Mental health in war-affected populations
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Citation for published version (APA):
Scholte, W. F. (2013). Mental health in war-affected populations
Chapter 3

A protocol for psychosocial intervention in refugee crisis; early experiences in Rwandan refugee camps

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Chapter 3

3. A protocol for psychosocial intervention in refugee crisis; early experiences in Rwandan refugee camps

Abstract
This paper describes the conceptual framework and application of a working model (EPSoCare) for psychosocial intervention for refugees living in camps in low-income countries. The intervention’s main objective is social reintegration of individuals with psychosocial problems. The model was applied in pilot programs in camps with survivors of the 1994 genocide in Rwanda. The interventions aimed to cover 360,000 refugees in camps in Tanzania, and 230,000 in a camp in Zaire. The pilot programs were heavily impacted by the prevalent insecurity in the camps and the atmosphere of mistrust resulting from it, as well as by the insufficiency of social services. The development of psychoeducation material took more time than expected. Medical staff was not very willing to be trained in psychosocial concepts. The course of the programs showed the need for protocols with a well-defined target group and support offer, and a clear-cut working plan.

Introduction
Until the 1990s, it was widely believed that a stabilized situation was a precondition for a successful psychosocial care program for refugees. After the multitude of psychosocial projects in Kosovo in 2000, the provision of psychosocial care during the emergency phase of a refugee crisis seems to be generally accepted. There is great variety in the historical, political, social and cultural contexts of refugee crises, and refugees’ psychosocial needs cannot be addressed adequately without tailoring interventions to these contexts. Factors such as the populations’ prior cohesion or the recipient country’s attitude towards an influx of refugees may play a determining role in what is needed and feasible. It is impossible, however, to foresee the contexts of future refugee crises. Much of the essential information, such as the composition and actual location of a stricken population, can only be gathered once a crisis takes place. Therefore, ready-made protocols are running the risk of being inadequate. Besides, the help provided by different aid organizations under the heading of “psychosocial” is diverse. It has become the subject of considerable debate surrounding its (cultural) adequacy and effectiveness, without any recourse to data evaluation studies.1-5 Clear definitions and protocols will increase the pace of implementation, and establish structured management and improved accountability of
intervention programs. In pursuit of guidelines with built-in procedures to adjust interventions to various contexts and circumstances, the Dutch section of Doctors Without Borders (Médecins Sans Frontières, MSF) developed an intervention model directed specifically to psychosocial assistance in the acute phase of a humanitarian crisis. The intervention model, called Emergency Psychosocial Care (EPSoCare), was designed in 1994 on the basis of previous programs and a number of exploratory missions in disaster areas and/or refugee situations (Uganda 1992, Sudanese refugees 1993, Burundi refugees 1993, India 1993).

It was first applied in the aftermath of the Rwandan genocide. In 1994 an unprecedented explosion of violence occurred in Rwanda and an estimated 800,000 people died within a few months. A large outflow of refugees occurred and refugee camps were consequently established. As part of the emergency response, MSF carried out psychosocial intervention programs in two locations.

In this paper we will address the conceptual framework underlying the EPSoCare model, the model’s first applications, the problems encountered while applying the model, and the lessons we learned.

**EPSoCare’s conceptual framework**

The model is aiming to provide support for people with psychosocial problems. The term “psychosocial problems” here refers to either psychological problems arising from a disturbed social situation (e.g., depression resulting from social isolation), or social problems stemming from mental disorder (e.g., violent conduct resulting from emotional hyper arousal). Following the EPSoCare intervention model, the support provided is primarily directed towards the individual’s social reintegration. It is not so much psychotherapeutic in nature, but rather focuses on the reinforcement of social relations, networks and institutions which enable people to find support from each other: the community’s own support capacity.

Two characteristics of the intervention model are essential. Firstly, the intervention should be embedded in a comprehensive relief program. It presumes cooperation with other aid programs to ensure the provision of basic needs such as food, water, shelter and sanitation, as well as possibilities for referral to social assistance and practical care facilities. Secondly, the intervention should aim to improve existing mutual support mechanisms in the target group, since these may not only allow members of the community to come to terms with shock experiences, but also facilitate rehabilitation of the community as such. Although the effects of shocking experiences have a certain universality,
important culture-specific differences exist in interpreting and coming to terms with trauma.\textsuperscript{10-15}

Therefore, anthropological knowledge of the community concerned is essential. Social norms, beliefs, customs and coping styles prevailing within the community must be identified. The supporting potential of social circles, such as may be formed by religious, professional, tribal or familiar relatedness, must be valued and mobilized. Because of their knowledge of, and participation in the refugee community, members of the community itself are the designated implementers of the intervention.

