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Supporting Children in War

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2010

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citation for published version (APA)

Jordans, M. J. D. (2010). *Supporting Children in War: Development of a Psychosocial Care System*.

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CHAPTER 1

Problem statement and dissertation structure

Introduction and dissertation structure

“It appears easier to set foot on Mars than to look back at the childhoods on this planet that have been and still remain overshadowed by war” (Heinl, 2001).

Background

This dissertation presents several articles that together discuss the development and evaluation of a comprehensive psychosocial care system for children in areas of armed conflict. The research took place in five ongoing-, and post- conflict settings; Burundi, Indonesia, Sri Lanka, Sudan and Nepal. The dissertation’s central trend is the interplay between research and intervention development. Ultimately, the objective of the dissertation is to contribute to the development of an evidence-based and replicable intervention framework for children affected by political violence in low-and-middle income settings.

The mental health needs of children worldwide are seriously underserved (Tyano & Fleishman, 2007). Recent data demonstrate that globally up to 20% of children and adolescents suffer from disabling mental illness and that suicide is the third leading cause of death among adolescents (Belfer, 2008). Moreover, childhood mental health problems tend to persist into adulthood with estimates of 50% of adult mental disorders having their onset before the age of 14 years (Kessler et al., 2005). Especially in low and middle-income countries (LAMIC) the mental health and psychosocial needs of young people are structurally unmet (Patel et al., 2007). Given the unawareness of, or stigma associated with, mental health problems, as well as the extremely limited human and financial resources (WHOa, 2005) there is an urgent need for development of community-based interventions that can be implemented by non-specialists (Leckman & Leventhal, 2008). In a review of child and adolescent mental health of children in LAMIC, Patel and colleagues (2007) conclude that there is a pressing need for more evidence and capacity for the development of public health strategies for prevention and promotion of child mental health. These barriers and needs are compounded for low-income countries that experience conflict. Worldwide millions of children are affected by war and conflict (Wexler, Branski, & Kerem, 2006). Meta-analyses have demonstrated higher levels of mental health problems among children exposed to conflict compared to general populations (Attanayake et al., 2009). While attention and consensus for mental health care are increasing within low-income and emergency settings (IASC, 2007; Lancet Mental Health Group, 2007), the evidence base for interventions is weak and the treatment gap remains vast (Patel, Flisher, Nikapota, & Malhotra, 2008; Remschmidt, Nurcombe, Belfer, Sartorius, & Okasha, 2007). A recent priority setting exercise covering global mental health research highly prioritized the need for research into child mental health globally. Six out of the ten top research priorities were related to children and family mental health issues (Tomlinson et al., 2009).

At the same time there has been a paradigm shift away from defining the mental health (of children) merely through the presence or absence of disorders to include psychological distress and social problems (Psychosocial Working Group, 2003; Stichick, 2001). Hand-in-hand with this paradigm shift, there is a growing call for community-based psychosocial and mental health care (Barenbaum, Ruchkin, & Schwab-Stone, 2004; Stichick, 2001). This new trend draws upon public health principles to deal with preventive rather than curative aspects of health and with population-level, rather than individual-level health issues. Furthermore, there is increasing consensus for the development of integrated and multi-layered care systems, as stand alone services can create highly fragmented care systems (IASC, 2007). Finally, and related, there is a trend to increasingly work towards a multi-disciplinary and multi-sectoral approach, incorporating psychosocial components within broader humanitarian and development goals (de Jong, 2009; Tol et al., 2009; Wessells & Monteiro, 2006).

Personal trajectory

The trajectory I followed started in 1999 when I moved to Nepal. In the beginning my work focused primarily on counseling as a single intervention. At the time, psychosocial care as a component of torture rehabilitation, care for survivors of trafficking or street children was increasingly common, which was often projected onto one intervention: counseling. Yet, conceptual understanding among donors and common practice among non-governmental organizations was at least questionable. My goal was therefore mainly to improve the quality of training of counselors, in a setting where such training typically consisted of a few days. This resulted in a standardized five-month training package (certificate level) for para-professional counselors that was practice-oriented and skills-based. This culminated in a one-year university-affiliated postgraduate diploma (PGD) course in counseling. The aim of this full-time practice and skills oriented PGD course was to create a pool of people with sufficient theoretical knowledge and clinical skills to strengthen the field of psychosocial care in Nepal (i.e. supervision of certificate level counselors; program development). Lack of funding prevented the initiative from continuing. Yet, despite our efforts the number of people we trained (approximately 300) was minimal considering the magnitude of needs. Second, integration of counseling within any sustainable system proved very challenging, especially in remote community settings. Questions arose as to how to cater for children with more severe problems (i.e. psychiatric needs), how to sustain quality over time, and how to work with the community at large (i.e. address issues such as gender- and caste discrimination). In settings such as Nepal (low income and undergoing political violence) these questions came forth from a set of structural problems that include a lack of mental health resources (professionals) and financial resources (Nepal spends approximately 0.08% of its health budget on mental health [WHO, 2005b]) to sustain services or referral options, unawareness and stigmatization

