

Mental health care for refugees from Kosovo: the experience of Médecins Sans Frontières

Since the mass expulsion of ethnic Albanians from Kosovo began in March, 1999, the media have reported stories of the suffering of thousands of refugees who have arrived in Albania, Macedonia, and Montenegro. Witnesses recount experiences of violence, executions, and destruction. Some were forced to leave at gunpoint, while others were given just a few hours to leave their homes. Many people have lost family and friends; some were witness to their execution. Beliefs in security, the future, and the benevolence of other people are shattered.

The psychological impact of war in emergency situations is a neglected issue. We examine the need for mental health support in the emergency refugee crisis in the Balkans. The international humanitarian aid organisation Médecins Sans Frontières is conducting mental health programmes at the border-crossing points of Brazda, in Macedonia, and Kukes, in Albania, where thousands of refugees are sheltered in camps. In Tetovo district, Macedonia, many people have found refuge in the homes of local people, and there is a separate programme to provide psychosocial services for these refugees.

Lessons from Bosnia

The principles of the MSF psychosocial interventions in Kosovo are largely based on experience gained over 4 years in the former Yugoslavian republic of Bosnia-Herzegovina. Sarajevo was besieged for more than 3 years and in this urban population original networks of families and friends broke down and cultural identity was shattered. The social disintegration and the daily confrontation with violence and death contributed to high levels of chronic and acute stress. The humiliation of being controlled from outside and the dependency on a divided international community undermined the self-esteem of the inhabitants.

The core elements of the MSF mental health-care programme in Bosnia were: the establishment of accessible counselling centres; in-depth training of local counsellors and supervisors; and the provision of specific short-term interventions. The various forms of assistance provided ranged from psychological

education and media sessions to crisis intervention and brief psycho-therapeutic counselling. Between the autumn of 1994 and January, 1998, about 10 000 people were helped through this programme.



MSF team in Kukes refugee camp, April

In situations of massive destruction and human tragedy, the tendency to focus on the immediate negative effects of violence on the human psyche is understandable. However, victims of violence should not be simply reduced to patients with serious mental disorders. Both in Bosnia and now in the Balkans people have developed, and will continue to develop, coping mechanisms to replace or restore the lost protective factors offered by social networks, religion, and culture. Mental health programmes should stimulate these mechanisms of adaptation.

The concept of a "normal" coping response to extreme stress is crucial. During the emergency phase and in a situation of continuing violence, mental stresses should be regarded as normal reactions to abnormal circumstances. In Bosnia, the widespread labelling of extreme stress as pathological disturbances contributed to the stigmatisation and victimisation of those already in a vulnerable position.

Training of local staff was of vital importance. In the Balkan hospital-based and drugs-orientated health system, psychiatric care is focused only on chronic and severe cases. MSF's training of local people was interactive: experts in trauma from other countries discussed concepts with Bosnian specialists. This interaction and its implicit message of respect was important for the Bosnian staff: providing support for their own people created a wider sense of dignity and self-control and a sense of future perspective. The staff training was effective only when it was continued and followed up by

education on the job. This vital part of training is commonly neglected by aid organisations involved in psychosocial programmes.

MSF focused its interventions on the provision of emergency primary health care in community settings. Limited counselling of no more than 10–15 sessions was effective. Group interventions were preferred because of the secondary benefits of sharing and mutual support. War-related disorders, particularly depression and post-traumatic stress disorder, meant that long-term treatment was not deemed appropriate. The media was also used to disseminate psycho-education to help create an environment in which war-related emotional problems could be acknowledged. A weekly radio programme explained the notion of traumatic stress, the normality of various responses to stress, the principles of self-help and support to others, and the possibilities of professional help. The programme was listened to by two-thirds of the population.

The past year in Kosovo

In March, 1998, a crackdown on ethnic Albanian separatists in Kosovo by Serbian forces began a conflict that has killed thousands of people and left hundreds of thousands homeless. In December and January, a period of comparative stability when people had returned from the hills and found shelter, MSF carried out a mental health assessment among the internally displaced population in Kosovo. During this period, MSF used mobile clinics to meet the primary health needs of the displaced population. The mental health assessment was undertaken as a result of requests from the physicians who worked in these clinics and observed a high rate of psychosocial and war-related symptoms in the population. These symptoms included headaches, stomach pains, fear, sleep disturbances, flashbacks and, less frequently, visual and auditory hallucinations, muteness, and social withdrawal; traumatic stress complaints were very common. MSF found that communities were generally supportive of each other. Focus group discussions revealed that people were willing to discuss their fears and the tensions caused by

their circumstances. It was clear that most of the internally displaced people interviewed had witnessed traumatising events or been subjected to life endangering situations. Since the assessment showed that the population would benefit from psychological support, a counselling element was added to the mobile clinics.

