UK NGOs and International Mental Health:

An Exploratory Review

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EXECUTIVE SUMMARY

Introduction

After a long period of neglect, mental health is now moving up the "development agenda". The aftermath of the tsunami disaster has also highlighted mental health issues.

There is no UK NGO forum specifically devoted to international mental health, so the extent and nature of UK NGO involvement in this area is not well known or understood.

Objectives

- To identify a sample of UK NGOs
- To examine how mental health issues are addressed
- To review best practice and experience gained
- To generate recommendations to inform future directions

Method of investigation

A semi-structured interview schedule was designed. Questions relating to both mental health and psychosocial issues were included. From 24 UK based NGOs which were contacted, respondents representing 19 NGOs were interviewed by telephone, e mail or in person. Responses were from individuals so do not represent the specific policies of organisations.

A thematic analysis of the questionnaires was then carried out.

Summary of findings

This review has highlighted the following:

- All respondents including those from non mental health specialist NGOs indicated interest in, and commitment to, mental health and psychosocial issues. Potential difficulties were highlighted, including organisational constraints, uncertainties regarding methods of evaluation, and perceived lack of specialist expertise.

- Experience in responding to the tsunami disaster has brought mental health and psychosocial issues to the fore for many organisations. Many have an increased awareness of emotional factors, particularly bereavement, and greater knowledge and understanding of the roles of religion, rituals and social recovery in psychological support and healing.

- Mental health and psychosocial issues are conceptualised differently by existing UK specialist mental health agencies and by other NGOs who carry out mental health and psychosocial programmes. These differences affect what kinds of programmes are implemented, how these issues are presented to donors, and, in some cases, affect the availability of funding.

- Differences in conceptualising mental health issues contribute to confusion among some non specialist NGOs. This is exacerbated by ongoing lack of clarity in terminology, and disagreements and lack of consensus between mental health specialists.

- Most respondents identified specific components which had contributed to successful mental health and psychosocial programmes and also identified a number of areas which they considered neglected or needed greater attention

- Respondents acknowledged the lack of a UK forum/organisation which could provide information and specialist knowledge, and enable the sharing of good practice and learning. There was no unanimity as to how this lack could best be rectified.

Proposals for the future

1. This report will be circulated to all organizations who took part and other relevant organizations. Feedback and comments will be invited.

2. A presentation and workshop will be given by the author (hosted by RedR/IHE) to which representatives of all NGOs will be invited. This will provide opportunities for the following issues to be addressed:

    - Feedback on this report from respondents/organizations who took part in the study
    - Assessment of the needs of organizations in relation to mental health and psychosocial issues, including what needs are not being met and why, and how this could be rectified.
    - To examine how conceptual and professional differences may be highlighted, clarified and overcome.
    - To assess levels of interest and commitment for future developments, including the establishment of a UK Forum for international mental health.
    - To review sources of funding.

A holistic approach

It is now recognised and accepted that “there is no health without mental health” and that a holistic approach to recovery - mind, body, and spirit - is required, both for individuals and communities. NGOs interviewed were either already carrying out effective programmes but with no UK forum in which this

work could be shared with others, or expressed commitment and interest in including mental health within their existing programmes. This review will contribute to future debate as to how increased sharing of knowledge and experience between UK based NGOs could take place in the future.

1 Introduction

After a long period of neglect, mental health is now moving up the "development agenda". The aftermath of the tsunami disaster has also highlighted mental health issues, and a great number of mental health and psychosocial interventions are being implemented in those countries most severely affected. Mental ill health now accounts for about 12% of the global burden of disease[1], and one third of the world's people (33 countries with a combined population of two billion) live in nations that invest less than one per cent of their total health budget in mental health. In Africa and South Asia more than 680 million people have access to less than one psychiatrist per million population [2].

There is no UK NGO forum specifically devoted to international mental health issues, so the extent and nature of UK NGO involvement in this area is not well known or understood. There have also been limited opportunities to share best practice and identify priorities.

This report will contribute to increased knowledge, raise the profile of international mental health within a development context in the UK, and provide a baseline for discussion and debate regarding future directions and developments.

2 Background

2.1 Rationale

In 2004 the first conference on International Mental Health Conference was hosted by the Institute of Psychiatry. It became clear that in the absence of a UK forum devoted to international mental health in a development context, the work of UK NGOs in this area was little known or understood. It was also evident that greater knowledge and understanding would have two potentially invaluable outcomes;

1) the findings could be shared with both researchers and NGO representatives attending the second conference in 2005;
2) the findings could inform debate and decisions regarding the possible setting up of a UK forum in the future.

The author was commissioned to carry out this work by Martin Prince of the Institute of Psychiatry and Vikram Patel of the London School of Hygiene and Tropical Medicine, and a proposal put forward for funding. Unfortunately attempts to obtain funding were unsuccessful. Due to the author's perception of the importance of this work, the project was therefore carried out on an expenses only basis, supported by the Institute of Psychiatry.

[1] WHO (2001) Fact sheet No 218
[2] WHO (2001) World Health Report: Geneva

2.2 The Author

Jane Gilbert is a Clinical Psychologist. Stemming from her work in The Gambia, she is committed to promoting a greater understanding of the cultural context of psychological and mental health issues, and specialises in the design and delivery of workshops and training. Before becoming freelance she worked within Mental Health Services in the UK and as a Consultant for the Health and Social Care Advisory Service (HASCAS). She is a regular contributor to mental health and cultural awareness courses for UK NGOs and has worked in the UK, The Gambia, Uganda, Lesotho and Ghana.

2.3 Acknowledgements

This work could not have been carried out without the time and patience of the respondents. Their contributions, experience and views have been invaluable and are gratefully acknowledged.

3 Objectives

The objectives of this research project were as follows:

- To identify a sample of UK NGOs
- To examine how mental health issues are addressed within NGOs
- To review best practice and experience gained.
- To generate recommendations to inform future directions.

4 Methodology

4.1 Identification of NGOs

NGOs who make up the Disasters Emergency Committee (DEC), specialist mental health UK based NGOs and NGOs known to the author were contacted and attempts made to identify a suitable contact from each one.

Some organisations did not respond and, particularly for those not specialising in mental health, it was sometimes difficult for organisations to identify an appropriate person. In addition, some worldwide organisations with an office in the UK have an organisational structure whereby personnel with specific areas of expertise are located in different parts of the world, and are the resource for the whole organisation. This sometimes included mental health, and thus some email responses were from personnel located outside the UK. Some of the large NGOs based in the UK also have offices in other countries which are almost autonomous in determining their own priorities. Thus, although advisers from the "parent" part of the organisation provided support and information to country offices, policies and priorities were decided upon locally and were not necessarily in line with those of head office.

Not all UK based NGOs are represented, but of 24 contacted 19 replies have contributed to this report. There are other organisations whose contributions would also have been of value but which are not represented in this review, particularly NGOs working with children and the elderly. However, the review is exploratory and does give a "snapshot" of how international mental health issues are addressed at present. The information will also provide the basis for more extensive future work.