of psychosocial and mental health problems and services, and structural violence undermining any community or service development initiatives. Considering these challenges, we aimed to improve the implementation of the intervention. This led to a broadening of scope of work, initially in the form of incorporating a second layer of community-oriented care for children affected by the armed conflict in Nepal (i.e. community psychosocial workers promoting community sensitization and mobilization with regards to the psychosocial needs of children within the targeted communities). Around the same time, I received the offer to work on a program to implement a school-based intervention within 4 conflict-affected countries.

This program brought two important changes for me. First, it provided the opportunity to apply our lessons learned regarding the need for more comprehensive and public mental health oriented care. In addition, this program entailed a combined intervention and research agenda, which presented the opportunity to transform myself from a slight research sceptic to a researcher. This dissertation is the result of these two changes. It presents an attempt to develop a *care package*, a system of care that includes different embedded layers of care to address a variety of mental health and psychosocial needs at different ecological levels (individual, family, school, community). Over time I got more and more convinced that thinking in terms of multi-layered care packages is essential when providing any psychosocial and mental health care in LAMIC. A set of complementary interventions for different sub-populations with varying degrees of severity of problems increases coverage, efficiency and equity in service provision. I believe we are just starting the development of such a care package; the precise content of such a package of care will still need much further development, research and revision. For instance, the care package requires improvements to better include targeting social determinants of mental health problems, to better link with provision of basic needs (i.e. livelihoods, shelter, education), and to link with existing psychiatric systems of care (where available).

Besides a description of the components of this care package, this dissertation focuses on research on these components that we developed. Irony, and the logic of science, has it that this implied applying several different research designs and methods for different components of the package, quite a turn of events for the once research sceptic. I hope that the research has contributed to establishing a stronger evidence base for the implementation of psychosocial and mental health care for children in LAMIC. It definitely has resulted in a changed opinion, as I consider rigorous research to be of utmost importance in the development trajectory of a care package. Especially considering that much more evidence and research into cost-effectiveness are required, also (or even more) after this dissertation. Moving from a fully practice-driven single intervention focus to a focus on combining research and practice within a multi-layered care package has been a personally and professionally fulfilling trajectory.

Research Themes

In settings with little financial or human capacity and little psychosocial and mental health care infrastructure, and with problems related to poverty and basic needs often overriding the psychosocial and mental health needs, development of services is challenging. The central theme of this dissertation is how to bridge the treatment gap and develop psychosocial and mental health services for children in low-income and conflict-affected settings. The research therefore emphasizes clinical relevance and direct applicability of the results. The following principal research questions underlie the dissertation:

1. How to develop and adapt a multi-layered psychosocial and mental health care package?
2. What psychosocial and mental health problems and (evidence-based) services exist for children in areas of armed conflict?
3. How feasible, valid and effective are mental health and psychosocial support interventions and instruments?
4. What are treatment mechanisms of individual psychosocial care?

In this dissertation I follow the IASC Guidelines on Mental Health and Psychosocial Support in Emergencies (2007) in using the composite term 'mental health and psychosocial support', as these are overlapping concepts that refer to a broad concept that encompasses "any type of local or outside support that aims to protect or promote psychosocial wellbeing and/or prevent or treat mental disorders". In turn, 'psychosocial' is defined as the close relation between psychological factors (emotion, behaviour, cognition) and the socio-cultural context. The use of the term 'psychosocial' comes largely as a humanitarian reaction against a perceived biomedical control of the field – to give more emphasize to context, resilience and non-disordered distress (Psychosocial Working Group, 2004). As a result the intervention framework moved more towards community settings and primary prevention as opposed to clinical settings and tertiary care.