Different phases in a refugee crisis determine different needs and consequently different types of program activities (see summary chart). In most refugee crises, the first days to weeks of unpredicted refugee influx are characterized by chaos. Physical survival, basic needs and acute medical aid constitute priorities. In this phase the program’s coordinators (at least two professionals with clinical psychological and anthropological expertise) are already at the spot. An anthropological assessment will help identify key informants among the population, which will in turn lead to the recruitment of a first small team of refugees. These will be instructed to find those refugees for whom, as a result of emotional and physical exhaustion, the threat of total collapse is most acute. A very basic one-day training will allow the team to refer these people to relevant and available resources in the camp. In this phase, the intervention is thus solely aimed at ensuring that material and physical help are made available for those who are not able to come and collect it themselves. Here, the target group consists of manifestly confused, bewildered, apathetic or withdrawn persons; those who have mental problems but are capable to take care of their most basic needs should be identified later.

A next phase (the first months following phase I) may show growing coordination of emergency aid, while social structures among the refugee population have not yet stabilized. Most families are still busy gaining and maintaining control over an uncertain and unpredictable situation and over their own functioning. An emotion-focused therapeutic approach, especially single-session techniques or unsystematic therapy, could have an undermining effect at this stage.\textsuperscript{16,17} Debriefing or any psychotherapeutic activity requires thorough and prolonged training and supervision. The intervention’s main focus in this phase is on strengthening existing coping mechanisms, combating social isolation, and further reassurance and normalization by systematically providing information on common stress reactions which may be experienced without an understanding of their origin. The goal is to facilitate the reconstruction of these basic coping
mechanisms and social structures that were devastated by the crisis. The team now consists of two to three expatriate specialists and five to fifteen refugees, who have been identified as eligible through key informants among the refugees and local CV-files of the United Nations High Commissioner for Refugees (UNHCR, the United Nations’ refugee organization responsible for the coordination of the aid to refugees). In an interactive and ongoing process the team gathers culture-specific and situation-based relevant information. The team internally discusses the relevance and applicability of basic psychological and psychopathological reactions, and sets out the details of the program. It designs and implements a short training course for those who are most in touch with the community: community leaders (e.g., teachers, religious leaders) and community workers (social workers employed by humanitarian agencies).

The course focuses on the recognition of psychosocial problems, and the application of an intervention directed at reintegration of the individual into his/her social context. Main elements of this intervention are to raise awareness of, and provide information on psychological issues; to give behavioral advice to individuals as well as the people around them (e.g., the advice not to withdraw but to share time together, to seek or provide emotional support, distraction or practical help, or to fulfil certain activities or pursuits); to guide people to related community members who could provide support (relatives, neighbors, fellow-believers, etc.); to refer people to health or community services where necessary (e.g., in case of physical disease or obvious material needs). The help offered is thus very much in line with existing social patterns and prevailing coping mechanisms.

At the same time the team translates information, gathered from the start of the program, into a psychoeducation campaign. Psychoeducational materials will contain culture-relevant information, i.e. they will avoid using concepts and words that may lead to misunderstanding, and mention those expressions of distress and coping mechanisms that are known to the population. The campaign is directed at the community at large, to raise awareness of the mental health issue, to provide information on common stress reactions and how to discriminate these (continuity, duration) from pathology, and to indicate ways to provide and receive emotional support. All available and adequate communication tools are utilized, such as brochures/newspapers, group discussions, theatre, and radio.

A later, third phase can be spoken of when the community shows some stability of structure and order. Problems and/or symptoms, however, may persist in spite of the social surrounding’s support capacity. Interventions now aim to provide emotional support through communal therapeutic activities. The individual or
family concerned is offered admittance to culturally adequate and applicable therapeutic group activities, prepared by the team in the second phase during an interactive process as described above. The therapeutic groups are composed of members who show a natural cohesion, such as women, children, elderly, neighbors, or religious groups. Depending on the nature of the activities, groups can contain up to some thirty people. Activities can vary from crafts or artistic skills to rituals or verbal exchange, depending on what is commonly practiced by the population as an activity providing emotional outlet or healing.

