

# **A perspective from experiences in post conflict Timor Leste: the IASC Guidelines on Mental Health and Psychosocial Support in Emergency Settings**

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*In this paper, several lessons are shared based on experiences in post conflict Timor Leste. In order to provide care to patients with mental disorders in their home settings, a specialist community based clinical service was developed as an alternative to using the (already) heavily dysfunctional primary health care system. We found that mental disorder accounted for a disproportionate amount of the disability in the community. Symptoms of post-traumatic stress were widespread and often represented a normative survival reaction to threat to life. Treatment is only warranted for the minority whose traumatic stress reactions result in lasting, severe psychosocial dysfunction. Finally, we discuss the need to identify the community's own concepts of mental suffering and their expressions of these experiences.*

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Ideally, any guidelines should be based on empirical evidence rather than on anecdotal experience, received wisdom, professional interests, or ideological traditions. The slender empirical foundation on which our field

is based means that even the best guidelines - and, in our view, the IASC document deserves that accolade - represent only a provisional consensus reached at one moment in time. Good guidelines provoke debate, analysis, and commentary as part of the recursive process of refinement. In that spirit, we offer some thoughts on key issues that emerged during our research and clinical experiences working with the people of Timor Leste.

*The focus of community based clinical programmes*  
While psychosocial programmes focus on population groups as a whole, clinical services attend directly to individual needs. No single service model will apply to all settings and the guidelines do avoid taking a prescriptive approach. Although emphasizing the role of Primary Health Care (PHC), the guidelines acknowledge that these services can be overburdened with too wide an array of tasks. We recognized quickly in Timor Leste, where most PHC centres had burned down or were abandoned during the emergency, that these frontline services would not be able to meet the needs of the mentally ill in the short term. As a consequence, our organization, PRADET (Psychosocial Recovery and Development in East Timor) established a specialist community based

clinical service, providing care to patients in their home settings (Silove et al., 2004). We gradually aimed to expand the role of the service by training PHC personnel once they were in a position to absorb and apply that knowledge. We also recognized that a small service could not treat all those with mental health problems. We therefore focused on people in severe mental distress who met a set of *social* criteria. This was defined as an inability to attend to personal survival needs, protect dependants, or in other ways to adapt to the demands of the post emergency setting. Many people using the service were suicidal, unable to care for themselves, or so disruptive that they posed a threat to their families and, in some instances, the community. They suffered from a wide range of: severe mental disorders (psychosis, bipolar disorder, melancholia, organic conditions); disabling traumatic stress reactions (not only posttraumatic stress disorder (PTSD), but also depression, anxiety, somatisation, grief and anger); and social crises or culturally specific reactions to stress. To cope with this wide array of problems, we adopted a multidimensional and multidisciplinary framework, with our team coining the term '*bio-psycho-social-cultural-spiritual*' to encompass the breadth of the model.

A community based clinical service of this kind requires its own identity, organizational structure, a broad skills base, systems of peer support, dedicated resources (particularly transport and medications), and a specialized training programme for local mental health workers. The notion that one worker focussed within a general psychosocial programme can perform all the necessary functions effectively, seems to be unrealistic. At the same time, close interaction is essential between mental health and psychosocial services – in Timor Leste this was achieved by establishing an inter-agency working group.

#### *Severe mental disorder: the scale of the problem*

Those with severe mental illness form a major component of referrals to clinical services. The guidelines are exemplary in highlighting the needs of the severely mentally ill, although the statement in the introduction indicating that this group is '*small*', while technically correct, could be misleading if not qualified. Early evidence from our epidemiological study in Timor Leste suggests that the point prevalence for clinically relevant disorders (psychosis, depression, PTSD, alcohol abuse, etc.) was about 5%, higher than the rough figure of 2–3% that is often used in planning emergency services. Mental disorder accounted for a disproportionate amount of disability in the community, compounded by the impact on the family and the community having the responsibility of care. For example, in a remote village in Timor Leste, the entire social structure of the community was disrupted because the chief (chefe) was suffering from untreated, severe manic depression. As in other settings (Silove et al., 2000), some mentally ill people were found tied up, put in stocks, or arrested and imprisoned.

