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Improving the outcome research on mental health and psychosocial programs in post-disaster and (post)-conflict settings

An Issues Paper for the CRED/EM-SEANET Expert Consultation

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Background to the Expert Consultation

The expert consultation, *Improving the outcome research on mental health and psychosocial programs in post-disaster and (post)-conflict settings* is an Emergency Southeast Asia Network (EM-SEANET) initiative, jointly organised by the Centre for Research on the Epidemiology of Disasters (CRED) and HealthNet TPO. In addition to other health-related aspects of conflicts, disasters and infectious diseases, mental health is one of EM-SEANET's focus themes. EM-SEANET falls within the International Corporation and Developing Countries (INCODEV) program, of the European Commission's Framework Program 5.

The theme for the expert consultation has been derived from the recognition that improving the quality of psychosocial and mental health services requires ongoing research and the development of stronger assessment, monitoring and evaluation tools in order to understand and improve upon the effectiveness of such interventions. This event was initially conceived upon the request of EM-SEANET Partners in Cambodia who identified mental health services as an area requiring strengthening in the region.

The main objectives of this consultation are to review the current status of psychosocial and mental health programs in relation to assessment, monitoring and evaluation methodologies and to develop a research agenda for improving the quality, efficacy and effectiveness of psychosocial and mental health interventions in post-disaster and (post)-conflict settings.

The issues covered here only touch upon some of the many controversies that exist in what is a very complex field. The current consultation will provide a forum for other research experiences and issues to be raised and discussed, with the aim of clarifying the priority issues for improving outcome research and ultimately, the quality and effectiveness of interventions in this field.

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1. Introduction

For the past 50 years, the international effort to mediate the impact and human suffering in the wake of natural disasters and conflict has grown significantly in scope and professionalism. Yet it has only been relatively recently that international policy makers, and humanitarian agencies have begun to recognise and respond significantly to the mental health consequences of humanitarian emergencies.

Every year millions of people - the majority of which reside in non-western, low to middle income countries - are affected by disasters and conflict. There is now wide recognition that disasters and conflict can have serious consequences on both the psychological and social wellbeing of individuals and their communities (Batniji, Van Ommeren, & Saraceno, 2006; Katz, Pellegrino, Pandya, Ng, & DeLisi, 2002a). As the international response to the 2004 Indian Ocean earthquake and tsunami demonstrated, mental health and psychosocial interventions have become a common component of many humanitarian programs.

However despite this proliferation in post-disaster and post-conflict mental health and psychosocial programs[1], a dearth of quality and quantity research has continued to fuel controversy and hampered consensus in the field. Major issues have revolved around the cross-cultural relevance and effectiveness of applying certain diagnoses and interventions which have been developed and tested in high-income, Western societies to low-income, non-Western settings.

Although there have been attempts to examine the effects of various trauma-related mental health and psychosocial treatments, many have been criticised for their lack of methodological rigor. Without well-controlled and randomized studies, critics argue that the efficacy of many of these mental health or psychosocial interventions remains unknown (Foa & Meadows, 1997).

While in other areas of health intervention scientific research tends to precede and influence practices on the ground, the reverse trend can be observed amongst psychosocial methods in emergency situations (Morris, van Ommeren, & Saxena, 2006). This is particularly true in the context of developing countries, although some evidence exists to support the effectiveness of applying direct psychological interventions to treat common emotional disorders (Araya et al., 2003; Patel et al., 2003).