A final step in the program is to decide whether, after about half a year’s presence, it is to be closed down or whether the activities need to be continued in a different set-up. Criteria to base this decision on should be formulated per context, at the start of the intervention.

The model’s first applications
The first program that was based on the model was run in Tanzania, around the village of Ngara, in a group of four refugee camps with a combined population of 360,000. The second program was run in the former Zaire, in the Katale camp that provided shelter for 230,000 refugees. This camp was formed after hundreds of thousands of Rwandans flooded into the town of Goma within days, many of whom died from cholera shortly after arrival.

The psychosocial programs ran for 18 months in the Ngara camps (starting June 1994) and for 12 months in Katale (starting October 1994), where it was integrated into the MSF emergency program after this had been running for 5 months. In both locations teams composed of expatriates (an anthropologist, a psychologist and a psychiatric nurse) and refugees implemented the programs in what turned out to be quite different settings.

The Ngara camps. An anthropologist was present from the moment the first camp was established. Principal tasks were the integration of the psychosocial element into the MSF program, monitoring the creation of social structures within the camp community and, via personal contacts with the refugees, establishing teams in each of the four camps covered by the program. The teams together contained an average of 25 members through the course of the program. Clear explanation of the objectives of the program resulted in good cooperation with other aid agencies not primarily providing psychosocial care, whose community workers were eventually trained by the program’s teams. Within 1 year, 2250 community workers were trained in the identification of possible clients and in mobilizing support. Ultimately, and despite initial resistance, it was possible to train all medical facility personnel in the identification of psychosocial problems.
Psychoeducation was carried out for the greater part through mass distribution of brochures. The team estimated that half of the camp population was literate, which they believed would guarantee at least one individual in each tent or hut being able to read the brochure. A total of 75,000 brochures were distributed, providing information about stress, normal and pathological stress reactions, possible ways to help each other, and how to access the additional help available in the EPSoCare program.

The expatriate teams decided not to impose any clinical (perhaps culturally inadequate) standards on the refugee teams members. The population itself made the ultimate selection; whoever registered for the program, or was referred by his/her relatives, neighbors or community workers, was in principle offered help through the program. The majority of people appeared to present with symptoms that in DSM-IV terms, would would be categorized as PTSD, depression, or a dissociative disorder (American Psychiatric Association, 1994). There were also frequent calls for individual or medical care, e.g., in case of psychotic states.

In the teams’ effort to provide support, many individuals were offered long-term and frequent contact, although individual assistance was not the EPSoCare model’s preferred choice. Ultimately, the teams themselves gave support to 392 individuals, including 60 children. The total number of people reached by the program was much higher, but the large number of community workers trained by the teams made it impossible to monitor (and supervise) their supportive activities.

*Katale camp.* The camp was badly co-ordinated. Because no agencies employing community workers were present for a long time, the EPSoCare staff employed and trained a group of 18 outreach workers, who were active throughout the camp (see figure). The team also arranged training for roughly 300 health workers and, once they were present, 220 community workers.

In designing the psychoeducation campaign, the team, in contrast to Ngara, concluded that literacy would be a problem. Psychoeducation took the form of face-to-face contacts, group discussions and role play, which would provoke immediate response; there was thus less chance of misunderstandings arising, e.g., concerning terminology. It was also possible to combine educational information provision with care giving: team members were immediately confronted with individuals’ actual problems, and consequently gave advice or mobilized support.

Like in the Ngara program, and consequent to the contextual sensitivity inherent in the working model, no clinical criteria to enter the program were
set on beforehand. Clients presented with the same categories of symptoms as in Ngara.

