



SOCIAL DEVELOPMENT NOTES

CONFLICT PREVENTION & RECONSTRUCTION

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MENTAL HEALTH AND CONFLICT

This note discusses the relevance and design of mental health care interventions in post-conflict situations. Mental health disorders and psychosocial problems arising from conflict need to be addressed as part of post-conflict reconstruction and reconciliation efforts. The note presents a conceptual framework for mental health interventions in post-conflict settings and illustrations from West Bank-Gaza, Bosnia, Burundi and Uganda.

Introduction

Addressing mental health is gradually being recognized as an important development issue, especially in the case of conflict-affected countries. Although mental health issues have received increased attention in post-conflict settings, there has been a tendency to implicitly assume that the impact of trauma caused by mass violence (i) may be transitory and non-disabling, and (ii) that interventions in the emergency phase are sufficient. However, a small but growing body of research on factors affecting mental health and effective treatment in post-conflict settings casts doubts on both assumptions.

Current research suggests that major depression and Post-Traumatic Stress Disorder (PTSD) are prevalent and chronic among refugee and displaced populations. Research also shows that the impact of trauma is long-term. Child survivors of Nazi holocaust and Japanese concentration camps were found to experience PTSD symptoms as late as 40-50 years following their traumatic experience. Some researchers postulate that these 'invisible wounds' can leave a society vulnerable to a recurrence of violence. Studies on Nazi Holocaust and Cambodian Pol Pot survivors show that their children and their children's children are also affected by the psychosocial impact of conflict.

This note argues that failure to address mental health and psychosocial disorders in populations that have experienced mass violence and trauma caused by conflict will impede efforts to enhance social capital, promote human development and reduce poverty. It argues that interventions dealing with mental health are both desirable and feasible, in order to support post-conflict recovery, the consolidation of peace and reconciliation, and the transition to sustainable development and poverty reduction. Support for mental health in conflict-affected societies can thus make an important contribution to meeting the Millenium Development Goals.

Definitions

Mental health is more than the absence of disease or disorder. It is defined as a state of complete mental well-being including social, spiritual, cognitive and emotional aspects. *Mental illness* is a disorder of the cognition (thinking) and/or the emotions (mood) as defined by standard diagnostic systems such as the International Classification of Disorders, 10th Edition (ICD 10) or the American Psychiatric Association's Diagnostic and Statistical Manual, 4th Edition (DSM IV). *Psychosocial disorders* relate to an interrelationship of psychological and social problems which together constitute the disorder. Psychological symptoms are those that have to do with thinking and emotions, while social symptoms relate to the relationship of the individual with the family and society. Save the Children and UNICEF define psychosocial well being as involving people's relationships, feelings, behavior and development.

Mental and Psychosocial Disorders in Conflict Settings

In every population, 1-3% have a psychiatric disorder. Where conflict is present, the number may increase due to PTSD, alcoholism/drug abuse and depression arising from conflict-related stress. A further group, maybe 30-40% of the population, may experience symptoms such as sleeplessness, irritability, hopelessness and hypervigilance—symptoms which can persist and become more severe, thus interfering with the normal functioning of individuals. This group is not classified as having a psychiatric disorder but may have psychosocial disorders manifested as domestic violence, criminal activities, school dropouts and other anti-social behavior. Lastly, following a traumatic event a large part of the population may suffer nightmares, anxiety, and other symptoms of stress, but these are often transient and will decrease in intensity and frequency over time.

At the core of every conflict is insecurity. This insecurity fractures social ties, breaks up families and communities, and displaces populations. The total number of refugees and internally displaced people is estimated at 37 million worldwide. Insecurity and displacement causes the breakdown of social services such as health and education. The stateless and displaced are unable to work in their fields or engage in productive activities, and weak or absent social safety nets there is a slide into poverty or dependence on humanitarian assistance. In addition, traumatic experiences directly related to conflict, often involving the loss of family members, participation in or witnessing of violent acts, cause further distress.

Although conflict is associated with an increase in the prevalence of mental disorders, there are few population based studies carried out among adults in conflict-affected areas and low-income countries.¹ Among refugees, it is estimated that acute clinical depression and PTSD range between 40-70%. Epidemiological studies among IDPs and refugees on the Thai-Cambodian border, in Algeria, Ethiopia, Gaza, and Uganda indicate that 15 to 53% suffer from PTSD as a consequence of conflict. In Uganda, 71% reported major depressive disorder, and in Algeria, Cambodia, Ethiopia, and Gaza, psychopathology prevalence was 17% among non-traumatized against 44% for those who experienced violence. These estimates compare with less than 10% in non-conflict countries—in the U.S, less than 10% of the adult population will experience PTSD or major depression in a year (US Department of Health and Human Services, 1999). A study in Somaliland over a decade after the conflict found that one in five families was caring for at least one family member with severe mental problems, most were former fighters, and in virtually all cases, they had abused khat (a local plant containing an amphetamine). The study also found that 15% of former fighters suffer from a severe mental disorder (mostly psychosis), they are four times more likely to suffer from this severe incapacitating mental disorder than the already high prevalence in the general population, and ex-combatants are two times more likely to be affected than civilian war survivors.² Overall, we can expect that the prevalence among the general population in a typical post-conflict country lies somewhere between the high rates found among refugees and the low rates in non-conflict countries.