[1] The draft pre-amble of the Inter-Agency Standing Committee (IASC) Guidance on Mental Health and Psychosocial Support in Emergency Settings refers to "mental health and psychosocial support" as a composite term to "describe any type of local or outside support that aims to protect or promote psychosocial well-being *and/or* prevent or treat mental disorder […] Although these terms are closely related, for many actors they have come to signal different, yet complementary, approaches […] Exact definitions of these terms vary between and within organisations, discipline and countries". The IASC's use of the composite term *mental health and psychosocial support* is intended to "serve as broad a group of actors as possible" whilst at the same time reinforcing that "diverse approaches are necessary for the provision of appropriate support" (Note that the IASC Guidance on Mental Health and Psychosocial Support in Emergency Settings is still in its draft stages. This information was provided via correspondence from van Ommeren, 2006).
More information on the IASC project can be obtained from:
http://www.humanitarianinfo.org/iasc/content/documents/default.asp?docID=1594&publish=0

Underlying the problem of insufficient data to guide future interventions is the difficulty involved in designing reliable and valid instruments by which to accurately assess of psychosocial wellbeing. Furthermore, the lack of an evidence base for interventions in non-western disaster and conflict settings means that most practical guidance tends to be based on expert and staff opinion and experience. As Duncan and Arnston note:

> *"…too often project practitioners must take a leap of faith that their projects are having a measurable and positive effect on the lives of children, families, and communities. Without indicators, however, practitioners are left in the position of asserting that projects are "helpful" in broad and often unverified ways."* (2004: i)

This situation has led to an increasing call to improve standards and strengthen the evidence-base for this field (Mollica et al., 2004). There have been recent efforts to develop consensus policy derived from best practice for emergency psychological and social interventions (e.g. the SPHERE standards project and the IASC Task Force on Mental Health and Psychosocial Support guidelines). Guidelines such as these have stressed the need for ongoing monitoring and evaluation practices not only to inform planning and policy, but to strengthen the evidence-base for psychosocial and mental health interventions (IASC, 2006).

By providing a review of current issues, this paper attempts to highlight some of the key areas where ongoing research is needed. It is expected that the expert consultation to follow will elaborate and expand on these and other issues further.

2. Needs and assessments

2.1 An overview of issues and challenges

Prior to any mental health or psychosocial intervention, some form of assessment should be conducted. Assessments are required to identify the problems and resources of the population in order to plan mental health and psychosocial interventions appropriately. They should cover factors such as the population's resiliency and risk factors, vulnerable groups' social and psychological health problems, as well as an overview of available psychosocial and mental health resources (de Jong et al., 2001; Mollica et al., 2004). Well-executed assessments enable implementers to tailor their programs to individual socio-cultural settings, whilst also avoiding assumptions about communities' psychosocial and mental health priorities[2].

Unfortunately, comprehensive assessments are not always performed by implementing agencies and conducting mental health and psychosocial assessments in unstable, emergency situations is often difficult. Analyses of psychosocial needs assessments conducted in Sri Lanka following the 2004 tsunami revealed that whilst some humanitarian organisations are reportedly developing them, few concrete tools were actually being implemented for assessing psychosocial needs. Instead, there was often

[2] It should be noted however that in the case of acute emergencies, detailed and time-consuming assessments may not necessarily reflect best practice. Instead NGOs may have to use standard emergency psychosocial interventions (such as psychosocial first aid) until the basic survival and psychosocial needs of the population have been met.

an assumption that communities affected by disasters have psychosocial needs and that therefore needs assessments were not considered a pre-requisite for intervention (Marsden & Strang, 2006).

While it is accepted that in the immediate post-disaster period almost the entire affected population is likely to display signs of distress (which may include signs of a range of disorders, such as mood and anxiety disorders, including posttraumatic stress disorder, PTSD) (Bryant, 2003), most people recover from traumatic events without professional intervention. One of the major challenges for more effective mental health care - and an area deserving further research - is therefore the development of better techniques for identifying which subgroups of survivors are at high risk of developing subsequent debilitating conditions requiring psychological or psychiatric interventions (Silove & Bryant, 2006).

Although they did not address this latter issue, recent studies by Thienkrua, et al. (2006) and van Griensven, et al. (2006) following the 2004 tsunami in Thailand have contributed to a better understanding of post-disaster mental health epidemiology. These studies consisted of rapid assessments of affected communities using outcome measures for self-perceived general health, social and emotional function, trauma, anxiety and depression[3] (Thienkrua et al., 2006; van Griensven et al., 2006). In addition to identifying factors that may render people susceptible to diagnosable mental illnesses, such studies provide evidence for what had been described by relief agencies in post-tsunami reports regarding the significant psychological impact that loss of livelihood has on people in low-income communities (Mashni, Reed, Sasmitawidjaja, Sundhagul, & Wright, 2005).