The program’s own outreach workers ultimately helped 1343 people. They saw clients on average twice a week over a period of 5 months. The outreach workers, each of whom had a clearly defined working area within the camp, were monitored and supervised by the team. Contacts with clients were primarily supportive and informative by nature, and were regarded as essential in replacing community support that was absent in this politicized setting. At a later stage, two experimental “third phase” activities were carried out: Cooperation was established with an organized group of practicing traditional healers present in the camp, and a therapeutic activity center was installed for women and children with psychological problems that had resulted in extreme social isolation. The objective of this center was to reduce stress complaints and to increase the activity level and number of social contacts during a 4-week program. Women were involved in income-generating activities like weaving baskets and repairing clothes; activities for children included drawing, drama and singing.

Problems in applying the model

The teams encountered successes and hardship in implementing the model. Community workers were trained, outreach programs were started, medical staff was trained, psychoeducation was delivered, and last but not least: clients were identified and helped. The coverage in Katale was small, and the total coverage of the Ngara program is unknown. Different kinds of problems were encountered in the implementation phase. We will list them here in chronological appearance, and discuss their backgrounds below.

A continuous problem was the security situation, which impacted implementation of the programs, from the level of access to the target population, selection of staff and development of communication, to the identification of local support mechanisms. In combination with the time it took to develop the psychoeducation material, this delayed operationalization of the model. Referral options proved to be limited. The overall inexperience of the teams in carrying out a psychosocial support program added to the delays. Collection of data was not possible as planned. In the course of the intervention it became clear that it was extremely difficult for the teams to decide who was, and who was not to be identified as “someone with a psychosocial problem.” The pressure on the teams to accept all as individual clients impeded timely development and implementation of group interventions.
Lessons learned
The EPSoCare working model is designed for rapid psychosocial interventions. In the chaotic situation of the Ngara and Katale camps, working with the model provided at least minimal structure and logic in preparing these interventions. The essentials of the intervention could be carried out. The structured approach allowed monitoring of the implementation process from the start, and helped the teams to provide interventions within a relatively short time span—although there were severe constraints that originated from the following factors:

The socio-cultural background of the Rwandan people
The teams encountered great difficulty in identifying existing local support mechanisms. In Katale camp, practically every family had lost one or more relatives, either during the war or because of the cholera epidemic. Mourning made the struggle for survival even more difficult, and resulted in little willingness to give mutual support.

Security issues were also important here. Katale camp was dominated by well-organized Hutu militias, which hampered the establishment of alternative social structures, as the teams noticed while considering using the social structures of the scouting movement that had been very strong in Rwanda. The militias considered any organized task carried out by the scouts a threat, and scouts actually have been killed for it.

The development of psychoeducation material was more time-consuming than expected. Coming to an agreement, within the teams, on the exact wording of messages that would be appropriate for the total population was a painstaking process. Correct, meaningful translation of concepts (e.g., “being nervous”) that were new to many was an underestimated process in the model design, as literate and illiterate Rwandans would use different words for the same phenomena. Once a culturally appropriate text was agreed upon, mass distribution of brochures turned out to be an effective way to provide psychoeducation in Ngara, where the majority of the population was literate. Psychoeducation via face-to-face contacts, given by the team itself as done in Katale, is immediate, offers the possibility of further discussion, and merges information giving with support provision. Coverage, however, easily gets reduced and becomes unsystematic. In group discussions and role plays there is a risk of stigmatization or reprisal. This should be minimized by skilled guidance, protecting individuals by only demonstrating and allowing constructive comments.
While security issues are relevant in many refugee settings, there were specific elements for the Rwandan crisis. The ongoing intimidation and political activity was a continuation of a process that eroded mutual trust in Rwanda for decades. The complex pattern of disintegration of the social fabric of Rwandan society, leading to more insecurity and consequently more fragmentation, is an important factor in the origins of the genocidal killings, as much as it is a factor in blocking healing processes.

The actual situation in the camps
Within the camps, security was a problem on all levels. Victims and aggressors, political activists and neutral civilians lived side by side. Conflict continued in the camps, murders took place on a regular basis, and people were afraid to speak out. The selection of local team members was complicated by actually having to include a check on involvement in the earlier killings (which obviously could only be done by interviewing the people concerned and checking formal records). ‘Innocence’ thus became a selection criterion that sometimes preceded competence. This affected trust between the local team members. Some feared they would be seen as political activists working under the direction of western powers. The fear held by many refugees that there would be reprisals if they spoke out about the violence they had experienced further complicated the process of entering into dialogue with the community.