4.2 Method of investigation

An interview schedule was designed (Appendix 1) in discussions with both academic researchers and those working in the field. As there is confusion and uncertainty in terminology (see Section 5.1) the questionnaire requested information on both mental health and psychosocial programmes. The questionnaire has three sections:

- Section A for completion by organisations who currently provide specialist mental health/psychosocial programmes;
- Section B for organisations who include mental health/psychosocial programmes as part of other programmes;
- Section C for NGOs who do not have mental health/psychosocial programmes at present.

The interview schedule was peer reviewed and 23 organisations were contacted. Of these 19 participated (Appendix 2), and the remaining 4 either were unable to provide a suitable contact, or did not reply. Responses were obtained by email, telephone interview or personal interview.

Section A was completed by nine organisations, Section B by eight organisations and Section C by two organisations.

A thematic analysis was then carried out.

The views expressed in the body of the report summarise the responses of those interviewed, but Section 12 contains both the views of the respondents and the author.

4.3 Respondents

Organisations varied considerably in size, organisational structure, focus, and the policies and priorities which guided their operations. Details can be found on the organisations' websites.

All respondents interviewed were highly experienced in the NGO sector. Some were desk officers who managed programmes in one particular sector or geographical area, others worked primarily in the field. The responses were from individuals, and therefore cannot completely represent the policies and views of their organisations, but all respondents were aware of those policies and had detailed knowledge of many, but not all, of their organisation's programmes.

5 Thematic analysis of questionnaires

The main themes arising from the responses to the questionnaire are outlined in sections 6 to 9. All quotations given in italics are verbatim.

As this study is exploratory and qualitative in its approach, respondents expressed a wide variety of views in their own words. It is recognized that the views expressed stem from personal experience and do not necessarily reflect the stated views of the organizations.

In general it is clear that confusion exists in the use of terminology, that conceptual frameworks for mental health differ from one organisation to another, and sometimes even within one organisation, and that epilepsy, which is considered a physical health problem in the UK, is included as a mental health problem by some agencies.

5.1 Confusion of terms/areas of controversy

As anyone working in the field of mental health is only too aware, confusion in terminology and areas of controversy continue. "Trauma" is now used with a multitude of meanings by both journalists and the general public, and newer words such as "psychosocial", "social well being" have appeared without being clearly defined. The distinction between mental illness and the normal and expected emotional distress following catastrophic events is often blurred and insufficiently clear, and there is disagreement amongst agencies as to whether mental health and psychosocial issues should be addressed if basic needs for food, shelter and safety have not been met.

Uncertainty and confusion about terminology, particularly in relation to the term "psychosocial", was reflected in the responses of many of those interviewed.

Comments included:

"predictable, understandable reactions to traumatic events are mixed up with other issues"

"there is a danger if it is called mental health, maybe it could be called a clinical approach – better to be called psychosocial in some environments"

"we are struggling with psychosocial as a term – we think it means a social worker who has worked in mental health"

"depends on what you mean by psychosocial"

"should avoid the word psychosocial altogether"

"everyone says they are doing psychosocial compared with work with individuals – very difficult to measure outcomes."

"Psychosocial – we keep well out of it"

"mental health needs to be incorporated in the broader sense but the terminology is problematic."

"*we don't know how mental health issues are dealt with – either locally or by other NGOs in Africa"*

"There is animosity and disagreements … two camps – psychosocial versus individual work"

Respondents from two large organisations who have psychosocial programmes initially said "we don't do mental health", but through further discussion it became clear that the programmes which they described had very positive mental health outcomes.

Differences in terminology reflected fundamental differences in the way mental health and psychosocial problems are conceptualised.

5.2 Conceptual frameworks

Some organisations carrying out psychosocial programmes conceptualised mental health issues as stemming from a "*life that is shattered*", and that the social fabric supporting an individual's life has been shattered. Therefore interventions are primarily to support the mending of that social fabric.

Other organisations conceptualised "psychosocial" somewhat differently. For example a respondent commenting on a programme which supports the reintegration of mentally ill people into their communities described psychosocial as follows: "*Our family and patient counselling sessions and the reintegration processes by a psychosocial supporter is part of the psychosocial programme."*

Another organisation which provides specialist mental health programmes gave this description, "*we use the social dimension to understand and work on psychological experience – the objective being that a person should recover a sense of identity/place through lived experience. The person needs to be re-integrated into the community."*

A specialist mental health NGO conceptualises mental illness primarily within the context of poverty, lack of livelihoods and human rights and therefore takes a more developmental perspective. Another conceptualises mental health problems predominantly within an individual trauma perspective, therefore focuses on the training of local health workers in individual work. Another providing specialist mental health programmes described their work as "*focussing on the mentally ill and thinking about the social separately".*

Mental health is confusing in terms of both unclear terminology and sometimes radical disagreement amongst professionals. Differences in how

mental health problems are conceptualised are also often not made sufficiently explicit for non professionals, further adding to the confusion.

The following definitions of "psychosocial" are given for information:

"pertaining to the influence of social factors on an individual's mind and behaviour" (Oxford English Dictionary)

"social interventions have secondary psychological effects and psychological interventions have secondary social effects" (Sphere Standard 3)

"the term is used to indicate commitment to non medical approaches and distance from the field of mental health, which is seen as too controlled by physicians and too closely associated with the ills of an overly biopsychiatric approach" (Van Ommeren et al, 2005, 71)

For an overview of current issues and attempts at achieving consensus the recent paper by WHO (Van Ommeren et al, 2005) is highly recommended.

5.3 Epilepsy

In Western countries epilepsy is considered to be a medical condition and treatment is provided most often by neurologists or physicians. However, respondents from specialist mental health NGOs regarded providing treatment and education for epilepsy as an essential part of their work. "*As of Dec 04 we have helped 17,123 mentally ill people of which 32% have epilepsy"*. Those organisations providing capacity building in relation to mental health also focussed a significant part of their resources on this, very often treatable, condition.

6 Funding

Responses to questions regarding funding for mental health/psychosocial programmes were very mixed. Non specialist organisations and NGOs who did not have any mental health or psychosocial programmes at present were sceptical about donor interest in mental health issues and the availability of funds or had had difficulty finding funding:

"it is quite hard to find funding from the general public in the UK – they don't recognise there are mental health problems in less affluent societies,"

" there is still a stigma about mental health, even with donors":

"Funding has not been easy"

"Mental health is not a topical issue, it needs to be connected to general health"

"We have sometimes excluded mental health, for example in a recent application. DFID not keen, but did get funds from the churches"

"Very difficult to obtain funding despite the huge need in post conflict, disaster and epidemic hit communities, e.g. HIV"

"It has been very difficult – had to do local fund raising in Ghana"

"Funding difficult – now impossible for Eastern Europe and Central Asia. UK donors have a very limited view of mental health."

