Full title: **Increasing mental health capacity in a post conflict country through effective professional volunteer partnerships: a series of case studies with government agencies, local NGOs and the diaspora community**

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Increasing mental health capacity in a post conflict country through effective professional volunteer partnerships: a series of case studies with government agencies, local NGOs and the diaspora community

Keywords: post conflict, recovery, working in partnership, mental health services, health systems, organisational training, multi-professional, culture, workforce development

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Abstract

The focus of this paper is on working in partnership with local practitioners and communities to strengthen local capacity building in the area of mental health and well-being in Sri Lanka. This paper will examine the context, organising concepts, organisational processes and the development of good working relationships and partnership building behind this work. Our involvement was based on requests which came to the authors as a result of their previous work in Sri Lanka over several decades. This work had been undertaken on behalf of the UK:Sri Lanka Trauma Group (UKSLTG), a UK based charity which was set up in 1994, and of which the authors are founding members (www.uksrilankatrauma.org.uk/). In the first section of the paper, contextual issues will be discussed. The second section of the paper provides details of the training undertaken on mental health promotion among youth in Sri Lanka for the Directorate of Mental Health. The third section of the paper reviews work undertaken with a major psycho social/mental health organisation on issues relating to writing and implementing an ethical code for mental health practitioners and briefly discusses some of the dilemmas associated with this.

Introduction

The two pieces of work demonstrate the importance and significance of considering culture and local context, (using participatory training approaches to work with and through frontline staff), as essential organising concepts in any piece of work conducted across cultures, rather than just considering culture as an additional factor or variable. Moreover, this appears essential, if any work, including training, is to be meaningful and useful to the participants and to effectively assist with local mental health capacity building. These pieces of work may raise issues for practitioners working with service users in any country, where the clinician and service user come from different cultures as well as mental health and humanitarian workers who work in countries and cultures which are different to those they grow up or trained in. The position adopted by the authors is that mental or psychological health and well-being is multi-faceted, and is embedded in a matrix of factors which may be influenced by familial, psycho-social, community, spiritual, cultural, socio-political, physiological and other relevant factors. We attempted to consider all these factors in our partnership working.

Contextual factors

The UKSLTG membership is drawn from all communities resident in Sri Lanka and all the languages spoken there are represented. Originally, all members had links of heritage or friendship to the country and therefore had a background and understanding of the culture and traditions of Sri Lanka. The volunteers at the UKSLTG are made up of psychiatrists, psychologists and psychotherapists

most of whom are from the Sri Lankan diaspora based in the U.K. and we respond to requests to work in partnership with local organisations in the governmental and voluntary sector, with the aim of helping to build capacity around mental health. The members of the group fund their own travel and expenses. We have a small resource centre located in Sri Lanka named Samutthana, which means renewal or regeneration" in Sanskrit.

Our specific aims are;

*To raise psycho-social awareness among policy makers, planners, politicians, the media, communities and community leaders.

*To increase skills and knowledge about the effects of mental health - among community workers, primary care workers, statutory and voluntary bodies - by offering training that is responsive to local needs.

*To carry out research into effective methods of working in partnership with communities and individuals in a culturally appropriate way.

*To facilitate adaptation to the new paradigms of a new chapter in post-war.

Legacy Issues

Sri Lanka is a diverse country in the Indian Ocean with a multilingual and multi faith population of approximately 21 million (Countrymeters, 2013). 74 per cent of the population are Sinhalese, mainly Buddhist, Tamils make up approximately 18 per cent of the population and are mainly Hindu. Approximately 16 per cent of the population define themselves as either Christian or Muslim, with an even distribution between the two faiths. Sri Lanka is designated a middle income country and it has maintained a growth of 8% over the last few years (World Bank, 2013). It obtained independence from British rule in February, 1948, having previously experienced colonisation from the Dutch and the Portuguese, and all of these colonisations have left a range of legacy issues which the Sri Lankan population have had to deal with.