Setting

The dissertation describes work in 5 different countries. Burundi, Indonesia, Nepal, Sri Lanka and Sudan have the experience of war in common, all of which represented conflicts fought mainly within the borders of their countries. Additionally, the 5 countries share, to some degree, challenges related to being low-, or middle-income countries. In all countries the work took place against the backdrop of a lack of resources, economic hardship, disrupted social fabric, structural violence and social exclusion, as well as a lot of resilience. At the same time, there are large differences between the countries. In Burundi our work took place in the context of a protracted cyclical armed violence between ethnic groups, culminating in a civil

war. The Republic of Burundi has seen killings and violence along ethnic and regional lines re-erupting in a civil war from 1993. Although peace agreements with diverse rebel groups were signed, violence continues to this date. In Sri Lanka, the Liberation Tigers of Tamil Eelam (LTTE) launched an armed struggle for a Tamil Homeland in 1983, due to perceived discrimination by the Sinhalese Government. Central Sulawesi, Indonesia, has seen violence between Muslim and Protestant populations, rooted in wider economic and political shifts, since 1998. Since 1996, the Communist Party of Nepal (Maoist), based on Maoist principles of agrarian and egalitarian revolution, began an armed struggle against government security forces further worsening the country's socio-economic and political situation. Sudan has seen 36 years of inter and intra tribal regional conflicts and civil war between the Islamist Central Government (consisting of Northern Sudanese elites) and the South of the country represented by the Sudan People Liberation Movement/Army (SPLM/A), caused by competition over meagre resources and power-positions.

Chapters

The chapters in this dissertation are structured according to the layers of the care package and the evaluation of the care package. It moves from the problem statement and rationale (chapters 2 and 3), the care package as a service delivery framework (chapter 4), the research related to the separate components of the package (chapters 5-10) and finally the evaluation of, and recommendations related to, the care package as a whole (chapters 11-12).

Chapter 2 presents a systematic review of the literature on the psychosocial and mental health care practices for children in war-affected low-, and middle-income countries. It includes a meta-analysis on the levels of evidence for treatment. This study was conducted to complement available reviews that were less systematic and not specific to children in war zones (Kalsma-Van Lith, 2007; Morris, van Ommeren, Belfer, Saxena, & Saraceno, 2007; Patel et al., 2007). Chapter 3 presents a study into the mental health status of former child soldiers, compared to non-recruited children, as an example of the psychosocial and mental health needs of specific and general child populations in violence-affected settings. Chapter 4 describes the care package around which the dissertation is centred. The different components and their rationale are discussed as well as examples of context-specific ways of implementation or adaptations. Chapters 5 and 6 address the paucity of validated instruments that have been developed in low-income settings (Miller et al., 2006) and present two validation studies on a screening instrument that was developed as part of the described program, to facilitate detection of children with elevated psychosocial distress for a classroom-based intervention. Chapter 5 describes the development, concurrent- and construct validation of the Child Psychosocial Distress Screener in Burundi. Chapter 6 describes the cross-cultural

construct validation of the screener. Chapter 7 presents an evaluation study of a school-based psychosocial group intervention. Within the multi-layered care package this intervention was conceptualized as a second layer intervention to cater for children with elevated psychosocial distress (subsequent to the primary screening process as discussed in chapters 5 and 6). A cluster randomized controlled trial was employed to evaluate the classroom-based intervention. The study was a parallel to a similar study in Indonesia (Tol et al., 2008). The next three chapters discuss the application of psychosocial counseling within the program. Within the care package, and in the absence of trained mental health professionals, individual or group counseling was offered to children with more severe mental health problems referred for follow-up care after or during the school-based group intervention discussed in chapter 7. A crucial component to realize this was to emphasize long-term and skills-based capacity building trajectories (Jordans, Tol, Sharma, & van Ommeren, 2003). Chapter 8 discusses a qualitative study on the direct and indirect beneficiaries' perspectives on counseling. Chapter 9 presents a conceptual overview of the cultural challenges of counseling within the Nepal context. Adaptations of interventions to the cultural context have been advocated in the literature (de Jong, 2002; Miller, Kulkarni, & Kushner, 2006), but are not necessarily the norm in practice. Chapter 10 presents a study that aimed to increase conceptual understanding of the key working mechanisms and treatment processes of counseling in Burundi through a single case design. The epilogue (chapter 11) reflects on the development of mental health and psychosocial support for war-affected children by posing a set of policy and practice recommendations for future replication and progress.

I hope that the dissertation contributes to a research-informed and evidence-supported care delivery framework, with replicable tools and modalities, for psychosocial and mental health care for children in LAMIC, especially after experiencing structural violence.

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