"very difficult, very few have an interest, little knowledge of mental health in developing countries"

Larger NGOs did not need to seek funding separately for psychosocial or mental health as they were components of larger programmes and faith based organisations had "ongoing supporters" which enabled them not to depend on other funding sources.

Other organisations had had much more positive experiences in obtaining funding. Success appeared to depend on established relationships and, as mentioned in Section 5.2, on how mental health was conceptualised for donors.

"Not difficult recently – good relationships, and a personal reputation"

"Depends on the region and context, whether it is urgent post crisis or ongoing development. Certain projects are regularly financed by the same donors."

"Not short of funders – Diana fund up to £80,000 over 3 yrs, specifically mental health and post conflict, Comic Relief"

"Not difficult – lottery, Comic Relief, DFID. Donors accept mental health in a development context, would have been rejected if it had been "welfare based" i.e. medical/psychiatric. We have a systems approach supporting Primary Care, and focussing on the economic contribution with people back in the community, and human rights."

7 Mental health and psychosocial programmes

Organisations interviewed carried out a wide variety of programmes in very many different contexts. It is not possible for these to be described in detail in this report but some brief descriptions of different types of programmes are given in Appendix 3. Further information can be obtained from participating organisations.

The following sections focus on establishing the common factors which were identified by respondents as having contributed to the success or otherwise of their programmes.

7.1 Components of successful programmes

Respondents were asked to give an example of a programme which their organisation had considered successful and, if possible, to identify the

components which they thought had contributed to its success. What constituted "successful" was deliberately left undefined in order to elicit the criteria by which organisations judged their own success.

Themes which emerged as contributing to the success of programmes are given below. Although the respondents described many different programmes in very different contexts, in practice the components which they considered had contributed to success were common to many.

7.1.1 Sustainability

"It was sustainable, leaving people with the skills to carry on"

"Conducted by local pastors – acceptable to local community, already part of their role, just strengthened"

"Need to know who is delivering the care, who can sustain training? Need long term personnel"

"Concept of psychological care in the long term"

7.1.2 Relevance to local culture and context

"use of culturally appropriate assessment methods, use of local language"

"Responding to context – different villages do it differently, must not generalise in terms of population/culture, people are still individuals."

"Taking time for proper assessment of local culture and services/structure of the Ministry of Health"

"Men and women react differently – need separate groups"

"Innovative, unique to Ghana"

" local staff, follow up, availability of trained local personnel"

"Being able to bring it about that the women themselves understood the emotional effects of what had happened to them. We used Inca categories to make sense of what is happening, did not impose Western terminology"

7.1.3 Quality of training and supervision

"well trained local counsellors and strict clinical supervision"

"regular support by experienced consultants and a committed team who understood the "invisible" value of the intervention"

"Quality of professionals – members of teams have at least 15 years experience, recruitment of expat psychiatrists, identification and formation of partnerships in an approach which respects the knowledge and practice of each person."

"Availability of technical support, weekly, monthly supervision of both expatriate and local practitioners"

7.1.4 Dedication of staff

"Dedication of project co-ordinator"

"long term personnel"

"community sensitisation with volunteers"

7.1.5 Community approach/livelihoods

"We are not medical specialists, the main focus is on livelihoods – not treating people as patients, rather building livelihoods together, therefore healing"

"They can discuss what they want with someone – and this is related to an activity/income. Women feel guilty doing "nothing" – life always involves so many tasks, therefore it is important to be doing something useful. Women group around the activities."

"integrated with vocational training/livelihoods"

"skill building"

"The programme was conceived as truly generating community based solutions, the involvement of community, government and other stake holders made it truly interactive and sustainable."

7.1.6 Documentation and evidence

"has demonstrated what works and what doesn't, well documented evidence, sharing and dissemination of information"

"recording of sessions on paper so it could be evaluated".

7.1.7 Building up local capacity

"developing clinical psychology in the university and health service, training GPs, teachers"

"the programme has an influence on the policy of community based rehabilitation programmes by the Ministry of Health and Social Services in Ghana"

"all programmes have been in existence for several years – patients are treated, professionals trained"

7.2 Components of unsuccessful programmes

There is much to be learned from what has already been implemented even when not successful, and it is to the credit of those interviewed that they

readily identified programmes which had not been successful, and from which they had learned lessons for the future.

Significant factors identified as contributing to the "non-success" of programmes are given below.

7.2.1 Cultural factors

"A Trauma recovery intervention in a post conflict situation – a short intervention, not culturally appropriate."

"Psychologist was not able to work because of language and cultural differences"

"Must not use a language that is alien. Terms such as schizophrenia are unknown to local people."

7.2.2 Lack of specialist knowledge

"In Rwanda – trauma counselling was new at that time. We did support trauma work but with no backup training. We learned that it was a complex area, and needs specialist knowledge, which we cannot judge ourselves. We backed off after that".

"Initial assessment was carried out by non professionals"

"Not having dedicated person for the psychosocial part of the programme"

7.2.3 Political factors

"Plan to train teachers as counsellors – did not choose the right people, political problems with the ministry"

"Did have high turnover of healthworkers so knowledge lost"

7.2.4 Community and context

"Community based rehabilitation programme in Swaziland – programme worked in isolation, was externally funded, no government support, poor documentation of experience, management committee not well informed regarding mental illness, lack of funding"

" less successful without community support and education"

7.3 Employment of specialist staff

There is ongoing debate as to the role of specialist, i.e. professionally trained, staff in mental health and psychosocial programmes. The debate ranges from whether they are essential for the provision of expert clinical care or whether their involvement pathologises what is essentially the restoration of mental health through psychosocial or development programmes which re-build local community structures. This debate will be addressed in greater detail in Section 10.1.

Even organisations who specialise in mental health do not necessarily use professionally trained mental health staff, and considerable use is also made of volunteers. As mentioned in section 4.1 some worldwide organisations based in the UK have access to specialist staff located in other countries or in affiliated or partner organisations. The type of staff employed also reflects how mental health and psychosocial issues are conceptualised by the organisation.

"We use a consultant for trauma programmes."

"Fieldbased staff with a psychology/counselling background. – 1 yr contracts, short term consultants for assessment/referrals."

"Mental health staff with backgrounds in community mental health, medical and psychiatric social workers, psychiatry. Recruited as consultants and advisers. One person trained in psychosocial interventions in Geneva".

"Use of volunteer psychiatrists, psychiatric nurses, psychologists"

"Psychiatric nurses, social workers, skills development – artisans, carers"

"Teams are composed of clinical psychologists, psychiatrists – may be expat or indigenous depending on what professionals are in the country."

"Mental health staff all volunteers. In Uganda staff employed by National Health Service – occasionally we pay per diem."

"Mostly development workers, one specialist per programme, employ locally, no expat in the field."