Sri Lanka has subsequently been subject to a series of large scale natural and man-made traumatic events. It was subject to a civil war, of 26 years duration, which was won militarily by the Sri Lankan army in May 2009. In summary, the Liberation Tigers of Tamil Eelam (LTTE), known more colloquially as the Tamil Tigers, were fighting against the Sri Lankan army for control of the north and east of the country, where Tamils form the majority of the population, with the aim of creating an

autonomous Tamil state within Sri Lanka. During the civil war, human rights violations were recorded by both the LTTE and the Sri Lankan army (European Commission, 2009; Amnesty International 2008; Human Rights Watch, 2009) and the issue of possible war crimes, though refuted by the present government, is still under investigation (Human Rights Watch, 2012). Approximately 70,000 men, women and children from all the ethnic groups lost their lives during the civil war (Reuters 2009) and 1.8 million people were uprooted by the civil war (UNHCR, 2009). Many of those internally displaced had been subjected to repeated trauma, loss and bereavement over a long period (Weerackody & Fernando, 2009). Sri Lanka also suffered its worst natural disaster when it was seriously affected by the Indian Ocean Tsunami in December 2004 – this affected three quarters of the country's coastline and caused considerable damage, including 36,000 casualties and over 800,000 displaced from their homes. In January 2011, the east of the country suffered from serious flooding which affected one million people and led to 400,000 people being displaced (Economist, 2011).

Many Sri Lankans have therefore lived through a range of difficult or traumatic events and it is likely that there are a range of legacy issues following the long running civil conflict which affected so many people. For example, many people under 30 years of age will have lived the majority of their lives within a civil war and this is likely to have changed their life experiences in many ways. Somasandaram & Sivayogan (2013) have written of collective trauma where an entire society can be traumatised or changed by the events which took place there. Many families lost family members during the civil war, either through them being engaged in the armed conflict or as a result of hostilities including bomb attacks outside the main theatre of war. Furthermore, whilst the current research consensus suggests that many children and young people are more resilient to traumatic events than previously assumed, multiple stress factors, including the prolonged effect of political violence and exposure to the Indian Ocean Tsunami, may carry more risk factors to later child and adolescent mental health due to its unresolved ripple effect on family cohesion and learning experiences (Punamaki, 2001, Punamaki,1987). Cantani et al (2008) studied 296 Tamil school children in the North East of Sri Lanka soon after the Tsunami, results indicate a link between war

violence, family violence and fathers' alcohol intake *which may affect family members and children negatively*. How a country moves forward and redefines itself in an inclusive manner after internal hostilities and divisions is a complex and multi-layered process.

Rebuilding Communities

Rebuilding communities presents as one of these challenges in post conflict countries. Different parties or interest groups may try and influence the dominant explanatory descriptors or narratives of historical events, leading up to, during and after a civil conflict or an event such as the continuation and then the ending of apartheid in South Africa. Attempting to control the way events are described and constructed and the language that is used is one of the subtler weapons of war which are used throughout the world. Collier (2006) writes that "Popular perceptions are shaped by the discourse which conflicts themselves generate. The parties to a civil war do not stay silent: they are not white mice observed by scientists. They offer explanations for their actions. Indeed, both parties to a conflict will make a major effort to have good public relations". p. 1.

While Bakarr Bah (2011) writes about this in regard to Sierre Leone, noting the importance of issues of power and how these play a role, examples from a number of countries have documented how 'explanatory' discourses have been managed or attempts made to manage these, by various interest groups. Brinton Lykes et al (2003) undertook some research in Guatemala and South Africa, and writes of the need to "dispel notions of "uni-vocal communities" and representational politics and how to develop an environment which facilitates reparatory and reconciliatory processes and of moving forward.

Within Sri Lanka, there have been cultural and political moves to re-focus on the future which is of course vital to the long term well being of the country, with language such as the 'New Sri Lanka' and 'One Country: One Nation.' These pragmatic nation building initiatives seek to redefine national

aspirations and a new collective conscience. Alongside this, anecdotal evidence suggests that there may be a clinical and political aversion to the use of the word trauma to describe people's reactions to experiences in relation to the war, as a local dominant discourse emerges within communities that the war is now over and that everyone should move forward and 'forget the past' and any trauma associated with it. Foster (2010) names this as the "politics of amnesia" and claims that this may not be the most helpful way forward. Yet, whilst the war is over, sadly many people may have experiences and memories associated with this period which they cannot erase from their memories. The traumatic memories from the period of the war mean that a different kind of war may be going on in the minds of the people affected by it. This is not to give anyone a psychiatric label but to recognise what might be classified as normal reactions to the abnormal life event of living through a long period of civil war for some people. It is also not to ignore the enormous resilience and survival strengths shown. Unfortunately as clinical theory shows us, not addressing issues can lead to them lying dormant or being repressed at the individual or societal level in some way. Therefore, managing the discourse and the legacy has implications both in terms of developing effective mental health services and in terms of current demands and early intervention and prevention services. Yet it also raises a number of ethical dilemmas, raising the question of whose role is it to raise these issues, and what is the role of people not resident there to facilitate reflective practice, cognizant of these issues?

