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Minding mental health

On the positive side, the global community's understanding of different mental illnesses have grown by leaps and bounds. Unlike in the early centuries where mentally-impaired patients were either tortured, imprisoned, or killed on the wrong belief that the person was possessed by evil spirits, there is now a growing awareness that people suffering from mental disability needs treatment and care.

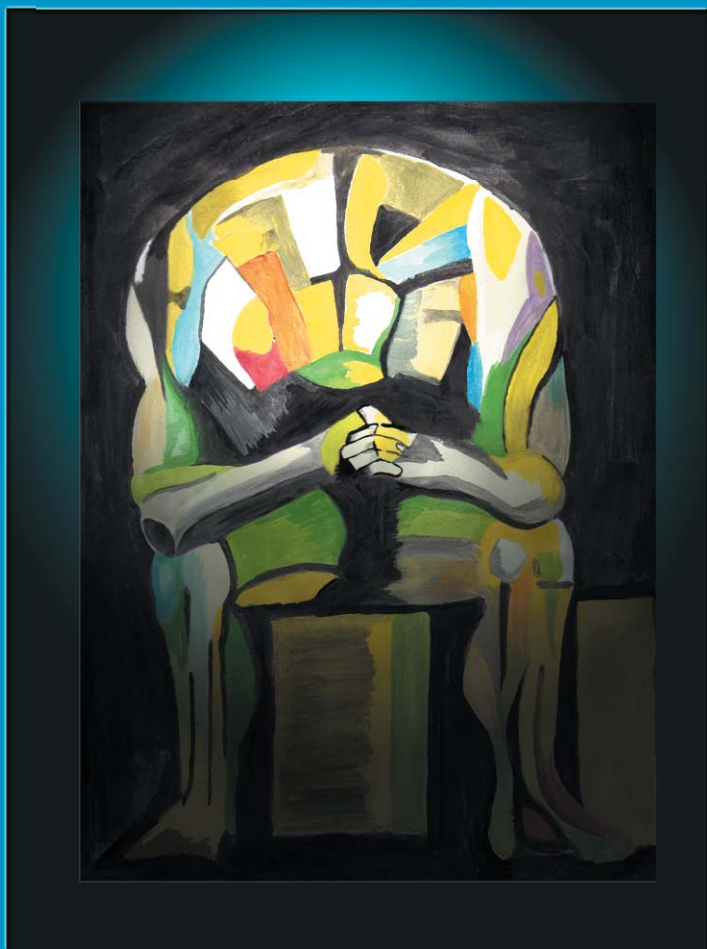
And now, for the not-so good news. Despite the advancements in the field of mental health, a large percentage of the global population still has no access to treatment and care. In addition, the number of people suffering from certain mental illnesses is expected to sharply rise in the years to come. These issues are discussed in the editorial, "Untangling the mental haywire," which also looks into the relatively new phenomenon of Internet addiction.

Suicide is a pressing mental health concern and this is discussed in the article "Intended death: a look at suicidal behavior." The sidebar shows how health workers and advocates can tap the media in preventing suicides, not just in providing the public with information but also through the responsible coverages of suicide cases.

In conflict-ridden areas, much of the intervention focuses on the physical health of the civilians, but the article "The hidden battlefield" shows a neglected area of concern - mental health. The article details how the stressors generated by wars affect the mental health of both the civilians and combatants.

"Community-based mental health programs: back to basics" shows how the implementation of community-based programs can help bridge the treatment gap in developing countries. It provides tips on how to implement a community-based program, as well as examples from three countries which have tapped the involvement of the community and the family in caring for a patient.

The last article, "Crash and burn" looks into the mental health of NGO staff and humanitarian aid workers, whose needs have been largely overlooked as they go about the business of helping other people.



Untangling the mental haywire

by Ross Mayor

Mental disorders are serious health concerns worldwide and more resources and actions are needed to address these.

Globally, an estimated 450 million are suffering from mental and neurological disorders such as epilepsy, dementias (e.g. Alzheimer's disease, vascular dementia), and bipolar affective disorder. According to the 2001 World Health Report entitled "Mental Health: New Understanding, New Hope," depression ranked fourth in the global disease burden; it is projected to jump to second place by 2020.

In the Asia-Pacific region, an estimated 13.7 million have dementia; as the region's population ages, the number of those with dementia is expected to hit 64.6 million by 2050.