While the studies demonstrate the feasibility of conducting rapid assessments of post-disaster mental health needs, caution is warranted over the interpretation of the reported rates of trauma symptoms (Silove & Bryant, 2006). Firstly, the measures used may not have been validated for that particular context, (i.e. a disaster-affected population or the culture in which it was applied). Secondly, as Silove and Bryant (2006) remark "the psychiatric indices were defined solely by the endorsement of symptoms, a method that might inflate prevalence rates unless psychosocial impairment is measured concurrently" (p. 576). Indeed, standard diagnostic tools, such as the ones used in the studies, have typically been developed and validated in western-settings, under "normal" conditions. However when applied in an emergency context (where non-pathological distress is a typical and expected reaction), such tools are likely to overestimate the number of people who would benefit from professional mental health care.

A related issue to consider is the continued controversy over the widespread application of the PTSD diagnosis, particularly when the validity of western diagnostic tools across many cultural settings remains unknown (Bragin, 2005; Summerfield, 2004). Many experts argue that the popularity and proliferation of clinical and research reports on PTSD has led to a general misconception that post-traumatic stress disorder is the principal or most important mental disorder resulting from disaster or other traumatic event (Bracken, Giller, & Summerfield, 1995; van Ommeren, Saxena, & Saraceno, 2005). In reality however, PTSD represents just one of a range of often co-morbid mental disorders which may become more prevalent following conflict or

[3] Instrument used included the Harvard Trauma Questionnaire, Medical Outcomes Study-36 Short-Form Health Survey SF-36 and the Hopkins Checklist-25.

disaster. Overemphasising PTSD in such situations is problematic as international organisations risk excessively channelling precious resources into narrowly-defined, vertical services that do not serve the people with other mental health or psychosocial problems (WHO, 2003).

2.2 Links between diagnosed disorders and disability

Another issue deserving further research is the extent to which the symptoms of a diagnosable disorder are associated with disability. It is possible after all that diagnostic criteria be met without significant psychosocial impairment. For instance, a survivor of the tsunami who exhibits "intrusive memories typical of PTSD may still be able to take his boat out to sea, raising questions of whether he warrants urgent mental health attention" (Silove & Bryant, 2006, p. 577). In other words, a PTSD diagnosis may not always be a robust predicator of an individual's capacity to keep functioning despite hardship or a reliable indicator that an individual is likely to benefit from clinical treatment (Summerfield, 1996, 1999).

According to Bolton, et al. (2004) insufficient attention has been paid to assessing the different domains of social functioning, changes in symptomology over time, impaired social functioning and the links between them. Of the research that has been conducted, results vary. For instance, previous research reported that children and adolescents not meeting DSM-III-R (American Psychiatric Association, 1987) diagnostic criteria still exhibited psychosocial impairment due to sub-threshold symptoms (Angold, Costello, Farmer, Burns & Erkanli 1999, cited in Bolton, et al. 2004). However research by Bolton, et al. (2004) on diagnosable mental health problems and psychosocial functioning across six domains[4], did not support these findings. Only the survivors of a traumatic event who met the diagnostic criteria for psychopathology in turn demonstrated impairment of psychosocial functioning. Survivors who did not meet DSM criteria did not demonstrate a measurable impact on their psychosocial functioning.

Such research may have important implications for designing appropriate interventions as the nature of the psychosocial impairment also appears to vary as a function of the type of pathology diagnosed. What is certain is that the associations between psychosocial impairments and psychopathology are highly complex, "varying between disorders in degree, kind and in the mechanisms involved" (Bolton et al., 2004).

Further research in this field will result in a better understanding of the effects of emergencies (social change, loss, trauma) on psychosocial functioning, how best to assess the needs and tailor the intervention to address specific impairment problems.