Mental Health Capacity: Infrastructure and current services

This section of the paper looks at the current mental health infrastructure in Sri Lanka, provides some comparative statistics and suggests that a community focus (as recommended and practiced by a range of Sri Lankan health professionals) may be one way forward. There are long established community systems and people who are providing support and assistance which have a long tradition within Sri Lanka, they can reach a lot of people and may also minimise the stigmatisation of individuals with mental health dilemmas.

The mental health policy objectives for Sri Lanka are extracted below: *(www. on_going_projects_mhp_slr.pdf)*

- To be an essential instrument to ensure clarity of vision and purpose in the improvement of the mental health and psychological well being of the citizens of Sri Lanka.
- To treat mental disorders in an efficient and holistic manner.

Table 1 compares the capacity of current formal mental health services in Sri Lanka and Britain in 2013 and highlights the very different ratios of mental health professionals to the population. Figures were obtained from a range of sources at the time of writing this paper, but may have subsequently changed.

	Sri Lanka (Total population = 21 million)	Britain (Total population = 61.4 million)
Total Psychiatrists	89 1 psychiatrist: 238,635	12, 502 1 psychiatrist : 4,879
Total Psychologists Clinical Psychologists Counselling Psychologists Educational Psychologists	20 1 1	9,373 Chartered Clinical Psychologists 6,365 Chartered Counselling Psychologists 1,260 Chartered Educational Psychologists 1,748
Other mental health professionals	Indigenous/alternative medicine practitioners Un-registered counsellors/ therapists	Registered Counsellors, IAPT workers, other therapeutic approaches and non registered alternative medicine practitioners.

Due to the shortage of psychiatrists in Sri Lanka, a one year diploma course in mental health training was introduced in Sri Lanka in 2008 with most of these specialist doctors working in rural locations single handedly.

There are also a range of indigenous healers and practices in Sri Lanka including ayeuverdic and siddha medicine. Fernando et al ,(2010) and Somasundaram & Sivayokan, (2013) have noted the importance of recognising what is being done by voluntary organisations and local people in addressing mental health needs. The latter fits with the UK:Sri Lanka Trauma group's philosophy of using (where appropriate) a community focus where a range of people who may not be psychiatrists or psychologists, can make an important contribution to promoting psychological health and resilience and ameliorating psychological distress. Parents and families, teachers, community or religious leaders and others can contribute in a number of important ways, which may assist with avoiding the negative labelling and stigma frequently associated with receiving psychiatric help. (The work we did with a major psycho-social organisation and discussed in the second section of this paper also describes this). In addition this extended community often has a more robust knowledge and understanding of the local context than some mental health professionals.

Samarasekera et al (2012) completed a small-scale study into the stigma of mental illness in Sri Lanka as viewed by community mental health workers, They claimed that " Stigma is associated with the family unit; there is strong faith in traditional beliefs and healers; and negative attitudes and behaviours exist regarding mental illness." Therefore a community focus can have benefits, and the challenge may be for psychiatrists and psychologists to identify and locate their most effective role within this.

In delineating professional boundaries, one also needs to examine and understand the perceptions and expectations of a mental health officer or psychiatrist in Sri Lanka which may differ from those working in another country. For example, in addition to case loads of up to 70 patients a day, and as

well as doing their 'normal' job, psychiatrists working in Sri Lanka are expected to consult to teachers and parents when children and adolescents are disruptive or are experiencing problems in schools. Their service context, as well as lack of specific psycho-educational training in this area invariably affects the type of service and interventions they can offer, resulting in an unconscious bias towards a medical "with-in" child treatment model of assessment and intervention. In contrast, in the UK, Republic of Singapore, Australia, USA and Canada, for example, educational or school psychologists and specialist teachers act as the intervening agency for children and young people presenting with difficulties in school or early years settings, which interfaces between the teachers and/or parents and psychiatrists, paediatricians or General Practitioners. The conceptualisation and positioning of public mental health services within countries is therefore very different, impacting on pathways to child and adolescent mental health services from early intervention to critical care.

Building capacity

Sri Lanka has one of the higher suicide rates found in the world, although this has declined somewhat recently and the pattern is different across gender and age (World Health Authority, 2012). Siva (2010) has argued that Sri Lanka continues to struggle with the provision of mental health services; De Silva & Hanwella (2010) argue that enough psychiatrists are trained within the state system, citing the figure of 88 being trained between 2002—09. Both arguments may be valid but highlight a need to have shared definition of mental health and mental health services which is embedded in the local context.