Substance addiction, whether alcohol, drugs, or tobacco, is also considered a mental health issue. Asia accounts for close to 55 percent of amphetamine-type stimulants (ATS) abuse worldwide, and majority of ATS addicts are youth. Alcohol abuse, on the other hand, account for 5.5. percent of the Asia-Pacific region's burden of disease. In some Pacific countries, the percentage of alcohol-related abuse and violence is staggering: in Papua New Guinea, close to 90 percent of emergency room trauma are due to alcohol; while in Guam, 62 percent of murders are also alcohol-related.

Mental health defined

The World Health Organization (WHO) defines mental health as "a state of well-being in which the individual realizes his or her own abilities, can cope with the normal stresses of life, can work productively and fruitfully, and is able to make a contribution to his or her community." With this holistic definition, mental health is simply not the absence of disorders; it also encompasses a person's emotional stability to handle pressures and other stressors.

Mental disorders can also have co-morbidity with other physical illnesses; either the illness may be a psychosomatic reaction to mental stress, or the stress may come from the diagnosis of a physical illness. Either way, this co-morbidity has a negative effect on a patient's treatment compliance; depressed patients are thrice more likely to default on treatment than non-depressed patients.

Mental health and poverty

While mental health problems can affect anyone, regardless of race, age, and gender, there have also been studies showing that the poor are more vulnerable. A study conducted by the Harvard Medical School in the 1990s showed that the rate of mental retardation and epilepsy was five times higher in poor nations than in richer ones. Those belonging to lower income brackets are also 1.5 to two times more likely to become depressed.

A Gallup study published in 2007 reiterated the correlation between having a higher income and a relatively excellent state of mental health. Only 27 percent of Americans earning less than US$20,000 a year reported having an "excellent" mental health and wellbeing, while the percentage increased to 58 for those who were earning more than US$75,000.

Mental disability and poverty feed on each other, perpetuating a vicious cycle. Poverty itself is strictly not a cause of mental disability, but it generates enough stressors and circumstances.

Treatment gap

While it is true that mental health has been included in the international agenda as early as 1991, policies are yet to be translated into concrete actions: a large percentage of patients still do not have access to treatment, and stigma still persists.

Even in developed countries, 44 to 70 percent of patients do not have access to treatments; the situation in developing and least developed countries is far

worse – treatment gap can be as high as 90 percent. This is because more than 40 percent of countries have no mental health policy in place. In the ATLAS study conducted by the WHO in 2001, 32 percent of countries had no specific budget for mental health. Of those with mental health budget allocation, 36.3 percent spent only less than one percent of the total health budget.

With the inadequate budget for mental health, the burden of mental disorders falls heavily on poor patients and their families. The Harvard study found out that in some Asian and African nations, about 90 percent of epileptic and mentally-impaired patients did not receive any treatment because of the high cost of medicines.

The high cost of treatment is not the only reason why patients often do not seek treatment; stigma is another compelling reason to hide one's mental illness. Stigma may come from the personal perception that mentally impaired individuals are prone to violence. It also has cultural factors where a patient is either seen as having a weak disposition, or is possessed by supernatural elements. Stigmatization may also come from a patient's very own family. At the National Center for Mental Health in the Philippines, some of the patients who are already treated are still staying at the hospital because their families have already abandoned them.

Stigmatization often results in the violation of human rights of individuals with mental and neurological disorders. According to the WHO, some forms of abuses include seclusion and isolation, inhumane conditions in mental health facilities, and rape and physical abuse. Worsening the problem is the fact that in most countries, patients often do not have legal personalities; they are largely looked upon as persons who are unfit to make decisions or even testimonies that have legal consequences.

The importance of ensuring the people's mental health has been largely overshadowed by the focus on physical health. It is high time for the global health community to recognize the fact that mentally impaired individuals, when given proper treatment and support, can still live productive lives.

Internet addiction

Another emerging area of concern for mental health experts is Internet addiction. As a relatively new type of addiction, experts are still debating the criteria to be used for a clinical diagnosis, its clinical definition, and even what to call the disorder. Some quarters are even proposing to broaden the definition to cover addiction to other gadgets as well.

However, they are one in saying that the addiction is characterized by the compulsive use of computer, which can affect a user's interaction with other people. In extreme but rare cases, players of violent computer games have carried out their fantasies in the real world.

