A. (2009). *Healing in the aftermath of war. Conceptualization and evaluation of mental health and psychosocial support for populations exposed to political violence in low-income settings*. Dissertation, Vrije Universiteit, Amsterdam.

UNICEF (2007). A guide to the evaluations of psychosocial programming in emergencies.

Veer, G. van der (2003). *Training counsellors in areas of armed conflict within a community approach*. Utrecht: Pharos Foundation for Refugee Health Care.

Veer, G. van der (2006).Training trainers for counsellors and psychosocial workers in areas of armed conflict: some basic principles. *Intervention. International Journal of mental health, psychosocial work and counselling in areas of armed conflict*. 4:2: 97-107.

Wessels, M. (1999). Culture, power and community:
International approaches to psychosocial assistance and healing. In: K. Nadar,

N. Dubrow & B. Stamm (Eds). Honoring differences: *Cultural issues in the treatment of trauma and loss*. New York: Taylor & Francis.

Wessels M. & M. van Ommeren (2008). The guidelines discussion.
Developing the IASC Guidelines on MHPSS. *Intervention. International Journal of mental health, psychosocial work and counselling in areas of armed conflict*. 6:3/4: 199-218.

Wickramage, K. (2006). Sri Lanka's post-Tsunami psychosocial playground: lessons for future psychosocial programming and interventions following disasters. *Intervention. International Journal of mental health, psychosocial work and counselling in areas of armed conflict*. 4:2: 163-168.

Williams, R., Mikos-Kos, A., Adjukovic, D. & Feldman, M. (2008).
Recommendations on evaluating community based psychosocial programmes. *Intervention*, 6(1), 12-21.

World Health Organisation (2001). Strengthening mental Health promotion.
Geneva, World Health Organisation (Fact Sheet: 220).

World Health Organisation (2005). *Promoting mental Health. Concepts, emerging evidence, practice*.
Geneva: World Health Organisation.

Appendix: Examples

1. Psychosocial interventions and the importance of offering additional resources

In a poor region in Africa, a local psychosocial NGO, trained and sustained by a western host organisation, works with communities that had recently been shattered by violent outbursts. The NGO endeavours to reunite lost families or at least tries to find information concerning their fate. Furthermore, concentrating on self-efficacy, positive coping strategies, adequate mourning by means of community rituals, psycho-education and so on, and the local NGO tries to restore hope and resilience in the targeted communities.
However, the communities concerned also suffered from the destruction of their agricultural possessions, there were no schools for children and there was insufficient material to restore their houses. In short, there was hunger and a shortage of resources to improve their living conditions. The local NGO, assisted by their host organisation, was the only organisation active in the region.
Mid term evaluation of their psychosocial interventions revealed a lack of improvement in the beneficiaries. On the contrary, the interventions appeared to have backfired, and worsened conditions of apathy, helplessness, despair, alcohol intake, etc. Closer scrutiny revealed that the psychosocial programme focused on self-efficacy, coping and resilience fed them with the detrimental assumption that they themselves were the source of their ongoing misfortune and not the circumstances. The lesson learned was that communities also need the resources to act on their newly learned psychosocial skills and convictions.

2. Unexpected spin-off

A school in the West Bank, as part of a regional project to provide psychosocial support for children, tried to involve the parents of their pupils for awareness raising and psycho-education on behalf of their children. When invited, hardly any of the parents showed up. A new invitation for parents followed. Somewhat conniving, parents were invited to take part in a cooking workshop. The attendance was much better. Having thus conquered the fear and apprehension of the parents, the teachers and school counsellors could later start with their programme. The parents are currently very committed to the school. The communication and collaboration between teachers and school counsellors on the one, and parents (mostly mothers) on the other hand improved significantly. This, of course, was the goal of the initiative anyway. Unexpected spin-off was that some of the parents jointly began to initiate collective activities, such as income-generating endeavours and past time actions, together as parents or with their children. They were offered an empty space in the school as workshop and a place to sell their goods. Community members and other parents now also visit the school, and in general feel more connected to and involved in the education and wellbeing of their children.

