UNITED STATES INSTITUTE OF PEACE
PEACEBRIEF 57
United States Institute of Peace • www.usip.org • Tel. 202.457.1700 • Fax. 202.429.6063
September 28, 2010

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Mental Health Services During and After Armed Conflict: The State of Knowledge and Practice

Summary

- There is increasing recognition that the violence, displacement, disruption of communities and social networks, and deprivation stemming from war deeply impact the mental health of individuals and the social cohesion of communities. In response, donors and providers are creating programs for psychosocial or clinical services that seek to be culturally appropriate, attentive to the need to build local capacity, and sustainable.
- The quality and comprehensiveness of mental health programs offered in crises, however, generally remains mixed. Too often the programs do not sufficiently differentiate among widely varying individual needs or focus predominantly on either community-based interventions or the clinical needs of more severely affected people but not both. Services for people with more severe disabilities often replicate institutional models, and accompanying human rights violations, that existed in the pre-war period. The challenge of providing sound programs, moreover, is complicated by a relatively thin evidence base.
- In the face of these challenges, the "Guidelines on Mental Health and Psychosocial Support in Emergency Settings" adopted in 2007 by the Interagency Standing Committee (IASC) offer a promising approach. They stress understanding local context, programming that attends to psychosocial support needs of the entire community, meeting clinical needs of people with more severe conditions, and respecting human rights. Following the IASC and building the evidence base by assuring adequate evaluation of funded programs can help meet the tremendous mental health needs of suffering populations.

> "Instead of viewing populations affected by war as a homogenous group, all of whom equally experience psychosocial consequences of war, the 'Guidelines on Mental Health and Psychosocial Support in Emergency Settings' recognize that programs need to be systematic in identifying particular vulnerable and affected populations as well as meeting needs shared by the entire community."

Introduction

As evidence of the severe mental health consequences of war accumulates, donors, humanitarian and development agencies, and ministries of health have begun integrating mental health services into their health and social interventions in regions of conflict. The challenges of identifying priority populations, appropriate models for services, training local staff and even determining the relationship between community and individual needs, however, have proved daunting, especially given the paucity of research in the field. In 2007, the U.N. Inter-Agency Standing Committee (IASC) promulgated "Guidelines on Mental Health and Psychosocial Support in Emergency Settings"[1] that seek to offer a coherent, sophisticated framework for understanding and addressing the mental health and psychosocial needs of populations affected by conflict.

On May 25, 2010, USIP's Peacebuilding and Health Working Group met to discuss the psychosocial and mental health impacts of armed conflict, programmatic responses to mental health needs of populations, and how research and global guidelines can lead to better understanding and more effective services to address these needs. Michael Wessells, professor at the Columbia University Mailman School of Public Health and former co-chair of the IASC Task Force on Mental Health and Psychosocial Support in Emergency Settings; Judith Bass, assistant professor in the Department of Mental Health at the Johns Hopkins Bloomberg School of Public Health; and Eric Rosenthal, executive director of Disability Rights International, presented findings from their work. Leonard Rubenstein, coordinator of USIP Peacebuilding and Health Working Group, moderated the discussion.

Vulnerable Populations and Challenges in Meeting Their Needs

A growing body of research has established that people who witness or experience violence, are forced to flee their homes, or suffer deprivation of the necessities of life or disruption of their social networks and communities often experience severe psychological injury or distress. Studies consistently find that populations exposed to war experience high levels of post-traumatic stress disorder, depression, and other conditions, as well as loss of community cohesion. The mental health and psychosocial consequences of conflict can be felt broadly in populations and more deeply affect children, people who have pre-existing mental health conditions, and individuals who have been subjected to gender-based violence, forcible recruitment into armed groups, discrimination, or social isolation.[2] In the post-conflict period, fear of sexual violence, joblessness, ongoing displacement and other factors may exacerbate or bring new sources of distress. The psychological responses of individuals exposed to the stresses stemming from war and disruption of social networks vary considerably. Many people living in a conflict setting show remarkable coping skills and resiliency and do not require specific psychosocial interventions.

