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Article

Planting seed for developing community mental health services nationwide: A community-based mental health demonstration project during the armed conflict in Croatia

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250,000 people were displaced within Croatia as a result of the armed conflict in the period from 1991-1995. This also created an additional burden on the Croatian mental health system. The openings of many community-based mental health and psychosocial programs suppported by the international community in Croatia at that time created an oppportunity to further development of Croatian community mental health services. This paper describes the „Center for Attitudinal Healing“ (CAH) mental health / psychosocial program with the overall objective to plant a seed for the development of community mental health services in Croatia. Specific objectives of the program were: (1) to support people in their emotional recovery from catastrophic events; (2) to train and manage a large cadre of volunteers in mental health / psychosocial support skills, and (3) to provide workshops, trainings and peer-support groups focused on mental health / psychosocial issues. Both qualitative and quantitative data collection methods were used for the purpose of program evaluation. Qualitative data collection methods included open-ended semi structured in-depth interviews, structured focus groups, and unstructured participant observation performed by the external evaluator. Quantitative data collection method included a survey of program beneficiaries.The results showed that the program was successful in promoting peer-support approach and improving mental health /psychosocial wellbeing of beneficiaries in three targeted areas in Croatia. It was not successful in planting seed for the development of community mental health services nationwide because of poor linkages with the Croatian government health sector and lack of financial sustainabilty.

Key words: psychosocial, mental health, community, conflict, internally displaced people,refugees,Croatia.

INTRODUCTION

According to the Inter-Agency Standing Committee Guidelines (2007), the psychological and social impacts of disasters can undermine the long term mental health and psychosocial well-being of the affected population.According to the World Health Organization (2005), about 30 - 50% disaster-affected people develop signs of either moderate or severe psychological distress. At the same time, rates of mild and moderate common mental disorders (mood and anxiety disorders) are expected to increase by about 5 - 10%, and the rate of severe mental disorders may be expected to go up by 1 - 2%.

One of the priorities in man-made and/or natural disasters is thus to improve people's mental health and psychosocial well-being. Both mental health and pychosocial programming in disaster settings include a wide range of interventions with objectives to help regain and develop resilience capacity for individuals and communities thereby also preventing development of

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more severe mental problems (Galappatti, 2003; IASC, 2007; Ntakarutimana, 2008), enable conflict-affected populations to achieve an adequate level of well-being (Galappatti, 2003; Williamson and Robinson, 2006; Ager, 2008) and restore social ties and cultural values (International Federation Reference Centre for Psychosocial Support, 2009). Psychosocial support empowers individuals and their communities to tackle emotional reactions to critical events (International Federation Reference Centre for Psychosocial Support, 2009). Fostering resilience,coping and recovery through facilitating natural support neworks is among the key aspects of early mental health / psychosocial intervention in disaster settings (National Institute for Mental Health, 2002). Different mental health / psychosocial group interventions were implemented for various groups of beneficiaries in many disaster settings worldwide, and they were both described and evaluated in the published literature (Pecnik, 1997; Ispanovic-Radojkovic, 2003; De Berry, 2004; Uitterhaegen, 2005; Ley, 2006; Berliner et al., 2006; Ntakarutimana, 2008; Richters et al., 2008; International Federation Reference Centre for Psychosocial Support, 2009).

The long term impact of conflict on mental health of affected populations also necessitates the establishment of a comprehensive mental health service that can competently address the psychological problems experienced by the community (Byaruganga et al., 2008). Man-made and/or natural disasters can even be a vehicle for major development programs and the political impact of damage and disruption can be a real catalyst for wide ranging health and social system changes (Macrae, 2002; Stephenson and Dufrane, 2005). According to Saraceno et al. (2007), professional understanding of effects of disasters, paired with post-emergency mental health interest, can also provide enormous opportunities for mental health system development.