3. Individual differences between one and the same cultures

Two demobilised child soldiers in a central African republic take part in a psychosocial programme that encompasses a wide variety of services. Let's call them Jean and Louis. They are currently both in their early twenties. They originally stem from neighbouring villages. Louis is an expressive young man, who is truly bothered by the memories of his past experiences, drug addiction and conduct. He talks about it with the psychosocial workers and also expresses his desire to be part of a community again, and to contribute to his community. At present he feels too 'soiled' to dare to relate to people he meets outside of the programme.
Jean, on the other hand, has an entirely different personality. He is much more reserved and aloof. While overhearing Louis talking about his wish to be a part of community again, a simple, hardly detectable nod was his only reaction.
Louis is offered group counselling in which he can weigh and share his experiences and feelings, both as a victim and as a perpetrator of gross violent acts. Furthermore, he is offered an apprenticeship as a carpenter. Jean, on the other hand, doesn't want to talk or think about his experiences and emotions at all. He declined all offers to join group sessions. With the help of a small loan he has opened a garage for motorbikes, and seems happy with it. When, however, he heard that some of the young men would go to a healer for cleansing rituals to make them acceptable for the community again, he chose to join them.

4. Volunteering as a means to restore social coherence

Almost directly after the war, in a former Yugoslavian republic, a psychosocial project based on volunteer work was initiated. In the small town the civil war, where former neighbours were now perceived as current enemies, the earlier social coherence was disrupted. Furthermore, economic adversity and lack of health care facilities, threatened the wellbeing of the residents. Especially vulnerable groups were the elderly, who lived in poverty and isolation disabled persons and children.
From the beginning to its present days, the programme aims at a restoration of a sense of community coherence and responsibility, the mutual protection and care of vulnerable groups, reconciliation, human rights advocacy, self-efficacy, and so on. Its vehicle is the recruitment, training and commitment of volunteers within the community. The organisation has closely linked with international volunteer organisations.
And although the bulk of the funding and training still has to come from abroad, the organisation is successful in acquiring financial or material support form local business as well. The organisation recently built a large community house, that will shelter their offices, consultation, meeting and training rooms, a day-care centre, but has also space for parties, play and sports. This community house, situated in the centre of town, is build with the help of volunteer labourers and youth from various schools, and partly with materials donated by local industries and business.

5. Supervision

Ravi has been trained and supervised for several years as a counsellor. His motivation was to help people cope with their problems. Some years previous to his training he lost a son as a consequence of enemy attacks. His youngest son, the only child still living at home, doesn't live up to his standards: he drinks more than is good for him and he does not seem to take any initiative to improve his life.
Ravi works as a counsellor in one of the field offices of his organisation with people who are referred to him by psychosocial workers who work in the communities. Lately Ravi feels troubled. He suffers from headaches and does not sleep well. He has lost his interest in his work, and even admits to feel aversion for his clients. Of course, this affects his work to a large extent.
During his supervision, Ravi expresses his difficulty with his clients. He especially loathes his male clients who start crying or show other signs of weakness, as he calls it. He knows that the expression of emotions is potentially helpful, but he can not control his repugnance. While talking with his supervisor he reveals that the recently escalated concerns about the conduct of his youngest son, has aroused an intense grief over the loss of his murdered son. He is afraid this sorrow will overwhelm him. Furthermore, he does not want to lose face by displaying emotions, despite him knowing better.
In this session with his supervisor, Ravi can share and express his anguish. They discuss how his grief and aversion concerning the expression of emotions affect his work. He now feels better and is motivated once more to help others by offering his listening ear, his empathy and comfort.

6. Helping teachers help students

In a small town in a middle income region, a programme has started to help school children cope with the consequences of a terrorist attack that in its gruesome conclusion killed almost 300 people. All the schools in the region were familiar with professional school counsellors or psychologists. However, these were not educated with more modern ideas concerning child-friendly didactics, child development or the prevention or care for children with psychological problems.
Traditionally, the schools were focussed on directive leaning methods, discipline and physical punishment. An international NGO, familiar with the specific traditions and convictions in the region took it on them to train teachers and the school counsellors or psychologists. The latter were trained (with know-how and skills in child development, age appropriate problem solving or coping in children and adolescents, and the such). Teachers were trained to become more child-centred, to understand and recognise behavioural peculiarities and to screen children with serious posttraumatic or other problems. Also the didactics of the learning material were gradually adapted to more interactive methods. Both the majority of the teachers and the school psychologists were very inspired and motivated by the programme. They became more aware of psychosocial problems in their students and, gradually, in the schools a climate developed where children felt respected, taken seriously and safe. Only

in this more open and child-friendly atmosphere the original target group of traumatised children could be reached and supported.