"Staff in the UK are generalists, not mental health. It is a development issue – we work with local partners. Depending on the programme we may recruit here, but more often local"

7.4 Evaluation

As one respondent commented, "*evaluation has to demonstrate what works and what doesn't*", but this can be an extremely complex undertaking in terms of mental health and psychosocial programmes. Some respondents did not know if or how programmes had been evaluated, some organisations did not evaluate mental health or psychosocial components separately, and others expressed general concerns about the validity of evaluation, per se, in a "soft" area where change is difficult to measure.

It is also not always clear for whom the evaluation is taking place. The kind of evaluation required by donors can be very different from the evaluation which may be most relevant to either staff working on the ground or people whose lives are directly affected. If "*the objectives of the evaluation are an outside look by a third party at the content of the work to validate/invalidate the direction of the programme"* then the locus of decisions taken is also likely to be external

“don’t know how much was implemented, but they were equipped for the longer term with more awareness of mental health issues.

“Mental health was a small component in larger programme, not evaluated separately”

“Have to do what funders ask us, usually numbers and money”

“psychosocial, very difficult to measure outcomes”

“Seemed pastors were competent but difficult to evaluate”

“Did not make cross over in evaluations between countries but records better now.”

“We do learn lessons but the country offices approach things differently so it does not translate into a policy”

NGOs who did not have mental health programmes were sceptical about how mental health needs could be assessed, and did not know of any available methods or guidelines.

“donors and people want problems that they can solve and where impact can measured, e.g. immunisation. You cannot measure the impact of mental health programmes.”

7.4.1 Methods of evaluation

As would be expected, where evaluations were able to be described by respondents, methods varied depending on the context and programme. However, it is unclear how much the results of the evaluation were disseminated to others, either within large worldwide organisations or between organisations which might work in similar ways.

“internal review, external consultant”

“Post intervention assessment tools – by consultants”

“Impact assessment methodologies”

“We ask activists to keep diaries. We have a data base of diaries.”

“Evaluations of workshops show they are successful, but no supervision afterwards. People need supervisors to be able to talk about cases, we would like to evaluate the work done afterwards.”

“evaluation by people on the ground – Likert scales, CHO examiner certified by the country. Audit – nature of cases.”

“Internal monitoring using participatory approaches collecting views from family members, patients, local leadership”

"Outside mental health professionals but the evaluations are prepared with psychiatric supervisors and the team in the field".

"Number of patients treated in each rural clinic – Male/Female, 1st attendance, re-attendance, diagnosis – 1 district compared with the other 9 – more people were treated"

"Monthly data – finance, quantitative, evidence based, participatory approach, report received by Chief Executive every 3 months. Each programme reviewed by Chief Executive at the end of first year and external review."

"Have to do what funders ask us, usually numbers and money"

7.4.2 Increasing awareness

In mental health, change is often "invisible" and difficult to measure. The outcome of an evaluation cannot always be as simple as "what works and what doesn't". However, both formal evaluation and experience in the field can also result in an increasing awareness of issues which had not previously been fully recognised or understood.

Overall, organisations in which evaluations had taken place were more positive about mental health and psychosocial programmes. Others had increased their knowledge and awareness through their experience.

"no policy level changes but greater emphasis on respecting culture and local organisations"

"Very positively – experience in Orissa helped us integrate psychosocial support as a key component of our disaster work."

"Had to increase our knowledge of PTSD, realise that it occurs 6-12 months after the event"

"The organisation now committed to including mental health/psychosocial to interventions where need is indicated in Africa".

"We have now embraced mental health work as part of our disability work"

"First district compared with the other nine – more people were treated, therefore going to roll this out into other nine and try to influence policy".

8 Tsunami disaster response

The tsunami disaster of December 2004 resulted in an unprecedented international aid response, including a plethora of mental health and psychosocial programmes supported by aid agencies worldwide. Respondents were specifically asked whether their organisation had developed new mental health programmes as part of their response to the disaster, and whether their experience in the aftermath of the tsunami had

changed their organisation's commitment to mental health and their priorities for the future.

8.1 Learning

It was clear from the majority of respondents that having to respond to the aftermath of the tsunami had resulted in increased awareness and specific further learning in relation to mental health and psychosocial programmes within many organizations. As programmes are further evaluated over time, this learning is likely to be further developed. For some organisations their experience in the aftermath of the tsunami has either already resulted in specific changes in policy or in greater awareness of psychological issues more generally.

"We are far more aware of the influence of religion, burial ceremonies. Bereavement has come to the forefront. Never seen a proposal before which funded rituals. More emphasis on respecting local customs and cultures. Need more locally trained people – more understanding that they are needed. Using theatre for the first time in Sri Lanka, will be reinforced. No change in organisational policy but greater understanding."

"Sri Lanka and Indonesia post tsunami response has acknowledged the importance of psychosocial and mental health support. Programme was designed as a community approach – orphans, widows, widowers, adolescents. Training, education support and organisation of various activities for children, income generation programme consciously looked at mental health needs of affected people and organised referral to mental health facilities in respective localities."

"Reinforced the importance and learning of the organisation in relation to trauma counselling, psychosocial and mental health in the aftermath of high impact emergencies."

"New training materials, programmes, workshops, advocacy efforts through the media. Tsunami has strengthened our existing understanding that this is an important component of disaster response programmes"

"Incorporated much bigger community support programmes. Psychological needs addressed by social intervention, e.g. women's groups. Many psychosocial programmes in Sri Lanka"

"The tsunami has given the opportunity to extend and expand, also the opportunity to show that good mental health programmes can be provided at Primary Care level".

"Made the organisation aware of the need to effectively include and protect the vulnerable groups during natural and human caused disaster. No new programmes but disability work in disaster has been a topical issue in the organisation."

"No change in organisational policy but greater understanding"

"Future policy not tied to the tsunami but has contributed to thinking. Long term approach to IDPs – Sri Lanka and conflict situations. We now have two programmes which are tsunami based – tested the model in emergency situations, now a 4 year programme in Sri Lanka – emotional support, mental illness and development"

9 Additional issues

Respondents were asked not only to comment on the future priorities for their own organisation in relation to mental health, but also to comment generally about mental health and the NGO sector. A wide range of issues and areas of concern were raised.

9.1 Is mental health “worth doing”?

Even with the difficulties perceived by many respondents in terms of funding, the evaluation of “soft” outcomes, and concerns regarding cultural issues, the majority of non specialist organisations were still committed to mental health, but expressed some significant reservations and concerns.

“Mental health is “worth doing” as part of an integrated programme. Holistic includes spiritual. In disasters – social , mental spiritual interwoven in other work, e.g. health education, women’s groups.”

“Been too much focus on commodities, sense of loss and pain is as acute as hunger. You can see water and grain but dislocation of communities was leading young women to prostitution (Rwanda) – symptomatic of psychosocial problems. People tend to focus on the obvious – mental health does not make good TV, and it is difficult to account for mental health afterwards.”