2.3 Cross-cultural issues

Some of the major areas requiring further research pertain to cross-cultural issues and the development of mental health and psychosocial tools that are sensitive to the cultural and contextual differences of low-income, non-western countries. Currently, most of the literature in the psychosocial and mental health field report on studies conducted in high-income countries. As Bryant (2006) notes, the bulk of data on the

[4] Psychosocial functioning was assessed with the Adolescent to Adult Personality Functioning Assessment (ADAPFA), across the domains of *Edcation/Work, Love Relationships, Friendships, Non-specific Social Contacts, Negotiations* and *Coping.*

psychosocial consequences of trauma derives from "small-scale studies of discrete trauma events in Western countries" therefore the degree to which such findings can be extrapolated to low-income countries and large-scale disasters (such as the 2004 Indian Ocean tsunami) is questionable.

Indeed a major challenge when conducting assessments in cross-cultural settings is ensuring that the tool being applied is *valid* – that is, that the tool measures what it purports to measure. For many countries in the developing world, locally-validated assessment instruments and appropriately trained mental health workers are rare. As such, undertaking criterion validity tests of standard instruments cannot often be performed with existing local resources (van Ommeren, 2003). Acquiring cross-cultural validity and reliability of standard psychiatric tools is further complicated by the absence of reliable baselines required for a 'gold standard'[5] approach to testing (Bolton, 2001).

Recent research has demonstrated however that such validity testing in resource-poor settings is possible (Bolton, 2001). The method relied on input from the local community as an alternative standard for testing criterion validity for the depression section of the Hopkins Symptom Checklist (DHSCL)[6]. Although this approach does not replace the usual gold standards for testing criterion validity, it may prove useful in other contexts where such standards are unavailable.

3. Interventions and evaluations

3.1 Cross-cultural issues

Like many of the tools used in assessments, most of the therapeutic techniques used to deal with the psychological effects of traumatic events have been developed and tested in western cultures. Critics have argued however that the common western approach based on individual and introspective clinical techniques may be less appropriate in other cultures (Summerfield, 1996). For example, in western cultures most PTSD therapies are managed on a one-to-one basis while in Asian countries group therapies represent a more common and feasible approach (Boehnlein, 1987; Bryant & Njenga, 2006). It is likely that the significance of the extended family and the strong ties that people in many Asian cultures have with their village and communities are likely to play a role in this. Other cultural and religious factors influence the way in which people react and comprehend a traumatic event, which in turn is likely to influence their responses to subsequent mental health interventions (Bryant & Njenga, 2006).

Whilst ways to achieve more culturally-appropriate interventions may vary, they often involve the local population (e.g. local government, community leaders and community representatives) in identifying needs and designing appropriate interventions. The engagement of indigenous social scientists, psychologists and other professionals in planning, implementing and evaluating intervention programs can also

[5] A "gold standard" refers to a "relatively irrefutable standard that constitutes recognized and accepted evidence that a certain disease exists" (Kassirer & Kopelman, cited in Bolton, 2001).

[6] It should be noted however the suitability of this validation method will vary depending on the degree of similarity between the locally-defined illness and the western-defined illness. As Bolton (2001) points out, the more a local illness corresponds with a western-defined illness, the more effectively it can be used as an alternative gold standard.

bring valuable insights into local culture. In all cases, careful dialogue is required to ensure appropriate adaptation of tools, cross-cultural understanding and acceptance of western psychological interventions (Bryant & Njenga, 2006).

3.2 Distinguishing between effective and ineffective interventions

In addition to adapting interventions to local cultures, more research is urgently required to test the effectiveness of the interventions being implemented. According to Bryant and Njenga (2006) controlled studies in this field need to "focus on both the capacity of the intervention to reduce symptoms and the willingness of the practitioners to embrace the intervention" (p. 78).