Mental health needs and services in Croatia

Although mental health services in Croatia were declarativelly oriented towards the development of community mental health services even before the 1991 - 1995 civil war, most of the mental health services before the war were provided in the psychiatric departments of general hospitals and specialized psychiatric hospitals. Reduction in number of psychiatric beds started with the beginning of war in Croatia in 1991. Three hospitals with psychiatric beds were closed at that time in war-affected areas, but it was only due to the military operations (Jukic, 2006). For comparison purposes, both the United States and United Kingdom have been reducing psychiatric inpatient facilities over the last four decades, favoring instead non-institutional alternatives (Raftery, 1992).

According to the Internal Displacement Monitoring Centre (2009), 250,000 people were displaced within Croatia as a result of the armed conflict in the period from 1991 - 1995. This created an additional burden on the Croatian mental health system, because of the increase in distress, common and severe mental disorders present among the disaster-affected population (World Health Organization, 2005). During the war (1991 - 1995), the international community assisted war-affected population in Croatia also with many mental health / psychosocial programs and activities implemented by different international and local non-governmental organizations (NGOs) (Zic, 1997). The openings of many community-based mental health and psychosocial programs for internally displaced Croatian population and later refugees from Bosnia, created an oppportunity to further develop community based mental health services in Croatia. Never before were there so many mental health programs in a war-stricken area (Mooren et al., 2003). According to Mimica and Agger (1997), only European Community Humanitarian Office (ECHO) has funded more than 25 European Union NGOs providing psychosocial support. The Center for Attitudinal Healing's (CAH) Croatia project was a program designed to establish a mental health organization in the Croatian capital Zagreb, and from that Zagreb-based organization create a network of mental health / psychosocial services throughout Croatia. The overall goal of the project was to support war affected population in their emotional recovery, and at the same time establish a community-based mental health organization which could serve as a model for the further development of Croatian community mental health services.

METHODS

Setting and participants

CAH program was conducted in three catchment areas in Croatia (Figure 1), with the estimated host population of 1,400,000 people (Republic of Croatia, Central Bureau of Statistics, 2009). The majority of internally displaced people (IDPs) and later refugee population in Croatia resided in these areas.The program was one of the first eight NGOs projects supported by the United States Agency for International Development (USAID) to provide services for IDP/refugee and host population in Croatia. It started on a volunteer basis in 1993, and continued its activities as the USAID-supported program in the period from 1994 - 1996. The main CAH Center was established in the Croatian capital Zagreb at the beginning of 1995, and outreach activities to two other catchment areas (Rijeka and Osijek) started later in the same year. The whole program was done in a close collaboration with the CAH Center in California. The staff from the CAH California Center offered technical suppport to the CAH program in Croatia from the beginning to the end of the program.The multi-disciplinary local team which consisted of Lawyer (Director of the Centre), Psychiatrist (Director of Volunteer Program), Clinical Psychologist (Program Director) and Social worker (Finance and Administration) were selected as permanent staff at the start of the program.Their professional qualifications and commitment to develop the CAH Center and its programs in Croatia were the main criteria for their selection. Recruitment of program volunteers began in 1995, and continued throughout the program period. The enthusiasm and

Figure 1. Photo of Croatia with highlighted catchment areas.

commitment to suppport the Center were main criteria for their selection. 10 volunteers formed a core group of Centre's volunteers, and 40 volunteers were occasionally engaged in CAH activities during the whole programming period. 75% of permanent staff and 90% of volunteers were women. The beneficiaries of CAH programs included host and IDP/refugee population in three Croatian municialities, Zagreb, Rijeka ad Osijek.

The number of direct beneficiaries during the two-year project period was estimated at 1,500 people. The majority of direct beneficiaries were Croats (host population and IDPs) between 27 and 69 years of age. More than 90% beneficiaries were women.