With a low user to computer ratio, a relatively unreliable Internet connection, and the lack of financial means of the population to purchase gadgets, experts in the Asia-Pacific region may be quick to dismiss this addiction as an irrelevant concern. However, South Korea, China, and Taiwan have long acknowledged that Internet addiction is indeed a problem. In South Korea alone, an estimated 14.4 percent of its schoolchildren are said to be Internet addicts. These three countries have already responded to the problem by opening treatment centers and boot camps to wean addicted users away from computers.

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Intended death:

A look at suicidal behavior

by Jennifer A. Ng

The global incidence of suicide is on the rise and unless concrete actions are taken, the number is expected to rise even further.

The World Health Organization (WHO) noted that suicide is taking the lives of more and more people worldwide. In the year 2000, the WHO revealed that approximately one million people died from suicide, representing a mortality rate of 16 per 100,000 or one death every 40 seconds.

In the last 45 years, it also noted that suicide rates have increased 60 percent worldwide; suicide is now among the three leading causes of death among those aged 15-44 (both sexes). These figures, however, do not include suicide attempts that are up to 20 times more frequent than completed suicide.

Further, suicide worldwide is estimated to represent 1.8 percent of the total global burden of disease in 1998, and 2.4 percent in countries with market and former socialist economies in 2002. Although suicide rates have been traditionally highest among the male elderly, rates among young people have been increasing to such an extent that they are now the group at highest risk in a third of both developed and developing countries.

In a 2008 global survey conducted by the WHO, Japan, whose culture allows people to commit *seppuku* (ritual suicide by disembowelment), had a suicide rate of 48 per 100,000, based on available figures for 2006. The Philippines, meanwhile, had one of the lowest suicide incidences at 2.10 per 100,000 population.

In its guideline for the assessment and treatment of patients with suicidal behaviors, the American Psychological Association (APA) defined suicide as self-inflicted death with evidence (either explicit or implicit) that the person intended to die. People wanting to die will do so by various means, either by poisoning themselves, by hanging or by other means such as throwing themselves on an approaching train.

Suicide is commonly associated with mood disorders, particularly depression and substance abuse. The WHO noted that mental disorders are associated with more than 90 percent of all cases of suicide. On the face of it, the usual symptom that can be a cause for concern for lay persons is the prolonged depressive episode observed in their loved ones. APA, however, said that despite the presence of a number of literature pointing to possible factors that can induce someone to take their life, it is still hard to be certain as to whether a person wanting to kill himself would make good of his plan. However, that person may drop hints, such as giving away his things. Dr. Lars Mehlum of the International Association for Suicide Prevention suggested that concerned individuals should ask a depressed person point blank if he is planning to commit suicide; in most cases, it provides the person with a chance to talk about his problems. As a matter of precaution, experts advise that a person suffering from severe depression and who has become withdrawn be brought to a psychiatrist so a professional evaluation can be undertaken.

APA said a number of factors may increase or decrease risk for suicide. These factors include the presence of psychiatric illness; specific psychiatric symptoms such as hopelessness, anxiety, agitation or intense suicidal ideation; unique circumstances such as psychosocial stressors and availability of methods; and other relevant clinical factors such as genetics and medical, psychological, or psychodynamic issues.

The WHO also noted that suicide results from many complex sociocultural factors and is more likely to occur particularly during periods of socioeconomic, family, and individual crisis situations.

To prevent the rise in the number of suicide attempts, the WHO has proposed a number of strategies. It said there is a need to adopt strategies involving restriction of access to common methods of suicide which has been proven to be effective in reducing suicide rates.

It said there is also a need to adopt multisectoral approaches involving other levels of intervention and activities such as crisis centers.

Also, it noted that there is a compelling evidence indicating that adequate prevention and treatment of depression, alcohol and substance abuse can reduce suicide rates. School-based interventions involving crisis management, self-esteem enhancement and the development of coping skills and healthy decision-making have demonstrated to reduce the risk of suicide among the youth.

Recognizing the need to combat the increasing number of suicide cases, the WHO itself launched its own Suicide Prevention (SUPRE) project to reduce mortality and morbidity due to suicidal behaviors, to break the taboo surrounding suicide, and to bring together national authorities and the public in an integrated manner to overcome the challenges. The project's strategies are to organize global, regional, and national multisectoral activities to increase awareness about suicidal behaviors and their effective prevention and strengthening of countries' capability to develop and evaluate national policies and plans for suicide prevention.