Numerous studies document the links between mental disorders and psychosocial suffering and dysfunction. This dysfunction persists over time and is linked to decreased productivity, poor nutritional, health and educational outcomes, and decreased ability to participate

and benefit from development efforts. Studies indicate that populations affected by conflict not only suffer mental health consequences, but also have associated dysfunctions, which can last up to five years after the conflict. The World Bank 'Voices of the Poor' study also demonstrated a clear link between poverty and mental distress. Mental health problems are also likely to affect the generation of social capital, which is increasingly recognized as a key element in sustainable poverty reduction and human development efforts. Conflict-affected societies face a particular challenge in rebuilding social capital, which is eroded as a result of violence and a breakdown of trust. An inherent attribute of social capital is active community membership and participation. If due to a mental illness an individual is unable to participate in the activities of a community, this constrains access and contribution to social capital in the community.

Children are the most vulnerable group in conflict settings. Due to their still sensitive neurological system, they are more susceptible to shocks to their development process. These shocks may include violent and traumatic events due to conflict or more indirect effects such as malnutrition leading to stunting and cognitive impairments. In conflict situations, mothers may be depressed or suffering from PTSD, thus unable to provide proper care or stimulus to their children. Stress in the external environment often manifests itself as violence in the home, which the children may witness or be the victims of. The mental health of child combatants and those suffering disabilities caused by the conflict (e.g., amputees in Sierra Leone or mine victims in Angola) also requires special attention. The Orphans and Vulnerable Children (OVC) group in the World Bank has adapted a framework drawing from work by USAID to address the various needs of conflict-affected children, depending on the character and severity of their situation.

A Conceptual Framework for Mental Health Programs in Conflict-affected Countries

Recognizing the importance of the linkages between poverty, conflict, mental and psychosocial well-being is not enough. It is also important to demonstrate that there are interventions that can address this dysfunction, that these interventions are feasible in post-conflict settings, that they will lead to increased productivity of those who are treated, and that they are cost-effective. Moreover, psychosocial interventions may contribute to peace and reconciliation by dealing with the anger, depression, and sense of hopelessness and helplessness suffered by victims of violence and insecurity. More research and development of good practices are clearly needed, but observations of experiences in mental health interventions can already provide some guidance on dimensions that must be addressed.

A model for mental health and psychosocial interventions needs to consider three basic dimensions: cross-sectoral, level of care, and coordination among policies and

¹ A current research proposal will analyze the prevalence of depression among the adult population in post-conflict Bosnia-Herzegovina and explore the impact of mental health on labor market productivity and use of health care services (K. Scott and M.P. Massagli).

² Men who display aggressive behavior (mostly ex-fighters) are likely to be chained by their families and to remain in chains.

stakeholders. The first dimension relates to the recognition that mental health care is multi-sectoral. The sectors involved include health, education, social welfare, refugee and displaced persons' welfare, and legal and judiciary sectors. There is great potential for interventions in the educational sector, within schools, to train teachers to recognize distress in children, provide initial interventions, and refer those who require specialized attention. The school setting provides an excellent opportunity for breaking the cycle of violence by integrating peace and reconciliation in the curricula.

The second dimension relates to the three levels at which care and interventions can take place. At the primary level interventions range from listening and support provided by members of family and the community, to programs in school and community centers, to support provided by primary health care providers. More specialized care is provided at the secondary level, through provincial and district hospitals, as well as outreach and support to primary care provider (PCP) centers and workers. Secondary level care can include play therapy, expressive art therapy, drama, and counseling support provided in a more structured environment than the primary level, often by NGOs. Such interventions may also be integrated into school programs. At the tertiary level is hospital-based mental health care with specialized personnel, diagnostic and treatment facilities, and psychosocial care such as residential transition and rehabilitation centers for war trauma survivors. Care at this level takes the form of specialized interventions such as group therapy and intensive individual therapy. There is a need for complementarity in the provision of these services as well as referral up and down the system. Each of the levels of care is crucial to successful implementation of interventions.