“Development goals cannot be achieved by individuals and/or communities who are dysfunctional as a result of mental health conditions – need to provide treatment/support for groups/families/individuals who have endured difficulties so that they can “move on with life””

“Psychosocial needs higher priority”.

“More acceptance within the organisation that there needs to be greater emphasis on mental health in the future., fund raising for mental health programmes, building capacity for existing staff, more qualified staff.”

“We are looking at planning for mental health programmes without necessarily building in house capacity.”

“Mental health does need greater attention but must not stand alone, must be integrated.”

“Feels under represented in the UK – been flagged as a concern in the past after the Gujurat earthquake, but there are concerns about counselling”

“we recognise the need to address these issues but have a very hectic portfolio”

“Should have higher priority. But if it is it is going to be high jacked by NGOs then people will be dictated to. Village elders have not been consulted in the past, even in

camps during famine. No mental health intervention will work in the longer term without traditional healers and community leaders."

9.2 Organisational constraints

Respondents employed by large organisations stated that even if there was an increased commitment to mental health in the future, it would need to be accommodated within the organisation's stated priorities. For example, one organisation's priorities are – livelihoods, HIV/Aids, accountable governance, the priorities of another organisation – participation, disability, health, secure livelihoods. Programme staff in each country determine which goal is being focussed on. Some countries focus on mental health within other goals which means it would be more difficult for an organisation to address mental health issues in a uniform way.

"Organisation is decentralised – regions are autonomous e.g. Southern Africa focuses on livelihoods, HIV."

"Each NGO has its own approach which may limit their capacity to respond to individual context and cultural differences."

Smaller organisations were limited in their capacity to address mental health issues either through a perceived lack of technical expertise or competing priorities.

"Mental health needs technical expertise compared with food, sanitation etc"

"It is a problem having any priorities when resources are limited."

It must be also noted that the imperative on organisations to concentrate their efforts on the achievement of the Milennium Development Goals may also limit their capacity to respond to mental health issues.

9.3 HIV/AIDS

A number of respondents considered that psychosocial and mental health issues were insufficiently taken into account in HIV/AIDS programmes and gave some examples where programmes could be improved.

"Grandparents have to take responsibility for 13 grandchildren when child rearing days are over. HIV has been seen as a medical issue for too long. Need to find ways of developing good practice principles so we can respond to mental health issues"

"HIV psychosocial issues are ignored – focus on medical and livelihoods – not professional psychosocial programmes. WHO does not do enough – nutrition and psychosocial issues neglected."

" psychosocial care for HIV positive people is now being discussed."

9.4 Rape

The emotional aftermath of rape was also raised as an area which receives too little attention, but concerns were raised about making sure that what was provided was appropriate.

"Rape needs a higher profile."

"Groups are not the answer for everyone, someone may need help, or just to be quiet"

"Must not generalise in terms of population/culture. Raped women need psychological counselling as individuals but need extra sensitivity, age differences, married or not, people are different."

9.5 Poverty and deprivation

A number of respondents commented on the lack of recognition, and absence of discussion of the psychological effects of poverty and deprivation.

"In Palestine fathers are humiliated in front of their children, homes demolished – do we understand the effects on children?"

"We need to recognise the effects of poverty – people do not talk about the lack of dignity or the psychological effects"

Perhaps one respondent's description of the difference between his agency and an African agency has much to teach.

"Rwanda – African relief organisation – got out of trucks and began hugging people first, food distribution second."

9.6 Mental illness

Non specialist organisations appear to remain unsure about the care of the mentally ill within their programmes. Specialist agencies articulated the danger of mental illness being "forgotten" in psychosocial programmes.

"The mentally ill in institutions "do not exist" from the point of view of the agencies"

"There is a neglect of the seriously mentally ill"

"Other areas are neglected – HIV, learning disability, serious mental illness"

9.7 Language, culture and religion

Apart from the specialist mental health organisations and those respondents directly involved with specialist programmes, there seemed limited awareness of the complexity of language and cultural issues in mental health.

However, some respondents considered that responding to the aftermath of the tsunami had greatly increased their knowledge of cultural and religious issues:

"greater emphasis on respecting culture and local organisations after the tsunami"

"We are far more aware of the influence of religion, burial ceremonies. Bereavement has come to the forefront. Never seen a proposal before which funded rituals. More emphasis on respecting local customs and cultures."

"different religions have different attitudes to mental health issues"

"We need to understand the influence of religion, need to liaise with priests and have training in counselling – eg rape. Need to combine with traditional healers in programmes"

"Role of religion in psychological well being not recognised"

However there was also a greater awareness of the dangers of imposing Western approaches and methods.

"we are sceptical about imposing Western approaches and concerned about cultural issues"

"I am aware that in relation to the tsunami that it's good there has not been much individual counselling."

10 What is needed

Respondents were asked about the future plans of their own organisations and what they would like to see in terms of the UK NGO sector to address mental health and psychosocial concerns. Their ideas are presented in the following section and used as the basis for the recommendations put forward in section 12.

10.1 The role of specialists

There remains ongoing concern and disagreement regarding the role of mental health professionals, particularly non local staff. Some organisations see them as essential for the provision of expert input, others remain concerned that there may be an overly "psychiatric" approach to normal and understandable reactions to abnormal events.

"We need professionals, cannot leave things to generalists. Need psychologists rather then psychiatrists – to assess how programme of livelihoods affects psychological well being"

"Need long term personnel – advocacy, writing proposals, donors"

"Hierarchy of needs – basic healthcare and physical health the priorities, once addressed mental health is in the second tier of assistance. Needs to be psychological rather than psychiatric."

Interviews also revealed a tension between the recognition of mental health as an area of work requiring specialist expertise but also a desire for mental health and psychosocial issues to be integrated within existing programmes.

"Need to integrate mental health into existing systems and services, not separate."

"Problem of having mental health as a priority when resources are limited."

"Mental health is not a topical issue, needs to be connected to general health programmes"

10.2 Advocacy and education

There was general recognition that mental health is not seen as a priority and that both within countries and within the donor community education and awareness raising were both urgently required.

"Donors provide money for vaccinations, malaria, HIV, chronic disease, mental health at the bottom, need advocacy."

"Need public education, reduction of stigma."

"Mental health has been overlooked by agencies in the past. Would welcome any change in recognising mental health. Need educational programme in UK, increase awareness of mental health issues and links with poverty."

"Still mental health stigma, even with donors"

"in some cultures including mental health in programmes could be misunderstood because of stigma, therefore need more education"

"there is no organisation like Help Age prodding us to remember mental health. In DEC Help Age had great impact by lobbying the organisations, not that for mental health."