The WHO, however, acknowledged that there is a long way to go to prevent suicide. It noted that worldwide, the prevention of suicide has not been adequately addressed due to lack of awareness of suicide as a major problem and the taboo in many societies to discuss openly about it. In fact, it noted that only a few countries have included prevention of suicide among their priorities.

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Responsible reporting of suicide

The media can be an important ally in educating the public about suicide; however, the sensational coverage of suicide cases may actually do more harm than good.

Experts are largely polarized on the issue of whether reports of suicide cases spawn copycat suicides, particularly when the suicide involves a celebrity. In Japan, however, there have been three documented cases of copycat suicides following the death of rock guitarist Hideto Matsumoto. Experts also looked into the number of suicide cases after rock star Kurt Cobain killed himself, fearing that it could trigger copycat suicides. To their relief, there was no spike in suicide cases and they largely attributed this to the responsible reporting of the media, which did not glamorize the singer's death.

To encourage responsible reporting, suicide prevention advocates should lobby to media organizations to include a guideline in handling suicide cases in their manuals. The following tips from "Preventing suicide: a resource for media professionals" released by the World Health Organization in 2000 are useful in such an advocacy:

- Avoid sensational coverage, particularly when a celebrity is involved. In reporting the suicide, the WHO advises media outlets to mention in the report if the person had a history of mental illness. For newspapers, do not put the article in the front page.
- Do not detail how the suicide was carried out or where it was done.
- Do not glamorize or glorify the person.
- For failed suicide, include in the report the physical effects of the attempt, such as brain damage.
- Do not oversimplify the reporting by attributing the suicide to a single event. The resource noted that suicide is a complex issue with many contributing factors.
- Whenever possible, include in the report the thoughts of families and friends left behind.
- Include helpful information such as the contact details of agencies and organization that can help a depressed person, as well as the tell-tale signs of depression, which could trigger a suicide attempt.

The hidden battlefield

by Cai Ordinario

Mental stress spares no one - civilians and combatants alike are at risk.

The destruction brought about by war and armed conflicts transcends the structure of cities and communities and encompasses the mortality and overall well-being of those who engage in it and those who are dragged into it. The victims, the perpetrators, and defenders may not share the same goals in war but they all share the trauma and suffering surfacing from such violent events.

The effects of war, according to a study by R. Srinivasa Murthy and Rashmi Lakshminarayana of the Regional Office for the Eastern Mediterranean of the World Health Organization (WHO), are varied and some are not even included in most available literature.

The known effects, the study said, included endemic poverty, malnutrition, disability, economic/social decline and psychosocial illness, among others. The authors said that only when conflicts and mental health problems are fully understood can effective strategies be developed to deal with the effects of war.

"The effects of war include long-term physical and psychological harm to children and adults, as well as reduction in material and human capital. Death as a result of wars is simply the 'tip of the iceberg,'" the authors said.

War trauma and mental health

Perhaps apart from death, injuries, and diseases that war brings to the world, lifelong trauma and mental illnesses would also be among the worst irreversible damages that can happen to civilians and combatants Family members and relatives who perished and comrades who have fallen during armed conflicts can sometimes bring families and friends to a mental breaking point.

Post-traumatic stress disorder (PTSD) is a common mental health problem among soldiers. It can result from war-related trauma such as wounds or witnessing others being killed or hurt. Quoting a RAND report, Reuters stated that about 300,000 troops returning from Iraq and Afghanistan suffered from PTSD or depression, or one in five of the more than 1.5 million who have been deployed.

Studies conducted among military personnel also showed that soldiers on repeat deployments are more prone to PTSD. Many of these studies also made the world realize that alcohol abuse among soldiers returning from combat is a symptom of PTSD.

But PTSD is not unique to soldiers. Citing two local studies in Afghanistan, the two WHO experts noted that the disabled and women had poorer mental health status during armed conflicts. The studies further showed that there was a significant relationship between the mental health status of the people and the traumatic events.

The first study showed that around 62 percent of respondents reported experiencing at least four trauma events during the past ten years. Symptoms of depression were found in 67.7 percent of respondents, symptoms of anxiety in 72.2 percent, and PTSD in 42 percent.

The second study, the WHO study stated, aimed to estimate the prevalence of psychiatric symptoms, identify resources used for emotional support and risk factors, and assess the present coverage of basic needs.