7. Learning by experience

According to current best practice, a local NGO in Africa, trained and educated key persons from within the community. This community consisted of refugees from a neighbouring country that tried to cope in the area for several years. As is it generally accepted as proper proceedings, these key persons were trained in a special venue. There they could somewhat unwind from their daily stresses, and take part, as a group, in the training processes.
The NGO, however, experienced that the trainees started to identify with the local NGOs staff and thereby distanced themselves from the community. They soon discovered that this adverse development could be avoided by training them within the community, and not separate them from their fellows.

8. Institution building

During the Balkan wars, many local initiatives emerged to help the many victims of war, violated and raped women, refugees, internally displaced persons and otherwise bereaved people by the collapse of former infrastructures. Supported by mainly western professionals, psychosocial support and mental health care were addressed. Some of these local initiatives came from health care workers and university teachers or professors. Psycho-traumatology and the principles of psychosocial support, however, were not part of the regular university curricula.
Supported by western expertise and financial support, a few of these initiatives remained active till to date. By now, psychosocial support is offered in some specialised clinics. The professionals involved work at various universities and hospitals in the region. They have become apt trainers of other local psychosocial workers and health care providers, not only in their own country, but also internationally. A network of professionals is still growing and they regularly meet in national or international seminars.
The process of embedding these mental health and psychosocial insights in regular health care facilities and training schools, however, is a quite slow one. Negligence and denial in governments and other authorities is still prevalent. And the initiatives, to a large extent, are still dependent on foreign support.

9. Balanced international support

A local psychosocial organisation in the far east has since quite some years gained independence, after having been supported, guided and trained by an international implementing organisation. The quality of their programmes to support local communities is of a high standard. They have been quite successful in raising funding for their programmes. Their organisation is well structured and solid. The employees are committed and skilled. Recently, with the aid of an international donor, they built a clinic for mental health care and psychosocial support in the capital.
Unfortunately, at about the same time, due to lack of funding, the organisation had to close their field offices that offered psychosocial support to the affected rural population. They fear that the networks in the province and the mutual referral system that had been built with care would soon fall to pieces.
Gradually, since becoming loose from the implementing organisation, they became more and more isolated from their colleagues abroad. They had missed out on speechmaking publications in the field, and also lack the capabilities to do research and thus get into contact and dialogue with foreign partners and colleagues.
They very much regret the closing down of the field offices, and the end of the opportunity to help and support rural communities in need. There is joy, however, about the opening of their in and outpatient clinic, but they are aware that their future prospects and work field have changed.

10. Unintentional adverse effects of post disaster relief

Some years before the tsunami struck the coast of Aceh on Boxing Day 2006, an international host organisation supported some local grassroots organisations in the region. After inter-religious violence and severe oppression by the government of their opposition, support, including psychosocial support, was offered to survivors.
In the aftermath of the tsunami, however, another wave followed suit; this time of a multitude of smaller and larger western relief projects. Despite all efforts of the UN to coordinate and equally distribute the support, the situation remained chaotic. The international host organisation soon lost their carefully built networks and infrastructures. The clients of the local organisations now wanted money or other material support, just as the tsunami victims did, and lost their interest in counselling or psychosocial community support activities.
At the end of the international relief projects the community was left with a formally bereaved population, now living in new houses, fishing with new boats, new schools, community centres and so on. The communities that were lucky enough to live on higher grounds or unlucky enough to life outside the range of support organisations were left empty handed. This resulted in tensions and friction between those that received support and those who did not.
Almost four years later, the international host organisation still noticed the ill effects of this overwhelming post disaster support.

11. Donor bureaucracy

A local psychosocial organisation in the far east does its utmost to deliver community based services and care for groups of individuals nation wide. They confer and collaborate intensely with other local and international organisations to enhance the impact of all the combined services and enhance their coverage.
Much of the energy and time of the management is however spent on fundraising. In many instances donor organisations grant money for singular one-time projects that may last for several month only. Since the local organisation is convinced that the support and services they supply should be more structural to maintain the positive effects of their interventions, they regret the short funding periods, that make it necessary for them to continue fundraising activities and fill out, time and again, the various application formats and evaluation reports.
Recently, one donor organisation wished for an official tax clearance. It was not enough that the local organisation was officially registered as a nonprofit NGO, and was therefore exempt for tax payments. In itself, they perfectly understand the wish of donor organisations that investments will not flow into the coffers of the state. However, it took the organisation enormous effort and far too much time to oblige the donor organisation. This was especially annoying to them since it was an unnecessary exercise in the first place.

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