Current needs of refugees

Kosovar Albanians have overcome over 8 years of repression. Their cultural strong family relationships, the sense of responsibility towards the community, and their resilience in the face of continual marginalisation resulted in an independent Kosovar Albanian education, social, and health system. Mental health programmes should foster these self-help mechanisms and avoid conditioning helplessness.

In the current emergency in the Balkans, formal training programmes are not possible. At this early stage, expatriate staff have a prominent role in individual training and providing help. The focus of MSF activities is support for refugees through outpatient departments in the refugee camps. The MSF programmes in Brazda and Kukës focus on the immediate psychosocial needs presented in our clinics and identification of vulnerable people through outreach work. Most refugees are exhausted when they arrive and food, shelter, rest, and medical attention must be provided. During the current chaotic phase, much distress is caused by the separation from, or disappearance of, family members. Consequently, MSF has identified three key objectives for its psychosocial programme.

The first aim is to identify people who are not able to care for themselves (physically, mentally, or socially) and refer them to health or social services. Specific groups in need are people with chronic psychiatric illness, mental disability, severe trauma, the elderly, and mothers with young children. The second objective is to provide back-up for the physicians who are working with refugees. Medical services are overworked and doctors are only able to cope with emergency cases and urgent physical problems. MSF's experience indicates that once the patient is helped physically, the urge to talk about their experiences is pressing. Medical staff are frequently confronted with an inhumane choice: silence the patient or listen and lose

time. The presence of counsellors trained to listen is beneficial for the medical staff and mental health of the refugees. During this immediate phase, the counsellor should refrain from in-depth probing of emotional details. The third goal is to provide



Roger Job/MSF

Refugees arrive in Kukës in April

back-up services for acute and chronic psychiatry. Once in safety some people break down, others are in a psychotic state. Moreover, among the refugees are patients with chronic mental illness who have been expelled from hospitals and institutions and who need appropriate care. Most of these people are given medication and referred to facilities for patients.

Once the physician has made a diagnosis of stress-related disorders, patients are referred to our psychosocial services. Sedatives and psychotropic drugs are prescribed for patients with psychiatric illness or acute anxiety. At this stage, the counselling services are mostly on an individual basis, although group services are possible. The support focuses on providing practical support, listening to personal stories, providing psychoeducation, and giving advice. Limited outreach services in the refugee camps are provided by community workers who offer social support such as familiarising the refugee with the camp facilities. Community workers also monitor people who have received counselling. People in need of health care or psychosocial support are referred to the MSF health services. When necessary, and in the absence of other organisations, MSF community workers can be involved in addressing the immediate social needs of the refugees for such things as food, blankets, and toilets. Indeed, assistance is often of a very concrete nature.

Concerns about advocacy

Many organisations are active in gathering testimonies of refugees from Kosovo. The aim of such activities at this stage is to advocate

on basic needs and also the levels of assistance and protection given to refugees or deportees by the UN High Commissioner for Refugees. At a later stage, the accurate reporting of human rights violations can serve to record the history of events and support international efforts to bring the perpetrators to justice. The immediate work allows for the objective recognition of a collective trauma and will also help the individual to come to terms with his or her trauma. However, advocacy must not be confused with counselling; the specific information obtained through counselling sessions is not used for advocacy. When pressure is put on a person for information, it can have a damaging effect. Such activities must, therefore, be sensitive to the psychological vulnerability of the individual.

Conclusions

Among the main medical aid agencies working in the current refugee crisis in the Balkans, many, but not all, consider mental health to be important: Unicef, Save the Children, and Oxfam all have current mental health programmes with a focus on crisis counselling and a long-term perspective. However, divisions remain among aid agencies as to whether mental health is a priority during the emergency phase or whether it should be developed at a later stage.

MSF believes it is important to initiate mental health programmes during the emergency phase of a refugee crisis: local staff must be identified and trained, time is required to understand the local cultural context, and people need to become aware that such help exists. Other medical programmes become overburdened during the emergency phase and mental health programmes can help to alleviate this burden. Helping traumatised people is a matter of restoring the bond between the individual and the surrounding society. MSF programmes are implemented in cooperation and with the active input of trained national staff. National staff are vital to overcome language and cultural barriers, and are ultimately the only way to ensure acceptance and sustainability of the programmes.

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