Nevertheless, policy and operational strategy must come together to ensure effective and timely access to appropriate mental health services. Whilst Sri Lanka may have 88 trained psychiatrists, low salaries for government employees, and increased global mobility for Sri Lankans may lead some to leave government service and work in the private sector or overseas, impacting on the provision of local mental health services. Yet, as has been outlined, psychiatrists should not be regarded as the only people who can offer assistance with mental health. The civil war often made the practicing of

traditional cultural rituals difficult and this may have been detrimental to emotional well-being at the individual and community level at that time (Somasundaram & Sivayogan, 2000). One of the ways in which the UK:SLTG works is by using a more holistic, community based approach to mental health and thereby offering training to a range of groups, including but not limited to psychiatrists, psychologists, nurses, religious leaders, community groups, teachers, parents humanitarian workers and other interested parties.

Case Study 1:Training for the Ministry of Health

This first case study looks at the training and capacity building work on promoting mental health among youth that was undertaken by the authors as a collaboration between the UK:Sri Lanka Trauma Group /Samuthana and PRDA (People's Rural Development Association) which was sponsored by the Trauma and Global Health (TGH) Program (www.mcgill.ca/trauma-globalhealth). The work was carried out with support from the Global Health Research Initiative (GHRI), a collaborative research funding partnership of the Canadian Institute of Health Research, the Canadian International Development Agency, Health Canada, The International Development Research Centre, and the Public Health Agency of Canada.

The authors brief focused on capacity building and workforce development. The Sri Lankan National mental health programme has 6 components which are linked to infrastructure development and human relations. Within this, the Ministry of Health had prioritised capacity building, providing one training a year for each professional category. Thus the training was in addition to the training provided to the district medical doctors and community physicians by the world mental health day and national forums.

The work was guided by the Inter-agency Standing Committee (2007) guidelines on mental health and psychosocial support in emergency settings. These guidelines stress the importance of inter-sectoral collaboration in mental health and psychosocial support including; the importance of collaboration, the possible use of volunteers who are steeped in the local culture, and the need to learn about where appropriate collaborations with local indigenous and traditional health systems can occur. We used these principles in thinking about our work with the objective of working in partnership to assist with building capacity in a targeted manner.

Agreed Aims and Objectives of training

The training had three objectives:

- To increase the knowledge and skills of participants' in relation to child and adolescent development and parenting.
- To identify a practical and realistic role for medical officers within community based mental health services to strengthen mental health support to children, youth, parents and carers.
- To share expertise and promote culturally relevant models of practice through a critical and reflective dialogue between participants and trainers

The trainers and participants represented individuals from both communities involved in the previous civil war, people currently living there, from the Sri Lankan diaspora community and from the UK. One of the strengths was that the trainers represented a range of professional backgrounds as well as diasporan Sri Lankans, working in collaboration with local organisations. The author's knowledge of the country, culture and traditional and allopathic medicine assisted greatly. The trainers had all worked in Sri Lanka, two of them for many years. For this piece of training, the team comprised of an Educational Psychologist, a Consultant Child and Adolescent Psychiatrist and a Professor of Applied Psychology; the team also represented the major communities present in Sri Lanka. For part of the training, two other UKSTG colleagues were also involved. All of the team had significant experience of adult learning and group facilitation, and this was used throughout, alongside participatory techniques and visual materials. For example, using mapping exercises, daily routine diagrams, and

resource maps to engage and empower the audience, and to ensure that culture was fore-grounded throughout. We also used case examples and asked the participants to give examples from their work. The participants were drawn from District Medical Doctors and Community Physicians across the country, including the North and East.

Challenges/issues

The planning stage: Negotiating between a range of agencies, with differing roles, responsibilities and requirements can be challenging, particularly if part of this is undertaken across international borders and different time zones. The authors had as their objective that the training should be based on what the ministry and the participants required, rather than offering a pre–planned package. This meant that much of what we had originally planned had to be disregarded and we worked with what the ministry and the participants required, making changes before and through the training. Fortunately, the training team had experience of working together which greatly assisted with this and allowed the authors to feel comfortable with some flexibility and challenges.

Flexibility: The brief given to the trainers some weeks before the training was on child development and parenting, suicide, risk and self-harm. Over a period of approximately one month communication between a representative of the Ministry of health and the trainers narrowed the training down to a 2 day training for 70 participants. In addition, after completing a wish list with the participants on the first day of the training, there was some discrepancy between this and the requirements of the participants which had been given to us, so further adjustments to ensure that we met the needs of the participants were made.