Intervention

The overall objective of the CAH program was to serve as a national community mental health demonstration project, thereby planting seed for far-reaching changes in the existing mental health services in Croatia. The specific objectives were to: (1) support people in their emotional recovery from catastrophic events, including but not limited to the war, (2) train and manage a large cadre of volunteers, both lay and professional, in mental health / psychosocial support skills, and (3) provide workshops, trainings and peer-support groups focused on mental health / psychosocial issues.

Design of CAH program

The whole CAH program was designed as a series of six trainings and workshops, each of them with the specific learning objective and content (Table 1). A continuous program of organized peer-support groups was concurrently delivered to program's beneficiaries.

The duration of trainings and workshops varied between two days (Facilitator training part I and II, Level I and II workshops, Home and Hospital Visitors' training), to once-a-week two-hour training sessions for six weeks (Volunteer training). All trainings and workshops were delivered in the capitals of targeted catchment areas (municipalities), Zagreb, Rijeka and Osijek. The manuals for delivered trainings and workshops originated from the CAH in California, and were translated from English to Croatian language by the local CAH staff.

Trainings and workshops were facilitated by the international staff from the CAH in California, with the support of the local CAH staff and volunteers. Peer-suppport groups were facilitated by the local CAH staff and volunteers in all three catchment areas. Separate peer support groups were held for adults (person to person groups, group for Bosnian refugees), school children and children in the hospital. Person- to- person peer support groups in Zagreb were held weekly in the CAH centre, and peer support groups for Bosnian refugees were held bi-monthly at the same location. Peer-support groups for school children and children in hospital were held bi-monthly in one local school and children hospital in Zagreb. Peer support groups in Rijeka were held bi-monthly in five Centres for Social Work in Rijeka, and also in the hotels inhabited by Croatian IDPs in the small coastal town of Opatija. Peer support groups in Osijek were held bi-monthly in the premises of the local NGO named „Center for Peace and Nonviolence“. Participatory approaches and formal lecturing were used in both trainings and workshops. Role plays, dyads and small groups were most often used participatory learning methods.

Program evaluation

Both qualitative and quantitative data collection methods were used for the purpose of program evaluation. Qualitative data collection methods included structured focus groups with program beneficiaries performed by the local CAH staff, and unstructured observation of program's activities and semi-structured in-depth interviews with program beneficiaries, performed by the external USAID evaluator. A survey of beneficiaries was used as a quantitative data collection method. All evaluation was done on a convenient sample of program's participants after one year of the program. The topic guide for focus groups included questions on usefuleness of and satisfaction with the program, and eventual suggestions on program improvement. Altogether, four focus

Table 1. Titles, learning objectives and content of CAH trainings / workshops.

No.	Title of the training / workshop	Learning objective	Content
1.	Volunteer training	To become familiar with the activities of and volunteer opportunities at the CAH center	General about volunteer opportunities and volunteer training, CAH principles and methods, Peer-support groups, Principles of helping and serving communities, Communication skills, Loss and Grief, Forgiveness
2.	Facilitator training part I and II	To learn how to facilitate peer-support groups	Characteristics of a group facilitator, Peer-support group model, Principles of group facilitation
3.	Level I and II workshop	To become more familiar with the philosophy, principles and practice of Attitudinal Healing	Philosophy and history of AH method, Emphatic listening, Loss and Grief, Forgiveness
4.	Home and Hospital Visitors' training	To learn skills specific for home and hospital visits	General instructions for home and hospital visitors, Home visiting program, Hospital visiting program, How to take care of yourself, Skills for home and hospital visiting programs