10.3 A new organization?

There was little unanimity on what would best support UK NGOs in terms of mental health. Some respondents expressed the view that the establishment of a new mental health NGO or Alliance would be a positive step, others had considerable reservations:

"A new mental health alliance would be positive – not aware of other organisations doing mental health, it would be good to share good practice, learn from others, meet colleagues"

“A new NGO would be lovely – technical assistance for others, advocacy for donors, needs to be based on research, need to build capacity in universities, advocate for mental health in country.”

“No more NGOs please, but a Mental Health alliance if they provided focussed support and guidance to other agencies or finding partners. Also useful role in evaluation”

“There should not be a specialist NGO, present organisations outside the UK doing a great deal.”

“New organization not the way forward. Far bigger actors outside the UK”

“Would be good to have a forum to share the work”

“An Alliance could provide a valuable resource, but would not change policy.”

“needs specialist knowledge, cannot judge ourselves”

“Now that there is consensus in the Sphere manual we need to focus on psychological well being.”

Specialist agencies commented:

“we do consultancy so no fear about other organisations starting but then there will be competition for funding.”

“*there is room for more than one agency”*

Other respondents considered that the formation of any new broad based mental health organisation would be extremely difficult due to the unlikelihood of reaching any consensus of approach between mental health professionals, and ongoing confusion in terminology:

“There is so much animosity and disagreements. Two camps – psychosocial versus individual work”

“If there was an alliance you would never get a consensus or agree on an approach between professionals”

“We need to incorporate mental health in the broader sense but the terminology is problematic”

“Predictable understandable reactions to traumatic events mixed up with other issues.”

“Need to distinguish between different problems/categories to make sure programmes are tailored appropriately.”

Other respondents considered that the evidence base for mental health and psychosocial programmes was “not proven”.

"What evidence is there to show to NGOs about effectiveness? New organisation could play a useful role in evaluation"

"Depends on funding and research and evidence base."

.
"We don't know how mental health issues are dealt with – either locally or by other NGOs in Africa"

11 Limitations of the study

This study was exploratory in nature and, as in all research of this nature, outcomes are very much determined by the questions asked. Analysis of the information gained has revealed some limitations of the present study which are outlined below:

- Differences in how mental health and psychosocial issues were conceptualized by different organizations is a fundamental issue. It would have been valuable to have asked more specific questions to enable differences between organizations to be elucidated more clearly.

- Personnel who are actively engaged in running programmes are often out of the UK, and, for some organisations, it was difficult to find the right person to interview. Thus there is less information about what actually happens in the field than had been hoped.

- The research was proposed in order to establish how mental health issues are addressed by UK based NGOs. However, many respondents replied in general terms, rather than directly describing how mental health issues present on a day to day basis in their work.

- There are a small number of specialist mental health NGOs based in the UK, most of recent origin. It would have been useful to establish their own perceptions of their role within the NGO sector more clearly.

12 Conclusions and recommendations

The rationale for the present research was to provide an overview of UK NGOs and international mental health. It was proposed that greater knowledge of what is being carried out, and greater understanding of the views and priorities of respondents from the major NGOs would enable potentially useful proposals for the future to be put forward.

12.1 Summary of findings

This research has highlighted the following:

- All respondents including those from non mental health specialist NGOs indicated interest in, and commitment to, mental health and psychosocial issues. Potential difficulties were highlighted, including organisational constraints, uncertainties regarding methods of evaluation, and perceived lack of specialist expertise.

- Experience in responding to the tsunami disaster has brought mental health and psychosocial issues to the fore for many organisations. Many have an increased awareness of emotional factors, particularly bereavement, and greater knowledge and understanding of the roles of religion, rituals and social recovery in psychological support and healing.

- Mental health and psychosocial issues are conceptualised differently by existing UK specialist mental health agencies and by other NGOs who carry out mental health and psychosocial programmes. These differences affect what kinds of programmes are implemented, how these issues are presented to donors, and, in some cases, affect the availability of funding.

- Differences in conceptualising mental health issues contribute to confusion among some non specialist NGOs. This is exacerbated by ongoing lack of clarity in terminology, and disagreements and lack of consensus between mental health specialists.

- Mental health and psychosocial programmes defined by the respondents as successful included the following components:

    - Sustainability
    - Relevance to local culture and context
    - Quality of training and supervision
    - Dedication of staff
    - Community and livelihoods approach
    - Clear documentation and evidence
    - Building up local capacity

- Respondents identified a number of areas which are neglected or which need greater attention:

    - the mental health consequences of HIV/AIDS and the role of psychosocial approaches in enabling support and care
    - the psychological effects of poverty and deprivation
    - the mentally ill and those with learning disability
    - people who have been raped
    - local language, culture and religion

- Respondents acknowledged the lack of a UK forum/organisation which could provide information and specialist knowledge, and enable the sharing of good practice and learning. There was no unanimity as to how this lack could best be rectified.

12.2 Proposals for the future

The following proposals combine the views of both respondents and the author. It is hoped that they will form a basis for debate and decisions for the future.

12.2.1 What needs to be addressed?

In terms of international mental health and the UK NGO sector the following issues need to be addressed:

- Terms must be defined more clearly — with agreement on meaning.

- Mental illness, acute emotional distress and normal reactions to abnormal events must be clearly differentiated.

- Good practice in psychosocial and mental-health programmes needs to be shared and disseminated more widely.

- Advocacy and education on mental health issues, and areas perceived as being neglected (Section 10.0), needs to be more effective - within the UK, with donors and in country.

- More sophisticated and sensitive measures of assessment, impact and evaluation must continue to be developed.

- The feasibility of establishing a new mental health "forum"/organisation within the UK needs to be considered.

12.2.2 First steps

It is anticipated that the presentation and circulation of this report will generate discussion, and possibly disagreement, as to how the issues raised can be addressed. This section proposes some first steps.

3. This report will be circulated to all organizations who took part and other relevant organizations. Feedback and comments will be invited.

4. A presentation and workshop will be given by the author (hosted by RedR/IHE) to which representatives of all NGOs will be invited. This will provide opportunities for a number of issues to be addressed:

    - Feedback on this report from respondents/organizations who took part in the study

- Assessment of the needs of organizations in relation to mental health and psychosocial issues - what needs are not being met? Why? How could this be rectified? (the author would be available to assist organizations in clarifying and thinking through these needs subsequent to the workshop if required)
- To examine how conceptual and professional differences may be highlighted, clarified and overcome.
- To assess levels of interest and commitment for future developments, including the establishment of a UK Forum for international mental health.
- Identification of areas requiring further information/investigation
- An action plan for the future.