There were about 1011 respondents aged 15 years old and above. Nearly half of those surveyed had experienced traumatic events. Symptoms of depression were observed in 38.5 percent of respondents, symptoms of anxiety in 51.8 percent and PTSD in 20.4 percent.

The main sources of emotional support were religion and family. The study said that people were able to cope only through their religious and spiritual practices.

"High rates of symptoms were associated with higher numbers of traumatic events experienced. Women had higher rates than men," the WHO study stated.

Malnutrition and other social problems

The first basic need of people that is greatly threatened in areas affected by conflict is food. Without food, people, most especially children, will suffer from malnutrition and starvation. This will make them susceptible to various illnesses and diseases since their bodies will not have enough nourishment to fight off such infections.

The desperation for food may also push people to do things that could be otherwise deemed as acts of mad men. Recently, IRIN Asia revealed that there have been unconfirmed reports in Afghanistan that a family

was forced to sell their children in exchange for food.

It said that the local media in Afghanistan reported that a father of four who was suffering from a mental illness offered his two children for sale but there were no takers. Another father, Jan Gul, explained in the article that because of hunger and cold, parents could not do anything and find it reasonable to sell their children just to make the other children, and themselves, survive.

This situation is just one of many acts of desperation in the outskirts of Kabul where 4,500 internally displaced persons (IDPs) now live. The war in Afghanistan has forced them to live in makeshift tents where food is scarce and disease is abundant.

Saving lives

The United Nations (UN) said that while there has been significant progress in obtaining international standards and commitments to protect people's rights affected by armed conflicts, these developments are insufficient, particularly in protecting the rights of children.

Among the international commitments formulated to protect the rights of children include the UN Convention on the Rights of the Child, Optional Protocol to the Convention on the Rights of the Child, and the International Labor Organization Convention No. 182 on the elimination of the worst forms of child labor.

In terms of answering the needs of those affected by PTSD among soldiers, reports showed that even the US has not been able to fully implement programs to deal with soldiers affected by PTSD. A report from Reuters even said that there were insufficient counselors, psychologists and psychiatrists available for returning soldiers.

Further, PTSD-affected soldiers still relied on group therapy over individual care and there was a lack of continuity in care among these soldiers.

Ultimately, the effects of wars and various armed conflicts lie not on how efficient governments and the UN are in creating international protocols and increasing facilities to answer the needs of affected civilians and military personnel in conflict areas but on their capacities to resolve conflicts.

It is imperative for governments and international organizations to work towards achieving and sustaining peace worldwide.

A closer look at PTSD

A person may be diagnosed with trauma if:

1. The person has experienced, witnessed or been confronted with an event that involves actual or threatened death or injury, or a threat to the physical integrity of oneself or others.

2. The person's response involved intense fear, helplessness or horror.

The stressors are overwhelming enough to affect almost anyone but not everyone experiences PTSD after a traumatic event. Individual preexisting biological and psychosocial factors and events that happened before and after the trauma must also be considered.

PTSD has three distinct symptom clusters:

1. Re-experiencing the event (recurrent intrusive distressing memories, recurrent distressing dreams, illusions, hallucinations, dissociative flashback episodes, intense psychological distress when exposed to reminiscent cues, physiological reactivity on exposure to external or internal cues)

2. Avoidance and numbing of responsiveness (avoiding thoughts feelings or conversations connected to the event, avoiding activities, places or people connected to the event, amnesia about certain important aspects of the event, decreased interest in once-enjoyed activities, feeling detached from others, emotional numbing/restricted range of affect, a sense of foreshortened future)

3. Hyperarousal (difficulty falling or staying asleep, irritability or outbursts of anger, problems concentrating, hypervigilance, exaggerated startle response)

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Community-based mental health programs:
back to basics

Capitalizing on local culture and strong family ties, community-based mental health programs make services more accessible to the people.

In the report ”Integrating mental health into primary care : a global perspective,” the World Health Organization and the World Organization of Family Doctors bat for the integration of mental health care program with primary health care since it results in greater access to much needed services.

The report resonates with truth, considering that confinement in mental asylums or rehabilitation centers is a common treatment modality for mental disorders. For poor countries dealing with fund scarcity and the lack of specialists, a psychiatric hospital-based approach alone may not work. However, there are cost-effective models of community- and home-based programs that work well.