groups were conducted; two in Zagreb and one in Rijeka and Osijek. Group size for focus group discussions varied with a minimum of six to a maximum of 15 people in each group. A majority of the participants were host Croatian women with the mean age of 42. Unstructured observation of program's activities (peer support group and training) was done in the CAH Center in Zagreb, and in-depth interviews with program's beneficiaries were held with three IDPs in Rijeka and Opatija.The interview topic guide included questions on the effectiveness and determinants of effectiveness of peer-support approach. Voluntary participation, anonimity and confidentiality were ensured during the interviews. A survey of peer-support group participants on the eventual improvement of their wellbeing as a result of the program was used as a quantitative data collection method. The survey was conducted with 39 participants who participated in four peer-support groups for at least six months; two groups in Zagreb, and one in Rijeka and Osijek. The participants completed 12-item questionnaire created by the CAH Program Coordinator. The face validity of the questionnaire was determined by three other members of the local CAH staff who were also affected by the war situation in Croatia. All answers were recorded on a five-level Likert scale. The Likert scale used following statements: Much worse (1), worse (2), same as before (3), improved (4) and much improved (5).

RESULTS

Qualitative data analysis

Formal analysis of interview and focus group data began after the transcription process was completed. The data were analyzed thematically, that is, common issues and ideas were identified and summarized into the categories discussed below.

Usefuleness and effectiveness of the program

The majority of beneficiaries metioned that the program was helping them in dealing with their personal fears. Lots of participants in peer-support groups said that the participation in groups helped them find common ground with others, instead of insisting on people's differences. Great majority of group participants considered peer-support groups as safe places where they could discuss their emotions. Many beneficiaries mentioned that the whole program was effective in helping them develop positive coping skills and offering them a constructive way on how to deal with personal fears and war destruction.Communication exercises in dyads and small groups, sharing of emotions in peer-support groups and relaxation techniques were most preferred by the beneficiaries. Most of the participants mentioned sincere atmosphere in peer-support groups and sharing of emotions as major determinants of effectiveness of peer-support approach.

Satisfaction with the program

Most benefiaries were satisfied with the organization of peer-support groups. Great majority of peer-support group participants were satisfied with the concept of peer-support. Some of them mentioned transportation problems to and from the venue. Most of the participants were satisfied with the trainings and workshops although some of them mentioned confusion regarding their role in the program after training completion

Suggestions for program's improvement

Some IDPs mentioned they would be willing to get more involved in the program if program staff takes more responsibility of all the logistical issues (finding a place, covering transportation costs). Some of the Bosnian

Table 2. The anaysis of survey of 39 participants in four peer-support groups.

No.	Item	Average score on a Likert scale(from 1 to 5)
1.	Ability to cope with difficulties in life	3.6
2.	Anger management	3.6
3.	Overall self-confidence	3.5
4.	Communication skills	3.8
5.	Decision making	3.6
6.	Helping skills	4.1
7.	Family relations	3.7
8.	Social relations	3.9
9.	Satisfaction with life in general	4.2
10.	Positive changes	4.3
11.	Ability to make plans for the future	4.0
12.	Feeling of self-respect	3.9

refugees thought they should be more involved in the organization of the program in order to improve it. Some volunteers expressed lack of confidence in facilitating peer-support groups after completion of all trainings and workshops. They thought they needed more encouragement from program's staff to improve their role as group facilitators. Lack of gender balance in peer support groups was mentioned by some participants as an issue which needed improvement. The formation of sewing classes and expanded delivery of mental health services beyond the funding period were identified by CAH volun-teers and some of the program' beneficiaries as possible areas of program's improvement in a future.

Observation of program's activities

CAH volunteer training and peer support groups were observed by the USAID external evaluator to identify major achievements and constraints of the program. All of the program's beneficiaries agreed to participate.A rapid expansion of the program as a result of publicity and word-of-mouth endorsements from peer group participants was considered as a major program's achievement. Peer support approach started to be publicly recognized in Croatia, not just as helping war-affected population, but also as helping people with specific mental health problems, for example depression, post-traumatic stress disorder, schizophrenia and anxiety. A shortage of male participants in peer-support groups and distrubution of only ceremonial, and not official certificates, after completion of workshops and trainings were considered as important program's cons-traints.Trained facilitators were seen in need of more en-couragement to start their own peer-support groups.More attention to the formative and outcome evaluation of program's goal and specific objectives was suggested.