While the interventions’ main objective, social reintegration, presumes some cohesion and solidarity within the community, political insecurity in the camps prohibited the re-creation of communal networks. This tempted helpers to develop a strong sense of attachment with clients, resulting in an emphasis on long-term individual contacts, and possibly causing further demotivation of potential social resources. Others may have started to count on ‘outside help’ instead of taking initiative themselves.

Another important assumption in the intervention model was the availability and accessibility of social and medical services. Community workers, however, were nonexistent for a long time in one of the program locations (Katale). Final responsibility for the provision of services for refugees lies with the UNHCR, and the responsibility for social services was not taken. Consequently, there was no opportunity to refer people to such facilities.

There was resistance of medical staff to being trained in psychosocial concepts by the EPSoCare team. This was in part due to social status: medical staff did not want to be trained by refugee team members who were not medical doctors. Another aspect was the fear of medical staff, feeling heavily overburdened, that
psychosocial and mental health awareness would rather add to their workload than lessen it. It took much longer than expected to address this vicious cycle. It was finally recognized on clinical grounds, and later quantified by means of systematic research, that one third of those attending the field-clinics were seeking help for complaints that indicated somatized psychosocial problems.\(^1^9,2^0\) This helped to convince the staff that there was a need for awareness. The inexperience of the general MSF team, where doubt existed initially about whether an early psychosocial intervention was both helpful and feasible, was one factor in the delay of relevant training. This absence of experience slowed down both the start and the general course of the program. There was at the time no pool of qualified candidates to implement the project, and a lack of existing material on which to build training curricula. In view of the growing demand for an evidence base for humanitarian interventions,\(^2^1\) the pilot EPSoCare projects sought to monitor the efforts made. In humanitarian crises, organizational reasons as well as ethical considerations constrain methodology for research. The first difficulty was in establishing a functional information system to monitor clients and activities of the outreach workers. The refugee team members were not able to systematically collect data. In spite of continuous supervision, documenting contacts with clients proved to be too problematic for local staff. They had technical difficulties in systematically recording and coding data (e.g., demographics, symptomatology, action taken, outcome), but, more importantly, also found it difficult to apply these systematics in their emotional role of care-provider. Security prevented others to actually get the job done, as data recording had a threatening effect on the refugees in a situation where death-lists had been used. Monitoring the achievements of the large number of trained community and health workers turned out to be a practical impossibility, which impeded quality control and evaluation of the program. At the time, we also considered it as ethically unacceptable to identify, assess and follow-up individuals in psychological need to act as a control group for the sake of a randomized controlled trial. Next to that, tension in the camps did not allow for taking unbiased and safe interviews in sites were the teams had no contacts yet and no interventions were scheduled. There were insufficient resources and time to explore alternatives, such as comparing the effect of different interventions. At both locations, the involvement of MSF in the psychosocial interventions ended abruptly. As a result of the politicizing of the camps and the misuse of relief supplies, MSF withdrew all its programs as soon as it became apparent that
there was no further reason to speak of a medical emergency. The psychosocial programs had to be handed over rapidly to another international agency that decided to stay, before third phase interventions could be completely implemented.

*The conceptual model*

A major shortcoming of the model was that it offered no precise definition of the nature of solutions that would be pursued in case of psychosocial problems. It was assumed that trained outreach workers would try to re-establish contact between clients and resources for social support in the camp, but this turned out not sufficiently to be the case. The model did not provide guidance in dealing with the exceptional complexity and fragmentation of the social fabric in the camps. The community and group interventions we had expected to develop in the course of the project materialized very slowly, leaving the emphasis of the work on general psychoeducation and individual support. Practical engagements in groups can be therapeutically effective, even if, for cultural or security reasons, participants may not be very open-hearted. We observed that the activity center in Katale enabled gradual and careful mutual exploration, thereby enhancing mutual support. Therapeutic group approaches probably could have been set up earlier. Focusing on social reintegration and using therapeutic approaches, though separately mentioned in different phases of the EPSoCare working model, cannot be strictly separated in practice.