Time constraints: In low and middle income countries one issue can be the lack of capacity and we were told that these professionals in Sri Lanka are often so stretched that they do not have time to

either run or attend training programmes, therefore training has to be extremely well planned and targeted to needs.

Awareness of organisational cultures: In planning the training programme, the trainers had to be cognizant and respectful of time differences between cultures for events such as welcoming addresses and mealtimes. For this training, the first part of the morning was dedicated to welcoming addresses, the sharing of information and protocols, which included the traditional Sri Lankan lighting of the oil lamp ceremony which is customary at such occasions. The authors were lucky to have some important dignitaries present at the inauguration ceremony, these included the Dr Lakshmi Somatunga, Director for mental Health who gave the welcome address and Dr Anil Dissanayake, the Director for Youth, Elderly, and Internally displaced people who gave a comprehensive presentation on the Health Status of the Sri Lankan Youth. Whilst Dr Prasntha De Silva gave the vote of thanks and Mr Chamindra Weerackody, spoke on behalf of the PRDA. Their presence and the information they presented helpfully set the context for the training.

Evaluation

In the oral group feedback at the end of the programme, the trainers were thanked for introducing and modelling new activities which they could apply and use in their work, the participants noting that whilst there were a lot of books with theory, the participants had previously not received ideas on how to use these in practice and to train others (such as parents). The multi-professional composition of the training team was also praised – one participant commented that, as psychiatrists, they were not used to seeing different professionals work together and it was good to see a child psychiatrist, educational psychologist and a counselling and organisational psychologist show good team work.

The training was formally evaluated on a number of dimensions using an 11 point likert scale. In summary, all the participants felt that the workshop was useful for better performance in their jobs. In particular, participants highlighted that the workshop programme had introduced new ideas, activities and trends in planning mental health services in their area and in managing youth mental health problems. Some felt that the workshop had been useful to help them "rethink and arrange" their work-plans with children and adolescents and to identify, assess and manage clinical problems presented in children and families in a "practical/effective way," which they could "practice in [their] settings. In particular, the workshop had been useful in looking at "the detection of children with behavioural issues and assessing them and their families in order to manage children appropriately," "counselling parents" and "educating people". Other participants found the programme useful to "share experts experiences and views "and valued "sharing knowledge" and "moving with international standards."

However, the lack of a continuous programme of training and the number of clinical scenarios, including child psychiatry cases were identified as areas of weakness in the programme content. Three key areas were identified in planning a repeat session of the workshop: These were to extend the duration of the workshop to 2 to 3 days, distribute the training materials and programme in advance so that participants could prepare relevant case studies to bring to the training and include more case discussions and role plays to provide a forum for discussion in particular areas.

Case study 2: Developing an ethical code and ethical practice

The authors were asked by a consultant psychiatrist who is a member of the board of trustees at a large counselling/psychosocial organisation named Shanthiham (www.shanthiham.org) , to facilitate a workshop on developing a code of ethics for their organisation. Shanthiham is located in the north of Sri Lanka. One of the authors had worked with this organisation over a number of years and knew

its work and goals well. The issue of cultural mores and practices were discussed in preparation and throughout the workshop. The importance of recognising these was central to the workshop and in ensuring that these formed the back drop or context of any code. The authors also had discussions with various key individuals prior to the workshop to try to enhance their familiarity with the current situation. The workshop was built on a facilitatory and partnership model of working. The workshop was conducted through an interpreter as there were several people present who were not fluent Tamil speakers including the facilitators, though the small group work was conducted in Tamil. Participants were from this agency and a range of other local agencies who were considering the same issues. The facilitators had previously presented and published on issues of ethics and culture and had also consulted a range of relevant literature and other ethical codes used around the world.

An overview of the particular context, of associated mental health and legacy issues relating to the war and the specifics of the situation in Jaffna and the north of Sri Lanka are discussed in detail in a recent paper by Somasundaram & Sivayogan (2013). They argue that collective trauma where whole communities are traumatised is key to understanding some of the contextual factors, as well as the post war situation in the north of the country which appears in some cases to be exacerbating mental health issues. They note that the labelling of individuals is not always the most helpful way forward and can lead to stigmatisation. They make a number of recommendations for improving mental health and well-being at the individual and community level within this area. These include more community based programmes, the importance of cultural rituals and ceremonies and the need for people to be able to return to their ancestral land and homes which have a particular significance in Tamil culture.