Strengthening methods of evaluation for current therapies is crucial in order to identify ineffective, or worse still, potentially harmful interventions. Western studies of psychological debriefing for example, have reported contradictory findings regarding the effectiveness of such techniques. This led to calls for the discontinuation of such practises until further research can demonstrate rigorous evidence of its efficacy (Katz, Pellegrino, Pandya, Ng, & DeLisi, 2002b). Subsequent research using randomized controlled trials suggest that psychological debriefing had no superior outcome effect compared to control groups (see discussion on research effectiveness of psychological debriefing in Gray, Maguen, & Litz, 2004). Despite these concerns, psychological debriefing was reportedly widely practiced by agencies in the emergency period following the 2004 Indian Ocean tsunami (Bryant & Njenga, 2006).

The effectiveness of other techniques such as the provision of self-help information (Turpin, Downs, & Mason, 2005) has also been questioned. Also, EMDR programs in Indonesia found no evidence for any therapeutic benefit, although this may have been due in part to the therapists' lack of training (Melville, 2003).

On a positive note, recent studies have demonstrated that through careful application and analyses, direct psychological interventions adapted from western traditions can be effective in treating PTSD and depression in non-western, low-income countries (Bass et al., 2006; Bolton et al., 2003). The studies tested group interpersonal psychotherapy (an approach recognised to be effective in reducing symptoms of depression in high-income countries) as a treatment method for DSM-IV major depressive disorder in rural Uganda. Not only were depressive symptoms significantly reduced in the period following the intervention, the six month follow up showed that the positive effects of the intervention had been retained (Bass et al., 2006). While such studies represent promising advances in the field there is a persistent need for more research of its kind.

4. Other issues

4.1 Long-term effects

Future research may want to consider evaluating the long-term outcomes and impacts of psychosocial and mental health interventions. Currently, such research tends to be limited and on the ground it is perhaps unrealistic to expect organisations and agencies delivering emergency programs to have the means or resources to conduct follow-up evaluations over extended periods (Duncan & Arnston, 2004). However as Bass et al. (2006) point out, "achieving long-term sustained benefits of mental healthcare is

particularly important in low-income countries, where scarcity of resources virtually precludes frequent offerings of further interventions" (p. 572).

4.2 Cost-effectiveness

Similarly, little is known about the effectiveness, let along the cost-effectiveness, of western-developed mental health treatments when applied in non-western community settings. Recent efforts in this area have included a study on the effectiveness and cost-effectiveness of different mental health interventions in Cambodia (Komproe, de Jong, O'Connell, Keo, & van Ommeren, 2006). The study found that mental health interventions based on counselling, psychotropic drugs or supportive group therapy resulted in decreased psychiatric symptoms, psychological distress and disability, which in turn resulted in participants becoming more productive and self-sufficient resulting in economic benefits for the community.

The advantage of cost-effectiveness studies is that they can provide an analysis of the differential cost-effectiveness. In developing countries, cost-effectiveness analyses are particularly essential for informing treatment selection to ensure the most efficient use of what are typically, very limited resources (de Jong, Komproe, & O'Connell, 2004).

5. Challenges for research and the next steps

The inherent difficulties of studying and assessing such a new and complex area of humanitarian intervention have contributed to the lack of both baseline data and post-intervention outcome data. As has been discussed briefly in this paper, it is widely acknowledged that much work needs to be done in the area of outcome research for post-disaster, (post-) conflict mental health and psychosocial interventions.

5.1 Bridging the gaps between the field and research

Conducting quantitative post-disaster psychosocial or mental health research in non-western settings involves numerous methodological, practical and logistical challenges. Furthermore although community-based interventions may be more feasible to the local setting, evaluating such programs is challenging as they do not easily lend themselves to testing by randomized control trials or other quantitative methods preferred by western scientific journals (Nutbeam, 1998). In fact this preference for quantitative, randomised studies in peer-review journals means that even the qualitative/descriptive research that does exist in non-western settings is rarely published (Morris et al., 2006).