5. After the workshop, and depending on the results of discussions held, further steps could include:

    - The setting up of a steering group to take forward future developments
    - Clarification of training needs
    - Examination of the differences between agencies in how mental health and psychosocial issues are conceptualised
    - Review of the potential role of present UK specialist mental health NGOs.
    - Consideration of the functions of any proposed UK Forum for International mental health. Functions could include:

        - provision of resources, information and expertise
        - sponsorship of events where reflection and shared learning can take place
        - a bridge between research and work in the field
        - design and delivery of appropriate training and consultancy
        - establishment of links with centres of expertise outside the UK

    - Review of models of organisational structure for any new forum
    - Review of sources of funding

12.3 A holistic approach

Mental health needs are wide and complex, involving psychological, social, educational, human rights, livelihoods and developmental perspectives. It is now recognised and accepted that “there is no health without mental health”[3]. and that a holistic approach to recovery which includes mind, body, and spirit is required.

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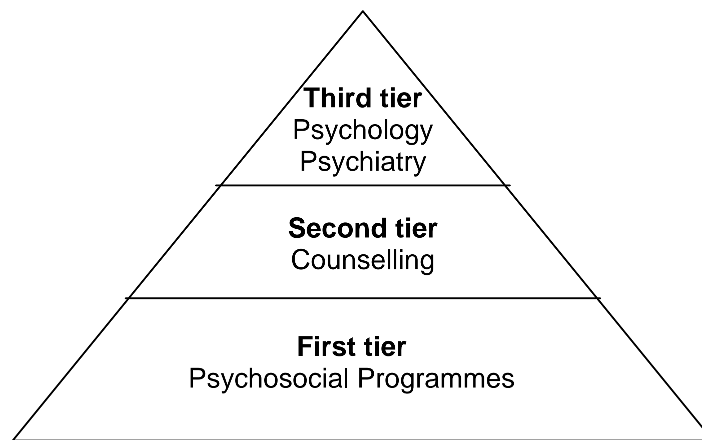
[3] Eldis id21 insights health, Issue 6. **No health without mental health.** www.id21.org/insights/insights-h06.

The Sphere Handbook clearly states the rationale for psychosocial work – that positive changes in social frameworks affect psychological well being. Connections between the restoration of the social fabric, religious practice, everyday activities and psychological wellbeing are 'common sense', even though emotional healing and the restoration of meaning are difficult to 'measure'. Unfortunately, since the 1990s many factors have contributed to an increased division between specialist medical/psychiatric input for mental health and psychosocial programmes.

The model used by the International Federation of Red Cross and Red Crescent Societies (IFRC) Reference Centre for Psychosocial Support is given below as an example to illustrate the essentially complementary nature of the assistance necessary to both aid recovery and further self sufficiency within communities.



IFRC define their work as follows:

> *"Our programmes are mainly psychosocial and focus on the non-pathological reactions of people to difficult situations. Recognition of pathology and knowing when and to whom to refer form part of our training programmes."*

First tier: general support, psychological first aid, and activities with the population
Second tier: Counselling offered to those who have more difficulties coping with the consequences of the event/situation
Third tier: Referral to special psychological or psychiatric care. It should be noted that normally only few people develop problems that might need this special care.

Psychosocial programmes are mainly in the first tier and partly in the second tier. Mental health in the second and the third tier (Margriet Blaauw, MD, personal communication).

Mental health professionals and organisations need to be able to respond and provide appropriate assistance within a holistic framework. This requires not only a holistic approach to individuals but also the whole of a society – including the mentally ill, those with learning disability, epilepsy, and HIV/AIDs – within many different cultural contexts.

For this to occur, every effort needs to be made to overcome ideological and professional differences, and for the complementarity of different contributions and approaches to be acknowledged and respected. It is essential to combine the empowering and strengthening of local and culturally appropriate community resources and care, with ensuring that the mentally ill, those with incapacitating emotional difficulties, epilepsy and learning disability receive the necessary specialist care.

ADDITIONAL READING

Gilbert, J. (2005) Psychiatrist or psychosocial adviser? Confusion, controversy and progress in mental health. **Health Exchange,** August, 31-33.

Parathara, M. (2005) Life after disaster. **Health Exchange**, May, 24-27.

Sphere Handbook (2004) Standard 3.
http://www.sphereproject.org/handbook/index.htm

WHO (2003) '**Mental health in emergencies: Mental and social aspects of health of populations exposed to extreme stressors'.**
www.who.int/mental_health/media/en/640.pdf

WHO (2005) '**Mental health assistance to those affected by the Tsunami in Asia'. See** http://www.who.int/mental_health/resources/tsunami/en/

WHO (2001) Fact sheet No 218

Eldis id21 insights health, Issue 6. **No health without mental health.**
www.id21.org/insights/insights-h06

Appendix 1

SEMI-STRUCTURED INTERVIEW SCHEDULE

There is sometimes confusion between mental health and psychosocial programmes. This questionnaire concerns mental health, but if your organisation carries out psychosocial programmes only, please give details. If your organisation carries out psychosocial programmes of which mental health is a specific component, please describe in the relevant sections.

Thank you again for your time and assistance.

Name of organisation: **Date:**
Respondent:

Please complete ONE section of this questionnaire: A, B or C

- **A** Complete section A if your organisation has any programmes which focus specifically on mental health.
- **B** Complete section B if your organisation has any programmes of which mental health is a component.
- **C** Complete section C if your organisation does not include mental health in its present programmes.

SECTION A

Organisations with specialist mental health programmes

1. How would you describe the main role of your organisation in the NGO sector? E.g. humanitarian relief, capacity building, advocacy etc Give a mission statement if you have one

2. In what context do your mental health programmes take place? Please tick those which apply.

   - complex emergencies
   - natural disasters
   - war zones
   - IDP/refugees
   - development of in country government services/policies
   - staff training/staff exchange programmes
   - developing infrastructure for Mental Health Services, e.g. building a psychiatric ward at a District Hospital
   - Primary Care
   - Advocacy/grassroots work for the mentally ill and their families
   - Collaboration with traditional healers

Staffing

3. Do you employ mental health staff, either from the UK or locally in the field? If yes, from which professional background/how are they recruited/on what type of contracts?

Programmes

4. Could you give an example of one of your mental health programmes which has been successful?
5. What factors contributed to this success?
6. Could you give an example of a mental health programme which has been unsuccessful?
7. What factors contributed to it being unsuccessful?

Evaluation

8. What methods have you used to evaluate your mental health programmes? By whom was this undertaken? From whose perspective?
9. What were the outcomes or process achievements?
10. How did they influence your future policy/programmes programmes?

Funding

11. Has it been easy/difficult to obtain funding for mental health programmes?
12 Have there been particular sources?

Future Policy (prior to the tsunami)

13 In what ways has your organisation's experience of mental health programmes (prior to the tsunami) affected future policies on mental health programmes?

Post tsunami

14 Did you develop new mental health programmes as a response to the aftermath of the tsunami? Please describe.
15 Has your experience in the aftermath of the tsunami changed your organisation's commitment/approach to mental health programmes in the future? If so, in what ways?
16 Does your organisation plan to expand and further develop mental health programmes? If yes, please describe your future policies and priorities?