The trainers who facilitated this workshop, started it by having an open discussion about the purpose of ethical guidelines in Shanthiham and other organisations. A discussion about the level at which ethical guidelines might operate, then took place, for example should this be organisational, regional or national? The authors had already researched the issue of whether there were any national

guidelines for psychologists or counsellors and found there were a number of ethical guidelines available in the country for counsellors, but that these were not national guidelines but agency based guidelines and therefore not generalisable. The Sri Lankan Psychological Association is in the process of being formally constituted and they hope to produce national guidelines in due course (de Zoysa, 2013).

The workshop also discussed the necessary process and potential sanctions that should be put in place if an ethical code is not adhered to. In small groups the participants came up with examples of ethical dilemmas that they had faced in their work. Many western codes of ethical practice are located in a culture of autonomy and individualism whilst many cultures value collectivism such as China and Singapore. This was discussed in relation to the Sri Lankan context, as was the issue of what is an ethical absolute and what is cultural relativity in relation to ethics. For example, in Sri Lanka which is a more collectivist society, many young adults live at home with their parents until they get married. Children who left home due to the civil war or for other reasons faced great difficulties adjusting when they returned home to their parents; this sometimes gave rise to a range of issues and difficulties for either or both parties. Any mental health professional would need to be cognisant and sensitive to the cultural and social mores and context when working in such a situation and bear in mind the ethical implications of this. Other ethical issues raised including relationships between people who were not married and the issues of touch.

The authors also discussed the work of Leach and Harbin (1997) who looked at codes of ethics in 24 countries which used 19 different codes and discussed the similarities and differences. The workshop included a mixture of presentations with information about various ethical codes used in different countries, several group exercises and scenarios with the participants defining what they thought should be contained within an ethical code. In addition various models of ethical decision making were also presented. The workshop finished with a range of suggestions about ethics and ethical codes which it was hoped that the staff and board of Shanthiham could use in developing an ethical code.

Conclusion

In summary, the authors have been working to increase mental health capacity in Sri Lanka (a post conflict country) through effective invited professional volunteer partnerships where most of the volunteers are mental health professionals from the Sri Lankan diaspora living in the UK. The context in Sri Lanka was discussed; this was followed by two case studies, one of which related to training work undertaken by the authors with the Ministry of Health (MOH) and one with a local NGO, Shanthiham. A number of issues emerged from the MOH training which highlighted to the community medical officers that a more holistic approach to family and child health might be required. Through group discussions, role plays and mapping exercises, it was evident that their requests to import parent training programmes that were used in high income countries, were neither relevant, feasible nor practical for Sri Lanka, given time and capacity constraints. Furthermore, the training highlighted the benefit of partnership working with other agencies and professionals to assist psychiatrists and medical officers to on occasions move away from a model of mental health that asserted the primacy of specialist "treatments" such as cognitive behaviour therapy programmes, various forms of trauma counselling and debriefing, to a more holistic, systemic and preventative approach to public mental health.

Multi-professional training teams also provide an opportunity to model different models of training that move away from traditional didactic methods used in some countries, to a more reflective approach. In this way, capacities building around community mental health programmes are re-defined in recognition of the long term impact and need for collective responsibility. Programmes and systemic examination of contextual issues is therefore required when planning mental health training and mental health, medical and psycho-educational services for adults, children and adolescents. Jones (2008) argues that culture, context and the specific meaning of events should be used as a framework for assessment and intervention, for to do otherwise risks denying large numbers of children and families of the early support that they need. Punamaki (2001) also argues the case for early (that is, before the age of 12 years) psychosocial interventions with children and young people affected by sustained political violence – her eleven year long term study with Chilean children

who had lost a family member through political violence found that early intervention and sustained psychosocial support to both the child and the family predicted better coping strategies and adult well being in later life, in terms of good mental health, family cohesion and positive learning experiences (Punamaki, 2001).

Whilst ethical and professional practice codes underpin and influence every aspect of service planning and delivery, as well as forming the cornerstone of appropriate and accessible services so are central building blocks. In addition, whilst rebuilding a nation, post conflict, can bring rapid national development and urbanisation, the impact of these changes in society on the mental health of a population must also be considered (Trivedi, Sareen & Dhyani,2008; Tan, Fung, Hung & Rey, 2008). Organising and delivering public health services, including mental health services, in post conflict countries is clearly complex and challenging (Piachaud, 2007). Yet, as this paper highlights, multi professional, inter-sectoral partnerships, both inter and intra country may be an effective way of meeting this challenge.

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