The third dimension refers to the need to coordinate and ensure consistency among components—policy, referral, supervision, and monitoring and evaluation—and stakeholders. The latter include the government, donors, non-governmental organizations, private providers, and UN agencies. Illustrations and experiences of interventions are drawn below from the West Bank and Gaza, Bosnia, Burundi, and Uganda.

Strengthening of the primary level and stakeholder coordination

At the primary level it is essential to train primary health care providers to recognize and manage common mental health problems.³ In the West Bank and Gaza, such plans are underway in the Ministry of Health of the National Palestine Authority. However, while services and providers supplied by the government are clearly identifiable, primary level mental health care is also

³ Health professionals require special training to decode signs of stress, because people are often afraid to talk of mental problems and be classified as mentally ill. Somatic signs and complaints are often the only culturally acceptable way to express mental suffering and stress.

provided through NGO programs. Although NGOs have begun to develop standards, guidelines and a regulatory framework, the counseling provided itself is not regulated in any way. More importantly, there seems to be a mismatch between resource allocation and demand for mental health services. The majority of public funds are spent on tertiary hospital care with virtually nothing at the secondary level and minimal amounts at the primary level—in effect, an inverted funding pyramid—whereas the majority of people in need of services need to be reached through the primary and secondary levels.

As part of its post-conflict recovery efforts in Bosnia and Herzegovina, under the War Victims Rehabilitation Project the Bank funded the construction of Community Mental Health Clinics but a subsequent evaluation found that the Clinics were underused and not well known to PCPs. To address the problem, the PCF supported the Harvard Program of Refugee Trauma (HPRT) to pilot in one canton a culturally-appropriate mental health program within the primary health care system. The initial studies of the project found that while 45% of refugees suffered psychiatric symptoms related to violence, and 25% of refugees were disabled because of those symptoms, primary health care personnel reported low confidence in treatment of mental health diseases. The three-year program conducted a needs assessment of patients, community, and primary health care providers in mental health; trained 103 primary care providers in mental health and trauma treatment; and conducted on-site supervision, consultation, and evaluation provided for PCPs on mental health skills. One of the barriers to access to care was the feeling by Primary Care Physicians that they did not have adequate knowledge and skills to manage mental health disorders. Following the training, there was a marked improvement in the management of common mental health disorders and an increase in the number of patients attending the Clinics. In addition, a National Advisory Board on mental health was established and national and local policy meetings held to integrate mental health in national health reform. As a result of these efforts, the project in Bosnia is seen as nationally-owned.

Early child development and cross-sectoral collaboration

The Bank-supported Burundi Social Action Project included a community-driven Early Child Development component, covering cognitive development, health, nutrition and psychosocial elements. Local psychologists assessed the knowledge and literacy of mothers in participating villages and on this basis developed a training package, including a training-of-trainers manual, teacher handbook and educational aids. Following discussions and consultations with the Education Ministry and key representatives of NGOs and early child education, the training package is being piloted.

Psychosocial programming in Uganda

The case of Uganda provides a good example of effective inter-agency collaboration and local planning. An initial assessment of the impact of conflict in Northern Uganda, supported by UNICEF, was carried out by the Ministries of Health and of Gender, Labour and Social Development, and five NGOs working on psychosocial issues. The results were disseminated to each district in separate workshops, designed to assist participants plan psychosocial interventions relevant for their districts. Results include: district multi-sectoral psychosocial plans; improved national, regional and district coordination on psychosocial issues; standardization of counseling provision and training; improved coordination, sharing of resources and advocacy work among NGOs; and guidelines on district-level monitoring and research of affected populations.

Cost-effectiveness

The need for cost effectiveness studies of mental health interventions is increasingly becoming apparent. The PCF is supporting a study conducted by the Transcultural Psychological Organization on the 'Effect, content and the cost-outcome of psychosocial and mental health interventions among adults and youth in post conflict areas'. The purpose of the study is to examine the cost and effectiveness of psychosocial interventions varying from interventions by local traditional healers to formal mental health programs in post-conflict areas in twelve developing countries. Preliminary results were presented in March 2003 and they are promising, estimating the cost of care at about \$8 per patient with a return on investment of \$40. Further work is being done to refine this data.

Conclusion

Experience to date indicates that it is possible to cost-effectively implement mental health and psychosocial programs in different sectors and with very different approaches. In all interventions, there is a need for collaboration within the health sector, between primary health care and mental health, but also with other sectors outside of health. Coordination between the Government, NGOs and the private sector is also vital to the success of mental health and psychosocial programming. The major challenge to mental health and psychosocial programming remains the lack of documentation on the evaluation of programs. These would provide process, outcome and impact indicators that would be useful for scaling up or replication.

Further Reading:

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