Mental health and the NGO sector

17 What do you see as the main issues for UK NGOs involved in mental health? Do you have any general comments on mental health and the development/humanitarian agenda for UK NGOs?
18 Do you think that mental health should have a higher priority in the NGO sector? If yes, please could you explain why and how this could be achieved.
19 Do you have any "psychosocial" programmes? Is mental health a component of these? What do you think are the differences between mental health and psychosocial programmes?
20 If a new "MH alliance" or new NGO providing consultancy and specialist mental health input to the NGO sector were established, would this affect your future planning for mental health programmes?

SECTION B
Organisations with programmes in which mental health is a component

1. Please describe the main role of your organisation in the NGO sector? E.g. humanitarian relief, capacity building, advocacy etc

Staffing

2. Do you employ specialist mental health staff, either from the UK or in the field? If yes, from which professional background/how are they recruited/on what type of contracts?

Programmes

3. Could you give an example of a programme which has included a mental health component which your organisation considers to have been successful?
4. What factors contributed to this success?
5. Could you give an example of a programme which included a mental health component which your organisation considers was not successful.
6. What factors contributed to it being unsuccessful?

Evaluation

7. If your programmes included a mental health component, how has this been evaluated? By whom was this undertaken? From whose perspective?
8. What were the outcomes/process achievements?
9. How did the evaluation influence your future policy on including mental health as a component of your programmes?

Funding

10 Has it been easy/difficult to obtain funding for mental health programmes?
11. Have there been particular sources?

Future Policy (prior to the tsunami)

12. In what ways has your organisation's experience of including mental health as component in your programmes (prior to the tsunami) affected future policies?

Post tsunami

13 Did you develop new mental health components within your programmes as a response to the aftermath of the tsunami? Please describe.
14 Has your experience in the aftermath of the tsunami changed your organisation's commitment/approach to including mental health within your programmes in the future? If so, in what ways?
15 Does your organisation plan to expand and further develop mental health as a priority?

Mental health and the NGO sector

16 What do you see as the main issues for UK NGOs involved in mental health? Do you have any general comments on mental health and the development/humanitarian agenda for UK NGOs?
17 Do you think that mental health should have a higher priority in the NGO sector? If yes, please explain why, and how this could be achieved.
18 Do you have any "psychosocial" programmes? Is mental health a component of these? What do you think are the differences between mental health and psychosocial programmes?

19 If a new "MH alliance" or new NGO providing consultancy and specialist mental health input to the NGO sector were established, would this affect your future planning for including mental health within your programmes?

SECTION C
Organisations which do not include mental health in their programmes

1. How would you describe the main role of your organisation in the NGO sector? E.g. humanitarian relief, capacity building, advocacy etc

2. Has your organisation ever considered the possibility of developing mental health programmes, either specialist programmes or introducing a mental health component to existing programmes? What factors have influenced the decisions taken?

3. Has your organisation's approach to mental health changed in the aftermath of the tsunami? If so, in what ways?

4. Does your organisation have any plans to expand its role in mental health? If yes, in what ways?

5. What do you see as the main issues for UK NGOs in responding to mental health issues? Do you have any comments on mental health and the development/humanitarian agenda for UK NGOs?

6. Do you think that mental health should have a higher priority in the NGO sector? If yes, please explain why, and how do you think this could be achieved.

7. Would the establishment of a new "MH alliance" or new NGO, providing consultancy and specialist input, change your organisation's approach to mental health in the future?

Appendix 2

PARTICIPATING ORGANISATIONS

Action Aid	www.actionaid.org.uk
Aga Khan Foundation	www.akf.org.uk
Basic Needs	www.basicneeds.org.uk
Care International UK	www.careinternational.org.uk/
Christian Aid	www.christianaid.org.uk
Handicap International	www.handicap-international.org.uk
IMC	www.imcworldwide.org/index.shtml
Islamic Relief	www.islamic-relief.com
Leonard Cheshire International	www.leonard-cheshire.org
Merlin	www.merlin.org.uk
MHID	www.mhid.uk.net
OXFAM	www.oxfam.org.uk
RED CROSS	www.redcross.org.uk
Reason Partnership (Richmond Fellowship International)	www.reasonpartnership.com
Tearfund	www.tearfund.org
THET	www.thet.org
UK/Sri Lanka Trauma Group	www.uksrilankatrauma.org.uk
VSO	www.vso.org.uk
World Vision	www.worldvision.org.uk

Appendix 3

EXAMPLES OF PROGRAMMES

1. VSO: Sri Lanka – rehab project, half way house with livelihood focus, reabsorb person into the community, income generation with agriculture, attached to mental hospital

2. Oxfam: Kosovo - Psychosocial support via groups, income generation and local person hired as facilitator by Oxfam

3. Oxfam: India 2000 earthquake – groups of young people/women, self help, income generation.

4. Islamic Relief: Palestine – addressing the psychological and trauma healing needs of the children, 3 year project.

5. Islamic Relief: Sri Lanka - Psychosocial programme to support orphans, widows and widowers after the tsunami

6. IMC: Indonesia after the tsunami. Community Mental Health Programme - trained nurses and added psychosocial activities, 4 sites now training 8 Mental health nurses.

7. Leonard Cheshire International: Ghana – integration of 300 persons in the last 5 years. 3000 persons with mental illness received psychosocial counselling and skills development training. Programme has an influence on the policy of community based rehabilitation programmes by the Ministry of Health and Social Services in Ghana

8. Handicap International: programmes in Algeria, Burkina Faso, Lebannon have been in existence for several years, based on partnerships with local organisations – patients treated, professionals trained.

9. THET: Mbarara,Uganda – Community Mental Health. Senior Ugandan psychiatric nurse training rural health workers to treat mental health and epilepsy – support, supervision and monthly outreach clinics in 10 subdistricts – very successful. In one district – coupled with a volunteer programme to reduce stigma, monitor drug treatment and identify new patients. A model for the rest of Uganda. In 2004 more people treated in Mbarara than in the national hospital.

10. Basic Needs: Sri Lanka - Now have two programmes, tested the model in emergency situations, now a 4 year programme. Emotional support, mental illness and development – 800 volunteers. Training programme, become master practitioners and become master

practitioners. They choose another 10 people, who then choose 100 families, can cascade to 36,000.

11. Christian Aid: Sri Lanka - Psychosocial programme; economic support to enable appropriate multi-religious rituals to be carried out on the 30th day memorial for the dead, community theatre enacting ongoing reality of life, discussion. (Parathara, 2005)

12. Tearfund: Sierra Leone – support and training to enable pastors of the church to provide post conflict counselling for those with severed limbs, emotional aftermath of rape, anyone in need.

13. World Vision: Uganda – community based intervention for depression using interpersonal therapy for groups in local language with highly trained local staff.

14. Reason Partnership: Peru – displaced Inca people on the outskirts of Lima. Trained government workers to recognise common mental disorders, set up self help groups.