From the field perspective, whilst practitioners may acknowledge the lack of data on the impact of mental health and psychosocial interventions in developing countries, the extent to which they engage in research or even systematic data collection is limited. Contributing factors for this include the lack of funding for such research (with the bulk of donor-funding channelled into program implementation) as well as limited local resources and skills to conduct such activities (Poudyal, 2006).

Researchers in low and middle income countries also have difficulties publishing their research in indexed journals (Morris et al., 2006). A lack of advice on research design and statistics, limited access to information, material and resources mean that they

often fail to meet the requirements for publication (Editors & WHO, 2004). In addition, the content of international indexed journals is not widely accessible in low and middle income countries. Local access difficulties are caused by linguistic and financial barriers and the fact that only a small proportion of local workers have sufficient education or technical knowledge to fully comprehend the issues upon which the academic debate is based (Galappatti, 2003). This situation has led to calls for greater efforts to bridge the gap between western-dominated academic debate and the valuable research and programs being implemented in low and middle income countries (Editors & WHO, 2004; Saxena & Sharan, 2003).

5.2 The next steps

While few would dispute that there are many areas of psychosocial and mental health interventions that require further research, strengthening the basis for assessments and evaluations of psychosocial and mental health interventions should be recognised as a research priority. While the systematic collection and distribution of data and information on locally-implemented mental health and psychosocial programs will be a valuable first step to reducing the duplication of activities, poorly-informed decisions and wasted resources, it cannot replace rigorous outcome research.

More effective, evidence-based interventions can only be achieved through the concerted efforts of academics and practitioners alike. Engaging in ongoing research for stronger assessment, monitoring and evaluation tools will result in more effective treatments and a stronger consensus on the minimum standards and methods of best practice for the field.

It is hoped that through continued dialogue and networking, our colleagues across a variety of disciplines, cultural settings and regional perspectives will continue to share their input and critical insights, and in so doing advance the collective knowledge on these issues.

The Proceedings of the Consultation, scheduled for the 26-27 October 2006, will be documented and distributed to all participants and interested parties.

Any feedback or questions can be directed to the Coordinating Team, via email to Lian.Parry@esp.ucl.ac.be and Marijn.Kraaikamp@esp.ucl.ac.be

References

Araya, R., Rojas, G., Fritsch, R., Gaete, J., Rojas, M., Simon, G., & Peters, T. J. (2003). Treating depression in primary care in low-income women in Santiago, Chile: a randomised controlled trial. *Lancet, 361*(9362), 995-1000.

Bass, J., Neugebauer, R., Clougherty, K. F., Verdeli, H., Wickramaratne, P., Ndogoni, L., Speelman, L., Weissman, M., & Bolton, P. (2006). Group interpersonal psychotherapy for depression in rural Uganda: 6-month outcomes - Randomised controlled trial. *British Journal of Psychiatry, 188*, 567-573.

Batniji, R., Van Ommeren, M., & Saraceno, B. (2006). Mental and social health in disasters: Relating qualitative social science research and the Sphere standard. *Social Science & Medicine, 62*(8), 1853-1864.

Boehnlein, J. K. (1987). Clinical Relevance of Grief and Mourning among Cambodian Refugees. *Social Science & Medicine, 25*(7), 765-772.

Bolton, D., Hill, J., O'Ryan, D., Udwin, O., Boyle, S., & Yule, W. (2004). Long-term effects of psychological trauma on psychosocial functioning. *Journal of Child Psychology and Psychiatry, 45*(5), 1007-1014.

Bolton, P. (2001). Cross-cultural validity and reliability testing of a standard psychiatric assessment instrument without a gold standard. *Journal of Nervous and Mental Disease, 189*(4), 238-242.

Bolton, P., Bass, J., Neugebauer, R., Verdeli, H., Clougherty, K. F., Wickramaratne, P., Speelman, L., Ndogoni, L., & Weissman, M. (2003). Group interpersonal psychotherapy for depression in rural Uganda - A randomized controlled trial. *Jama-Journal of the American Medical Association, 289*(23), 3117-3124.