Also, a clear definition of what would constitute a client for the programs was not available. The current debate on the adequacy of psychosocial interventions in humanitarian crises comes down to the question if one can clearly define which individuals need help from outside, why and how (are we imposing western/medical standards and practices?), and whether screening and outcome instruments are available with proven validity in the specific linguistic group and culture.\(^1,4,5\) The level of mental health problems (defined as justifying a support offer) among the refugees was estimated as extremely high.\(^22\) The most important criterion according to the model was the level of self-sufficiency of families or individuals. But while in any situation it would have been difficult to stick to a definition of self-sufficiency, the conditions in the camps made it hard to refuse any requests for help. The emphasis was on the community’s demand, rather than on staff’s assessment: active case-finding was done through the population itself. Individuals with psychosocial problems were indicated to the outreach/community workers by their own social surroundings (this, admittedly, carries the risk of bias of all kinds). Consequently, the teams felt no need for a screening
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instrument. Besides that, no screening or outcome instruments with proven validity in this specific linguistic group and culture were available, and time was too short for their development on the spot.
The EPSoCare model did not provide a sufficient answer to the frequent calls for individual, medical care. For psychiatric cases, a psychosocial approach wasn’t always the most adequate response, while at the same time ‘de-medicalizing’ psychosocial problems was one of the model's objectives.

**Conclusion**

There is a need for ready-made work plans for rapid post-war psychosocial interventions, which are appropriate to different circumstances and cultures. In protocols, it should be clearly defined which people will be considered for support by the program, and how these individuals will be found in the community or selected from those seeking help.

Interventions should contain an operational research component to improve our knowledge of psychological morbidity in emergencies, and to be able to demonstrate the validity and effectiveness of methods. The methodological problems met in the pilot interventions described here were not inherent to this particular refugee crisis. In any humanitarian emergency intervention, the formation of control groups, case definition, cultural validation of instruments and systematic data collection will be extremely complicated.

In the EPSoCare model, the idea is to limit interventions to social reintegration in the first phases, while later on therapeutic approaches can be provided for those who need more individual help. The attempt to “de-individualize” psychosocial problems would have benefitted from earlier involvement of medical staff—who could have referred individuals to groups, while outreach workers could have referred some of their case load to health staff. Also, obvious psychiatric symptoms need to be addressed primarily at a medical level.

As for the security situation, the vicious cycle of violence, lack of trust, and eroding mutual support leading to more violence, was clearly a serious obstacle in the programs’ implementation. In itself this is by no means an argument to “wait for security,” but rather an argument to focus interventions in general on ongoing insecurity. A condition for future psychosocial interventions is that the international community present guarantees a minimal level of security.
References


# Summary chart of EPSoCare intervention model

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<th>Characteristics</th>
<th>Objectives</th>
<th>Activities</th>
<th>Time plan</th>
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| **First Phase** | Influx of refugees in area/camp  
Mental shock  
Arrival of first emergency aid | Connect the most debilitated individuals to the emergency aid | Expatriates  
Identify first refugee staff, provide one-day training and supervision  
Refugee Staff  
Identify the most emotionally/physically debilitated individuals, connect these to food/water distribution, material and health care | Within days |
| **Second Phase** | Lack of social structures, chaotic living circumstances  
Struggle for life  
Growing co-ordination of emergency aid | Installation of community based psychosocial support system, aiming at social reintegration | Expatriates  
* Anthropological assessment  
* Recruit refugee staff and outreach workers  
* Train and supervise refugee staff  
* Connect with other agencies  
* Prepare therapeutic interventions (with refugee staff)  
* General co-ordination and monitoring  
Refugee staff  
* Train and supervise outreach workers  
* Train community leaders/workers and medical personnel  
* Install referral system from/to medical facilities and community services  
* Prepare and carry out psycho-education campaign  
* Prepare therapeutic interventions  
Outreach workers (included after the experience in Katale camp)  
* Identify problem cases and provide/mobilize support aiming at social reintegration  
* Provide consultation to community leaders/workers and medical personnel | Within 1-2 months |
| **Third Phase** | Recognizable living patterns and social structures  
Basic security  
Available basic material resources | Consolidation of support system  
Application of therapeutic group interventions  
Preparation for closing or handing over program | Expatriates  
* Continue coordination, training, supervision and monitoring  
* Prepare close down or hand-over of program  
Refugee staff  
* Continue training and supervision  
* Apply therapeutic interventions for groups  
Outreach workers  
* Continue provision of support and consultation | Within 5-6 months |