Community-based mental health program

A community-based mental health program is not meant to replace the treatment and services offered in hospitals; it rather complements these services by making these more accessible to the people.

Such a program is also more culturally appropriate and capitalizes on the tightly-woven social fabrics of most Asia-Pacific countries. The involvement of the community and family members in caring for a patient helps ease stigma and provide a more healing and nurturing environment for a patient.

The shift to a community-based program is evident in Samoa, which deliberately closed down the mental ward at Tapua Tamasese Meaole Hospital. Mentally impaired in-patients are admitted at the general ward,usually for two weeks and are then sent back home to be taken care of by their families. Mental facilities are available at the primary health care level and mental health teams periodically visit the country’s two main islands to conduct assessments and follow-ups.

Samoa’s approach to mental health adheres closely to its *aiga* culture - a culture that places utmost importance on the family and the value of kinship. David Lui, a Samoan mental health care provider, explains that “in Samoa, the unit of society is the family not the individual.” The Samoans’ preference to be taken cared of by their own families - and to personally take care of a sick relative - stems from this belief.

Starting a community-based program

In starting a community-based mental health program, it is important to provide community health workers with basic skills on mental health, such as the signs and symptoms of different mental disorders to allow them to easily diagnose a patient.

In the manual “Where there is no psychiatrist,” Dr. Vikram Patel provided a comprehensive guide in implementing a community-based mental health program. As a general rule, health workers must establish rapport by treating the patient with compassion and respect.

Linkages with specialists should also be done to ensure that patients needing advanced medical care will be able to access this.

Diagnosis

Interview is the first crucial step in diagnosing a patient; a health worker must not rely on a patient’s outward appearance alone. Dr. Patel cautions health workers against rushing through an interview since they might miss the real problem. In addition, it sends a signal to the patient that the health worker is not really interested.

Samoa’s approach to mental health adheres closely to its aiga culture – a culture that places utmost importance on the family and the value of kinship.

A diagnosis may be made based on the clinical manifestations of an illness, as well as a deeper probing of the patient's personal life to establish why he or she is ill. For example, a patient may be depressed as a result of a particularly traumatic experience such as the death of a loved one.

Interviewers should also pay particular attention to a patient's body language and expressions, such as restlessness, very fast or very slow rate of talking, and strange body movements.

Treatment and therapy

Depending on the severity of the illness, a health worker may opt to treat the patient or refer him or her to a specialist for advanced treatment. Medicines may be prescribed to a patient, but health workers must ensure that proper doses are given and that patients are monitored for compliance as well as for side effects.

Counseling, when properly done, can also help a patient deal with his or her own problem. For some patients, the mere thought of having someone they can talk to and who is willing to listen to them is already therapeutic.

Aside from the usual treatment modalities, health workers can also tap into the local culture to devise innovative treatments.

In Hawaii, for instance, researchers from the University of Hawaii showed that a residential program for substance-addicted pregnant and post-partum women was effective in rehabilitating the women. The program, called Na Wahine Makalapua (NWM), represented a paradigm shift from the way the island treats addicted Asia-Pacific islander women.

Instead of bringing them to rehabilitation centers and in effect isolating them, they were allowed to stay at home with their children as they recovered from their addiction. The setting provides the women with a nurturing and non-punitive environment where they are allowed to bond with their children and to resolve their issues without being judged. NWM also utilizes Hawaiian deep cultural therapy, which includes conflict resolution, storytelling, and massage. Like the Samoans, family is also integral for Hawaiians, and as such, mending broken family relations is essential for the women's healing. Facilitating these processes are respected community elders.

In the Philippines, a local organization employs the play-and-learn method to teach children with mental and physical disabilities. Parents are also taught touch and massage therapy so they can do this at home.

There are indeed plenty of practices that can be adapted in any local settings and can be used to complement the traditional modalities.

Support groups

Setting up a support group can help both the patient and the family. A support group provides a patient with a sense that there are others who have the same illness. Patients can draw strength from each other as they struggle to cope with their illness.

For families of patients, support groups also give them a venue where they can share experiences and practical tips.

Caring for the caregivers

In most cases, a support group is perhaps the only avenue where the mental health needs of family members are met. This is a gap that needs to be addressed since family members, particularly the caregiver, are also suffering emotionally, physically, and mentally. A caregiver may suffer from a myriad of emotions ranging from anger, guilt, despair, and frustration. In cases involving a patient who has been incapacitated by an illness, a caregiver may have to give up his or her work and even social life to care for the patient full time.