Bracken, P. J., Giller, J. E., & Summerfield, D. (1995). Psychological Responses to War and Atrocity - the Limitations of Current Concepts. *Social Science & Medicine, 40*(8), 1073-1082.

Bragin, M. (2005). *The Tiger is Our Guest: Helping Children to Grow Up in Times of War and Afterwards. A Review of CARE's Psychosocial Programming in Emergency and Post-Emergency Contexts (Kosovo & North Caucasus).*

Bryant, R. A. (2003). Early predictors of posttraumatic stress disorder. *Biological Psychiatry, 53*(9), 789-795.

Bryant, R. A., & Njenga, F. G. (2006). Cultural sensitivity: Making trauma assessment and treatment plans culturally relevant. *Journal of Clinical Psychiatry, 67*, 74-79.

de Jong, J. T. V. M., Komproe, I. H., & O'Connell, K. A. (2004). *Effectiveness and cost-effectiveness of mental health care in five low-income countries: Burundi, Cambodia, Gaza, Nepal and Uganda* (Project report PCF 059). Washington: World Bank.

de Jong, J. T. V. M., Komproe, I. H., Van Ommeren, M., El Masri, M., Araya, M., Khaled, N., van de Put, W., & Somasundaram, D. (2001). Lifetime events and posttraumatic stress disorder in 4 postconflict settings. *Jama-Journal of the American Medical Association, 286*(5), 555-562.

Duncan, J., & Arnston, L. (2004). *Children in crisis: Good practices in evaluating psychosocial programming.* Save the Children Federation, Inc. Retrieved 23 August 2006, from the World Wide Web: www.savethechildren.org/publications/Good_Practices_in_Evaluating_Psychosocial_Programming.pdf

Editors, J. S. b., & WHO. (2004). Galvanizing mental health research in low- and middleincome countries: role of scientific journals. *Bulletin of the World Health Organization, 82*(3), 226-228.

Foa, E. B., & Meadows, E. A. (1997). Psychosocial treatments for posttraumatic stress disorder: A critical review. *Annual Review of Psychology, 48*, 449-480.

Galappatti, A. (2003). What is a psychosocial intervention? Mapping the field in Sri Lanka. *Intervention, 1*(2), 3-17.

Gray, M.J., Maguen, S., & Litz, 2004. (2004). Acute psychological impact of disaster and large-scale trauma: Limitations of traditional interventions and future practice recommendations. *Prehospital and Disaster Medicine, 19*(1), 64-72.

Inter-Agency Standing Committee (IASC) Taskforce on Mental Health and Psychosocial Support. (2006). *Guidance on Mental Health and Psychosocial Support in Emergency Settings, Fourth Working Draft.* 120pp. Retrieved 19 October, 2006, from the World Wide Web: http://www.humanitarianinfo.org/iasc/content/documents/subsidi/tf_mhps/IASC%20guidance%20Peer%20review%20version.pdf

Katz, C. L., Pellegrino, L., Pandya, A., Ng, A., & DeLisi, L. E. (2002a). Research on psychiatric outcomes and interventions subsequent to disasters: a review of the literature. *Psychiatry Research, 110*(3), 201-217.

Research on psychiatric outcomes and interventions subsequent to disasters: a review of the literature, 110 201-217 (2002b).

Komproe, I. H., de Jong, J. T. V. M., O'Connell, K. A., Keo, P., & van Ommeren, M. (2006). *Effectiveness and cost-effectiveness of mental health care in Cambodia*.Unpublished manuscript.

Marsden, R., & Strang, A. (2006). *Assessing psychosocial needs: What are we looking for and why? Analysing psychosocial needs assessment in Sri Lanka post-tsunami*. Edinburgh: Institute of International Health and Development

Queen Margaret University College.

Mashni, A., Reed, S., Sasmitawidjaja, V., Sundhagul, D., & Wright, T. (2005). *Multi-Agency Evaluation of Tsunami Response: Thailand and Indonesia*.