In the past, the mental health needs of people caught in armed conflict were largely ignored by donors, governments and providers. In recent years, mental health and psychosocial interventions in conflict areas have proliferated. Sophisticated and successful programs offer interventions and programs of services responsive to the often widely varying needs of the population, ranging from clinical treatment programs for severely affected people to holistic, community-based supports for larger populations are coping reasonably well but still experience distress. The overall record of mental health programs in emergencies, however, is quite mixed. It is not atypical for providers to offer a narrow set of interventions based on their prior experience or skill set rather than grounded in an assessment of population needs or proven effectiveness. For example, in some emergencies providers offer an abundance of community-based psychosocial support programs but no response to the needs of people who suffer the most serious mental distress or impaired functioning and need specialized support. Conversely, in some settings, attention has focused nearly exclusively on clinical support for severely affected people, with little attention to community-based supports.

The field is also characterized by clinical challenges and a small evidence base. For example, some experts urge that the greatest attention be focused on exposure to trauma, while others believe a more effective response would consider underlying symptoms of anxiety or depression. Complex questions also arise about establishing priorities in targeting individuals for services, engaging persons with little formal training in mental health programming as local service providers, identifying community structures to support mental health and engaging these structures in programming.

Comparative effectiveness research on mental health interventions in conflict and post-conflict settings is limited, a product both of the methodological challenges in studying these interventions and a lack of priority for health services research spending in conflict regions. Nevertheless, with a commitment to evaluation, appropriate studies can be designed. Given the low-resource context in which most of this work is done, studies are also needed to investigate the impact of non-mental health programs, such as economic interventions on mental health and well-being. These types of interventions do not reduce the need for attention to the mental health impacts of trauma, but can contribute to the resolution of mental health issues.[3] More systematic methods of identifying at risk and in-need populations can also support effective interventions.

Another concern is that mental health programs sometimes have goals beyond the immediate mental health needs of populations, such as reconciliation among ethnic groups or nationalities. Such programs may assume congruence between these political goals and individual and community needs where none exists.

Yet another challenge is service design and human rights protection for people with more severe disabilities. All too often in the past, international assistance in mental health has resulted in replicating outmoded and abusive mental health systems or rebuilding existing institutions and leaving countries with segregated services systems. Even where donors and providers have claimed to include the needs of people with serious mental illness in post-conflict health programming, as in Kosovo, administrators responsible for health programs ignored severe abuses perpetrated against residents in the institutions they supported and failed to provide appropriate non-institutional treatment until the practices were publicly exposed.

Consultation and participation by local stakeholders—including individuals with disabilities—is essential in addressing these challenges and providing solutions to mental health problems. Peer support and advocacy by people with mental disabilities can be an extremely important part of post-conflict recovery, particularly where there is a shortage of mental health professionals. Stigma and de facto or de jure discrimination against people with disabilities in recipient countries, however, often hinder participation by people with disabilities in assistance efforts and can undermine psychiatric recovery. The participation of people with mental disabilities can help shatter prejudices, overcome discrimination, and establish a basis for future participation in society, all of which represent critical components to post-crisis psychiatric recovery and mental health.

The IASC Guidelines

In 2007, the Inter-Agency Standing Committee (IASC), the mechanism that brings U.N. agencies, NGOs and other providers together to coordinate humanitarian assistance, adopted the "Guidelines on Mental Health and Psychosocial Support in Emergency Settings"that seek to bring more coherence and structure to programmatic responses to mental health needs in conflict-affected populations.[4] The guidelines are based on principles of human rights and equity and the ethical principle of doing no harm. They also emphasize the need to understand the local context and nature of the crisis in order to identify populations most in need of services. Instead of viewing populations affected by war as a homogenous group, all of whom equally experience psychosocial consequences of war, the "Guidelines on Mental Health and Psychosocial Support in Emergency Settings" recognize that programs need to be systematic in identifying particular vulnerable and affected populations as well as meeting needs shared by the entire community. The guidelines focus on building on available knowledge, resources and capacities in an integrated, multilayered support system.