Based on epidemiological data, we were able to calculate that 300 mental health workers would be required to assist those adults with disabling mental disorder in Timor Leste a small country of 1 million persons. At the time of the study, the number of workers in the newly established National Mental Health Program (Saude Mental) was just 15. This meant that, by far, the majority of people with severe mental disorder were denied treatment. Therefore, although a numerically '*small*' group, the resources needed to attend to the needs of the mentally ill are substantial. Furthermore, to ignore their plight constitutes a serious neglect of a core human right.

**Traumatic stress** The guidelines acknowledge the ongoing controversy about trauma and PTSD, choosing, probably wisely, not to enter into the debate. At the same time, ignoring the issue will not make it go away. We would do better to develop some provisional directions in this area. Since DSM-III, psychiatry has relinquished the distinction between a 'reaction' and an 'endogenous' condition, with unfortunate consequences for our conceptualization of traumatic stress. By recognizing that acute PTSD symptoms represent a normative survival reaction to threat to life, we could avoid assuming that all affected persons require immediate clinical intervention. Treatment is only warranted for the minority whose traumatic stress reactions result in severe psychosocial dysfunction. For the majority, it can be expected that the early PTSD 'reaction' will resolve, particularly if peace and stability are restored. In Timor Leste, the high rates of PTSD appeared to drop dramatically after four years of peace. At the same time, although peace may be the best therapist for most cases of acute traumatic stress reactions, in all survivor communities, there is a residual group of variable size that suffers a chronic form of PTSD (now legitimately considered a disorder).

In Timor Leste, these persons remained undetected in the community, yet manifested high levels of disability. The simple lesson therefore may be: 'not too early, not too late'. This means, there is no rationale for offering universal interventions for PTSD in an early post emergency phase, but the needs of those with chronic PTSD should not be overlooked in the medium term. Ironically, this is often when many humanitarian agencies 'rush out' to attend to new emergencies elsewhere!

**The human rights context: culture and gender** It is vital to identify the community's own concepts of mental suffering and their ways of

expressing these experiences. In Vietnam, in Timor Leste and more recently in working with West Papuan survivors of persecution, we have identified a range of indigenous expressions of distress that overlap, but are not identical with, western categories. The task ahead is to devise methods for incorporating indigenous and 'international' concepts of mental disorder within an integrated clinical programme. Furthermore, unless gender issues are addressed directly, mental health interventions are at risk of making grievous mistakes. For example, the priority to maintain the integrity of the family may be misplaced in cases of domestic violence, a problem that commonly is undetected or minimized (Rees & Pease, 2007). In conclusion, it is valuable to remind ourselves of the four pillars of human rights that should guide all humanitarian programs; a sensitivity to: history, conflict, gender and culture (Silove & Zwi, 2005).

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## A new Mental Health Psychosocial Support Network

*In October the website of the Mental Health Psychosocial Support Network was launched.*

This network aspires to **improve mental health and psychosocial well being in humanitarian and other extreme stress settings.**

The key purposes of the network are:

- Implementation and contextualisation of the IASC guidelines on MHPSS;
- Encourage Research and development to consolidate and codify existing knowledge and generate new knowledge;
- Peer mentoring providing ongoing review and support;
- Capacity building strategies for maximising existing capacity through support and training;
- Information and resource sharing through website, conferences and collective initiatives;
- Building a database of psychosocial and mental health practitioners.

At the heart of this network is an interactive website. I would like to encourage all of you to become a (free) member of this network and to post relevant documents on the website you might want to share with other professionals in the field. It is important for all of us to establish and/or consolidate our professional peer network. On this website you will find your peers: [www.psychosocialnetwork.net](http://www.psychosocialnetwork.net)

**See you there!!!**