Melville, A. S., Faye. (2003). Psychosocial Interventions Evaluation of UNICEF Supported Projects (1999-2001) (pp. 92): UNICEF Indonesia.

Mollica, R. F., Cardozo, B. L., Osofsky, H. J., Raphael, B., Ager, A., & Salama, P. (2004). Mental health in complex emergencies. *Lancet, 364*(9450), 2058-2067.

Morris, J., van Ommeren, M., & Saxena, S. (2006). *Emergency mental health: Increasing the evidence base.*Unpublished manuscript.

Nutbeam, D. (1998). Evaluating health promotion - progress, problems and solutions. *Health Promotion International, 13*(1), 27-44.

Patel, V., Chisholm, D., Rabe-Hesketh, S., Dias-Saxena, F., Andrew, G., & Mann, A. (2003). Efficacy and cost-effectiveness of drug and psychological treatments for common mental disorders in general health care in Goa, India: a randomised, controlled trial. *Lancet, 361*(9351), 33-39.

Poudyal, B. (2006). Psychologist, International Catholic Migration Commission. *Personal correspondence*. 1 May 2006.

Saxena, S., & Sharan, P. (2003). The endeavour to become international. *British Journal of Psychiatry, 183*, 561-561.

Silove, D., & Bryant, R. (2006). Rapid assessments of mental health needs after disasters. *Jama-Journal of the American Medical Association, 296*(5), 576-578.

Summerfield, D. (1996). *The impact of war and atrocity on civilian populations: Basic principles for NGO interventions and a critique of psychosocial trauma projects*. Retrieved 10 September, 2005, from the World Wide Web: http://www.odihpn.org/documents/networkpaper014.pdf

Summerfield, D. (1999). A critique of seven assumptions behind psychological trauma programmes in war-affected areas. *Social Science & Medicine, 48*(10), 1449-1462.

Summerfield, D. (2004). Cross-cultural perspectives on the medicalization of human suffering. In G. M. Rosen (Ed.), *Posttraumatic Stress Disorder: Issues and Controversies* (pp. 233-245). New York: John Wiley & Sons.

Thienkrua, W., Cardozo, B. L., Chakkraband, M. L. S., Guadamuz, T. E., Pengjuntr, W., Tantipiwatanaskul, P., Sakornsatian, S., Ekassawin, S., Panyayong, B., Varangrat, A., Tappero, J. W., Schreiber, M., van Griensven, F., & Mental, T. P.-T. (2006). Symptoms of posttraumatic stress disorder and depression among children in tsunami-affected areas in southern Thailand. *Jama-Journal of the American Medical Association, 296*(5), 549-559.

Turpin, G., Downs, M., & Mason, S. (2005). Effectiveness of providing self-help information following acute traumatic injury: randomised controlled trial. *British Journal of Psychiatry, 187*, 76-82.

van Griensven, F., Chakkraband, M. L. S., Thienkrua, W., Pengjuntr, W., Cardozo, B. L., Tantipiwatanaskul, P., Mock, P. A., Ekassawin, S., Varangrat, A., Gotway, C., Sabin, M., Tappero, J. W., & Mental, T. P.-T. (2006). Mental health problems among adults in tsunami-affected areas in southern Thailand. *Jama-Journal of the American Medical Association, 296*(5), 537-548.

van Ommeren, M. (2003). Validity issues in transcultural epidemiology. *British Journal of Psychiatry, 182*, 376-378.

van Ommeren, M., Saxena, S., & Saraceno, B. (2005). Aid after disasters - Needs a long term public mental health perspective. *British Medical Journal, 330*(7501), 1160-1161.

Van Ommeren, M. (2006). Technical Officer. Department of Mental Health and Substance Abuse, World Health Organization. *Personal correspondence*, 20 October 2006.

WHO. (2003). *Mental Health in Emergencies: Mental and Social Aspects of Health of Population Exposed to Extreme Stressors*. Retrieved 1 December, 2005, from the World Wide Web: http://www.who.int/hac/techguidance/pht/8656.pdf