The guidelines provide that services should be modeled on a four-tiered model of increasingly specialized services, starting with basic services and security for all, moving next to community and family supports, then to focused non-specialized services, and finally to specialized services. They recognize the need for social interventions as well as the need to meet specialized needs of particular groups or individuals for clinical services. They are also designed for implementation that respects context and engages multiple agencies.

The IASC guidelines are principally addressed to emergency interventions but the approach they take is highly relevant to long-term planning for post-conflict services. For example, integration and coordination among donors and implementers, and ending the practice of funders supporting a single intervention, can increase opportunities for learning across intervention areas. Moreover, an integrated approach can help transfer knowledge within the development and humanitarian community. Such an approach would avoid the kind of stovepiping that resulted in a lack of application of the lessons learned from psychosocial support in HIV programs to agencies working in armed conflict.

Finally, the guidelines confirm that mental health needs cannot be seen in isolation. Primary health care workers need to understand mental health and provide simple interventions as well as take into account survivors' needs for privacy and adequate space for religious and other cultural practices. Projects emphasizing healing of individuals must recognize the need to provide protection of populations and prevention of violence or instability. Without safety and prevention, communities cannot progress in healing.

The guidelines, however, provide a framework, not all the answers. For example, how and whether programs can contribute toward reconciliation, reintegration and healing remains uncertain, even though these goals remain a broad aim of programs in conflict settings. Moreover, the guidelines cannot successfully be implemented without the support of a growing knowledge base.

Conclusion and recommendations

In the past, mental health services in crises were largely ignored. The availability of funding and programming for mental health services in recent years, though encouraging, too often is premised on the idea that doing something is better than doing nothing. Inappropriate approaches, however, cause harm and waste resources. Donors, providers, researchers and ministries must be more sophisticated in differentiating among the varying needs of subgroups within an affected population, designing responses for all, expanding the evidence base, and assuring that interventions do not themselves violate human rights. The IASC guidelines provide a useful starting point in designing programs that respect culture and human rights and respond to individual and community needs. They limit harmful practices and encouraging holistic, coordinated, comprehensive and community-based psychosocial approaches that are responsive to varying individual and population mental health needs. This requires collaboration across agencies, sectors and donors.

It is imperative to continue to share experience and build the evidence base not only as independent research protocols, but also as a core element of programs. Through such services research, the field can better understand how, whether, and for whom particular approaches are effective in a particular setting.

Finally, because stigma and discrimination may well be exacerbated as a result of armed conflict and pressures on communities, human rights protection remains essential. Such protections include assuring that people disabilities have the opportunity to participate in the design of services.

About This Brief

The need for mental health services as part of emergency and long-term health development responses in regions of armed conflict is widely recognized. To date, responses have too often been fragmented, lack comprehensiveness, and based on assumptions rather than on evidence of effectiveness. This Peace Brief reviews the challenges and how Inter-Agency Standing Committee guidelines can point a way forward. Leonard Rubenstein is a visiting scholar at the Center for Public Health and Human Rights at the Johns Hopkins Bloomberg School of Public Health and is the coordinator of USIP's Peacebuilding and Health Working Group. Anjalee Kohli is a doctoral student in International Health at the Johns Hopkins Bloomberg School of Public Health.

Endnotes

1. Inter-Agency Standing Committee (IASC). "IASC Guidelines on Mental Health and Psychosocial Support in Emergency Settings." IASC.

2. F. Baingana, I. Bannon, and R. Thomas . "Health Nutrition and Population Discussion Paper: Mental Health and Conflicts: Conceptual Framework and Approaches." World Bank.

3. K.E. Miller and A. Rasmussen. "War exposure, daily stressors, and mental health in conflict and post-conflict settings: Bridging the divide between trauma-focused and psychosocial frameworks." *Social Science and Medicine* 70, 7-16.

4. Mental Disability Rights International. "Not on the Agenda: Human Rights of People with Mental Disabilities in Kosovo." Mental Disability Right International.

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