Quantitative data analysis

The results of the survey showed that peer-support group participants felt they have made progress in all the areas questioned-in the range between improved and much improved. The highest average scores were in the areas of feeling positive changes, satisfaction with life in general, helping skills and ability to make plans for the future. The lowest average scores were in the areas of overall self confidence, ability to cope with difficulties in life, anger management and decision making. The analysis of the conducted survey of program's bene-ficiaries is presented in Table 2.

DISCUSSION

This study adds to the evidence base on mental health / psychosocial interventions in disaster settings. There is a little question that emotional distress and psychological problems can be directly related to being a survivor of violence and displacement (Marsella et al., 1994). On the other hand, the scientific evidence regarding mental health and psychosocial support for people who are exposed to conflict and other disasters is still weak (IASC, 2007; Patel, 2007). However, evidence for mental health and psychosocial support in disaster settings is constantly emerging (International Federation Reference Centre for Psychosocial Support, 2009). CAH project served both host and IDP/refugee population in Croatia as a national mental health demonstration project for two years (1994 - 1996). However, it did not manage to fulfill its overall objective of planting a seed for the deve-lopment of community mental health services nation-wide, namely, CAH Center was not accorded a formal recognition as an official mental health unit within the Croatian mental health services.

The first pilot community mental health center which was

accorded recognition as an official mental health unit within the Croatian mental health services was established only 10 years later in January 2006 as a part of a Mental Health Project for South-Eastern Europe (SEE) initiated under the South-eastern European Stability Pact's Social Cohesion Initiative (WHO-Regional Office for Europe, 2008). Besides its operational aspect, the SEE Mental Health Project had a high political nature by using health and mental health to improve social cohesion in the whole SEE region (WHO-Regional Office for Europe, 2008). This showed the importance of politics for initiating some real changes within the national mental health system. Political will to develop mental health services after disaster was also of utmost importance in other disaster settings, for example in Sri Lanka (Saraceno et al., 2007).

CAH project was not sustained beyond the two-year USAID funding period also because of the insufficient budget of the Croatian public health sector to support the development of community mental health services in Croatia. Training and salary of staff and volunteers and organizational costs are often impossible to add to the already insufficient budgets of the public health sector in disaster-affected societies (Van de Put and Van der Veer, 2005). Only with the financial assistance of European countries, especially Greece, during the period from 2002 – 2008, some real progress towards community mental health services has been made. It resulted in changes in mental health legislation and policy, and opening of pilot community mental health center in Zagreb (WHO-Regional Office for Europe, 2008). The reality is also that services follow the dollar (Barton, 2000).

Still, CAH project was able to reach its three specific objectives. According to the outcome evaluation of the program, the majority of its beneficiaries felt supported in their emotional recovery from catastrophic events, and most of them were satisfied with the peer-support approach. The improvements as a result of CAH project were noticed in the areas of social cohesion (communication skills, family and social relation), coping skills (ability to cope with difficulties in life, anger management, helping skills, decision making, overall self-confidence, ability to make plans for the future), and reduced distress (satisfaction with life in general, positive changes). Many other similar mental health / psycho-social community-based projects described in the literature also achieved improvements in different aspects of well-being by their targeted beneficiaries. (Van de Put and Van der Veer, 2005; Uitterhagen, 2005; Ley, 2006; Ntakarutimana, 2008; International Federation Reference Centre for Psychosocial Support, 2009).