Community health workers should take time to also talk with them and find out how they are coping. Counseling - and even medicine - should be given when the caregiver is already nearing his or her breaking point.

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Crash and burn

by Noemi Bayoneta – Leis &
Ross Mayor

Whether the work involves the mass evacuation of civilians in war-torn regions, or the setting up of peace channels, aid workers are exposed to mental and emotional stressors.

Humanitarian aid workers and staff of non-government organizations (NGO) are often praised for their selfless devotion in making the world a better place to live in. But put the accolades aside, and the question begging to be asked will surface: who takes care of this sector's mental health needs?

NGO staff and aid workers are often at the forefront of humanitarian work. It is inevitable that in the course of their work, they are exposed to a dreadful environment where death and suffering are common occurrences. In some instances, they themselves are threatened with bodily harm. In his paper, "Mental Health and Aid Workers: The Case for Collaborative Questioning," Thomas Ditzler of the Center of Excellence in Disaster Management and Humanitarian Assistance, asserts that "the nature of humanitarian assistance puts workers in contact with the local environment in ways that can erode the normal personal / professional boundaries which provide some measure of psychological protection."

A 2001 study published in the Journal of Traumatic Stress showed that 30 percent of returning aid workers reported being stressed, while ten percent could be suffering from PTSD.

Burn out

A humanitarian aid worker need not be exposed to traumatic incidents to be stressed out; the social development scene itself has stressors that can leave a worker feeling immensely frustrated. In development work, sources of stresses vary. One is environmental – it may be within or outside the organization – where desired results are not met. Within the organization, sources of stress may be the lack of policy to respond to the staff needs and the need to address growth and changes.

In addition, development work requires multi-sectoral partnerships which exposes the worker to stressors outside the organization. It may be exposure to different personalities, working environment, and demands. The issues being addressed are stressors themselves, as they continuously evolve and open new avenues to cope with in terms of the need for integration and deepening the understanding on issues.

Burn out is an area that needs further studies since there are no data available on this subject matter; this article relies more on anecdotal evidences provided by people who have either left or are contemplating to leave their organizations because of frustration. One such person, who is involved in an HIV and AIDS intervention program, had to temporarily leave the organization she helped establish because she was frustrated that the injecting drug users (IDU) she was organizing did not show any signs of changing. Fortunately, her time off allowed her to put things in a clearer perspective. When she was persuaded to return, she set a condition that she would not directly handle the program; a partner organization was called in and the IDUs themselves had to take on a more active participation.

In some instances, frustration stems from the fact that despite spending massive amounts of money, time, and effort in a project, it still does not seem to make enough impact. At a certain point, a staff might become disillusioned and ask if the effort is all worth it. On the other side of the pole, there are organizations carrying out effective programs but are hampered by the lack of fund. This is a particular problem among organizations in developing or least developed nations; there is so much work to do, but so little resources to begin with.

Since a large percentage of an organization's budget is allotted for the actual provision of services or the implementation of a program, some NGOs cannot afford to hire additional staff; multitasking among staff is a reality. This leaves a staff with little time to attend to his or her personal life, or to pursue other things. In the long run, this can leave a staff physically, mentally, and emotionally drained.

A hidden problem?

Mental stress among NGO and humanitarian workers has been acknowledged as a problem, but very little

is still being done to address this. This is highlighted by the fact that there are no recent studies being done on the subject matter, even in regions where relatively affluent NGOs already have a mental health program for its staff.

With the lack of data on burn out, for instance, it is hard to qualify its impact on an organization. What is clear though is that staff and workers who are leaving bring with them a wealth of invaluable experience that may be totally lost on an organization.

If the extent of the problem is still largely unknown, how can an effective measure be implemented? One cannot simply come up with clear solutions for a vague problem.

Sources:

Ditzler, Thomas. “Mental Health and Aid Workers: The Case for Collaborative Questioning.” http://www.jha.ac/articles/a063.htm

Stefan Lovgren. “Aid Workers, Too, Suffering Post-Traumatic Stress.” http://news.nationalgeographic.com/news/2003/12/1203_031203_aidworkers_2.html

Aiding the aid workers

Addressing human resource needs is essential in maintaining a balanced perspective. Look at incentives, existence of mentoring, recognition of achievements, and clear policies to serve as a guide to staff.