The important part of CAH project were organized peer-suppport groups for both IDPS/refugees and host population. Peer-support was also effectively implemented in other programs and settings worldwide for sexual abuse, eating disorders, anxiety, loneliness, conflict in the family and drug problems (International Federation Reference Centre for Psychosocial Support, 2009). A major project within WHO which drafted an essential health package for mental, neurological and substance abuse disorders also recommends community based group interventons, such as peer-support groups and self help groups,for depression, schizophrenia, alcohol problems, and dementia (Patel et al., 2009; Mari et al., 2009; Benegal et al,2009; Prince et al.,2009). According to The Academy of Medical Sciences (2008), the provision of community and family supports improves the mental health of significant proportion of disaster-affected population.

The CAH project provided education through trainings / workshops on mental health / psychosocial issues to IDPs / refugees, staff, volunteers and host population.Trainings and workshops were also extensivelly used to provide psychoeducation to disaster-affected populations in different settings worldwide (Uitterhagen,2005; International Federation Reference Centre for Psychosocial Support, 2009).

The CAH project managed to train a large cadre of volunteers in techniques of peer-support. Although only a smaller number of them actively participated in project activities, they were of utmost importance for smooth program implementation. The involvement of volunteers and para-professionals in mental health / psychosocial activities is certainly an important strategy in war-related distress (Kos and Huzejrovic, 2003; Senjak et al., 1997).

According to the International Federation Reference Centre for Psychosocial Support (2009), psychosocial support is typically provided to affected population with the help of trained community members.

Limitations

The major limitation of the CAH program was a lack of systematic program's evaluation. It is important to design the evaluation as the program is designed, according to formal “program evaluation” methods available from multiple sources, including USAID (LaFond and Brown, 2003). The other important limitation of CAH project was a lack of proper linkages with the Croatian national health system. Health system serves as a catalyst in the area of development of community mental health services (WHO-Regional Office for Europe, 2008). According to HealthNet TPO and London School of Hygiene and Tropical Medicine (2008), integrating mental health / psychosocial programs into the system is preferred to stand-alone programs. Although CAH project developed linkages with many different international and local stake-holders, its long-term impact and sustainability depended first of all on the linkages with the Croatian government sector, especially with the national health system. CAH project was also limited in human resources and could not provide activities as a comprehensive community mental health center (WHO-Regional Office for Europe, 2008).

Strengths

The CAH was one of the first eight NGO mental health / psychosocial projects supported by the international community in the Western Balkans. Its services were available, accessible, adaptable and appropriate for host population, IDPs and later refugees in Croatia. According to Westermayer (1991), all services for refugees should possess above mentioned qualities. CAH's strength was that it promoted a concept of peer-support in Croatia for different mental health / psychosocial problems and various groups of beneficiaries. At the same time, the CAH promoted mental, emotional, social and spiritual aspect of well-being of program's beneficiaries. According to Williamson and Robinson (2006), the most significant goal of any psychosocial intervention is to promote overall well-being of targeted population. According to Alison and Alastair (2003), humanitarian psychosocial programs in areas of armed conflict are by definition concerned to promote well-being.CAH project also provided safe space and socio-therapeutic milieu for a war-affected population in Croatia for two years, and an opportunity for further development of Croatian community mental health services. According to Barton (2000), from such programs may evolve comprehensive mental health centers.

Lessons learnt

CAH project demonstrated its acceptability, usefuleness and effectiveness as a mental health demonstration project in one war-affected country. However, it did not demonstate integration within the existing mental health system in the country, and sustainability beyond the funding period provided by the international community. Many training, pilot and demonstration mental health / psychosocial projects have been conducted in different geographic areas worldwide, but generally without plans for sustainability or scaling up (Lancet Global Mental Health Group, 2007). According to HealthNet TPO and London School of Hygiene and Tropical Medicine (2008), the main issue to keep in mind is how to make such projects more sustainable beyond funding period usually provided by international donors for some time after the disaster. Scaling up of such programs should be done in a cooperation with governments of affected countries, usually through their health and / or social welfare sectors. Similar community mental health / psychosocial projects could plant a seed for developing community mental health services after major disasters, only if properly integrated within and sustained by the appropriate sectors of governments of affected countries.

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