Here are some tips to help even smaller NGOs take care of their staff’s mental health:

- Conduct a thorough pre-deployment/pre-employment orientation. Tell the staff the real situation on the ground; this way, they would know what to expect and they would be able to better prepare themselves.
- Conduct rest and recreational (R&R) activities. Aside from fostering camaraderie among staff, R&R may also provide an informal venue for a stressed out staff to air his or her concerns.
- Managers should be mindful of the signs and symptoms of mental stress, as well as who among their staff is exhibiting these signs (ex; tardiness, absenteeism, irritability); they should then reach out to this particular staff. This is particularly true in the Asian region where the people are generally non-confrontational and where culture dictates deference to authority figures. In such a setting, a stressed out worker is likely to keep his concerns to his or herself.
- Set realistic goals and expectations. In a rush to make a difference in the society, some NGOs may set an unrealistic goal; adding an unnecessary pressure among its staff.
- Annual strategic planning should incorporate individual personal plans to help staff meet their personal goals as well. This would also avoid conflict of interest and time. Since most of development workers do not get paid for overtime work, flexibility should be defined properly to avoid abuse.
- Mentoring is important to be able to deliver quality outputs.
- Transparency, openness, understanding and observance of good conducts would greatly contribute to a less stressful environment.
- Staff cannot live on idealism and commitment alone. This is a tricky reality for NGOs coping with limited funds. However, even non-monetary benefits (ex; tapping a network to provide scholarship to a child of a staff) can provide staff with a safety net, particularly in times of emergency.

RESOURCE LIST

Mental Health Legislation in Developing Countries with Special Reference to South Asia: Problems and Solutions by AK Kala & K Kala. Global Social Policy 2008: 8:308. http://gsp.sagepub.com

The article examines the development of mental health policies in South Asian countries including provisions and implementation. The article also links existing policies to judicial system specifically protecting the human rights of those who are mentally ill.

Natural Disaster and Mental Health in Asia by Kokai, M, et al. Psychiatry and Clinical Neurosciences 2004: 58 (110-116)
The article is a result of a review of literature on disaster mental health in relation to natural disasters which happened in Asia. The review findings include recognition and acceptance of mental health in the light of post-traumatic stress disorder (PTSD) brought about by these disasters. This opens up opportunities for greater involvement of mental health professionals by providing support and further research. It is suggested that standardized diagnostic tools should be developed for a more appropriate response. For fair use, copy of the article may be requested from HAIN.

Where There is No Psychiatrist: A Mental Health Care Manual by V Patel & W Acuda London: Gaskell, 2003, £8.00 pb, 288 pp.

Access to mental health care in low-income countries is still extremely poor and there is a serious shortage of mental health care workers. However, most of these countries have large numbers of community workers who could be deployed to deliver mental health care if they have the necessary knowledge and skills. Where there is no Psychiatrist provides such knowledge and skills. Order from http://www.amazon.com/Where-There-Psychiatrist-Books-Beyond/dp/1901242757 or write to source@ich.ucl.ac.uk

The World Health Report 2001: Mental Health: New Understanding, New Hope. Geneva: WHO, 2001.

A comprehensive review of what is known about the current and future burden of disorders, and the principal contributing factors. It examines the scope of prevention and the availability of, and obstacles to, treatment. It deals with service provision and planning and recommends action adaptable to countries depending on needs and resources. Full report or selected chapters may be downloaded from http://www.who.int/whr/2001/en/.

Mental Health and HIV/AIDS: Reasons for Concern and Some Ideas What Can Be Done, 2008. Powerpoint presentation by M Freeman.

Examines factors affecting mental health situation of people living with HIV in African and other regional setting but can be a jump-off point for examining the Asia-Pacific context. Download from http://www.eecaac.org/file/5May_1Ses_Freeman.pdf.

Time Magazine Asia Edition, November 10, 2003, Vol. 162 No. 18

This edition features two articles on Asia's intensifying behavioral and mental illnesses. http://www.time.com/time/magazine/asia/0,9263,501031110,00.html

Source is an international information support center providing free online access to 25,000 comprehensive references to information sources and organizations in the fi elds of international health and disability issues, with links to full text resources provided where possible. The focus is on grassroots information from developing countries, and subjects include HIV and AIDS, primary health care, poverty, disability and development, evaluation, training, health communication, and information management. Search Source at www.asksource.info

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