Psychosocial Assistance in Humanitarian Interventions – Six Years of Experience in IAN (1997-2003)

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Abstract

Six years of the IAN Trauma Centre work and three years of work in the IAN Centre for Rehabilitation of Torture Victims have been marked with socio-political and professional challenges, as well as with challenges common to the work of humanitarian organisations in emergencies. The predominantly psychological and psychiatric profile of the organisation and its core programmes was gradually supplemented with an orientation towards a wider psychosocial context of assistance to victims of torture and war-related trauma, inlcuding not only psychological aid, but also classical humanitarian programmes of emergency material aid distribution, repatriation and integration programmes, skills training and economic self-reliance programmes, medical aid and forensic expertise. This paper provides an overview of key principles underpinning the work of various segments of the comprehensive programme of assisance for torture and trauma victims as the basic operational framework in which specific project activities have been implemented.

INTRODUCTION

The International Aid Network Trauma Centre began to work in December 1997, several months after the organisation had been founded, and was the first, principle and core programme that represented the backbone of all other programmes designed and implemented in IAN. This was a period of almost two years after the Dayton Agreement, when the war in Kosovo could already be forseen, and the operational focus of most humanitarian agencies in the region was shifting away from emergency programmes. At the same time the psychiatric institutions in the country were registering a constant rise in the number of persons exposed to stressfull war experiences and therefore requiring assistance (Ilic, Jovic & Lecic-Tosevski, 1998). In September 2000, undeer the auspices of the IAN Trauma Centre and financial support of the European Commission, the Centre for Rehabilitation of Torture Victims was founded as a section specialised for working with persons who have survived the most severe forms of ill-treatment in captivity. During 2001, CRTV and Trauma Centre were restructured into one functional unit with slighly modified programme aims.

This work aims at outlining the development and basic principles of psychological and psychiatric assistance models in the Trauma Centre. In order to achieve this it is necessary to describe the context in which we have been working. Some other papers in this monograph deal with social, political and other conditions in which IAN psychosocial programmes have been implemented, whereas here we shall look at the professional context with its two aspects: a) humanitarian and b) professional - psychological and psychiatric.

HUMANITARIAN ORGANISATIONS AND PSYCHOSOCIAL ASSISTANCE DURING WARS IN FORMER YUGOSLAVIA

The International Committee of the Red Cross (ICRC) is the leading and probably still the most influential humanitarian agency in the world. Its basic principles, ever since it was founded by Jean Henri Dunant after the battle of Solferino, have been the humanity, impartiality, neutrality and independence. During last decades of the twentieth century some of the basic principles, particularly the one of neutrality, have been criticised and abandoned by most of the other major humanitarian organisations (including the European Community Humanitarian Office - ECHO, Oxfam and Médecins Sans Frontières - MSF). Misuse of humanitarian aid by dictatorship regimes (such as in Somalia), directing aid toward victims who have previously commited crimes (such as in Rwanda), or appeasing social aor political discontent against the regime by improving social or health conditions through humnitarian assistance (such as in Iraq or Serbia), are all factors that have contributed to the creation of the concept of "undeserving victim" (Stockton, 1998) and indirectly to actions aimed at assessing who among those who need assistance deserves it. Neutrality in humanitarian organisations became undesirabe, a "dirty word", something imoral, since the silence meant siding with criminals in a conflict, which has indirectly

turned NGOs into political players. The issue of human rights was placed before the issue of unconditioned assistance. MSF is a representative of a strategy in which a strong attitude against human right abuse must be expressed even at the price of denying the assistance to those who need it. Because of this attitude MSF was prevented from working in Ethiopia during the eighties, but their policy at that time gained plenty of supporters when compared to the humanitarian activities implemented; their approach was fundamentally promoted with awarding them the Nobel Prize for Peace in 2000 (Fox, 2001).

Furthermore, humanitarian aid is now conditioned and the priorities are assessed on the basis of long-term effects and development potentials, which are evaluated by the NGOs themselves. The ultimate outcome of this is that important and far-reaching decisions about complex issues are made by people who are neither chosen nor competent to make these decisions, frequently in an environment whose culture is completely alien or unknown to them. Serbia under Milosevic is a very good example of the concept of "undeserving victim": the fall of the regime has led to a total shift in the attitude on humanitarian aid (Fox, 2001). Due to UN and EU sanctions during the nineties, even the UN humanitarian agencies such as UNICEF and WHO were allowed only monitoring missions (Garfield, 2001), and the UNHCR was unable to utilise assistance funds for former Yugoslavia in the them FRY, since it was "negatively earmarked" (Black, 1993). Medicines were exempt from sanctions, but the relevant body in New York in charge of approving medical imports kept delaying the shipments for several months due to bureaucratic procedures regarding import licences, wheras the raw materials for production of drugs were not exempt from sanctions (Black, 1993). When immediately after the NATO air strikes in 1999 IAN, with support of CAFOD, began the drugs distribution programme for psychiatric institutions and homes for disabled children, from friends in other NGOs we have heard an oppinion that IAN is reducing social tensions and thereby assisting the Milosevic regime. The position of the then IAN Board of Directors was that the overriding priority was to provide assistance to patients who were completely deprived of medication during that period.

The debate about new principles of humanitarian work shall certainly lead to revising the role of NGOs in future conflicts, their credibility and responsibility, but also the development of technology of disaster interventions. What remains in the shadow of this debate is the relation of major agencies towards the NGOs in the field, i.e. their local partners and partner organisations. Unfortunatelly, the Balkans have during the nineties been a theatre for testing numerous roles and models of humanitarian aid, and this is likely to be a topic that many will yet write about. Hundreds of agencies that enter crisis area with recognisable iconography («*landcruisers, celular phones and car stickers*») have become a usual phenomenon marking the nineties throughout the world. Major international organisations, through systems of subcontracts, have been encouraging the development of indigenous local NGOs who became "implementing partners", frequently in implementation of inapplicable, culturally and environmentally inappropriate programmes based on the «*copy/paste*» technology. Dependency of local NGOs on the international ones usually did not lead to a creative partner relatioship.

However, the proliferation of agencies was not necessarily a bad consequence: very strong competition led to the quick development of assistance models, and humanitarian organisations with their rapid response, flexibility and cooperative capabilities by far surpass the government agencies of developed countries participating in humanitarian emergencies (Stockton, 1998). Despite everything, a significant number of humanitarian organisations in Serbia managed to provide much needed assistance to the population, especially the refigees. It would be unfair to name some of them and omit others. Some international NGOs have given an invaluable contribution to the development of the third sector during Milosevic regime, through training of staff, capacity building and contacts with European and other international institutions. After the fall of the regime, a significant number of former local NGO activists have taken over positions in state bodies, contributing to the quicker revitalisation of the country. At this time several local NGOs have passed the growing stage of amateurism and are able to contribute with their professionalism and experience to the improvement of certain areas of knowledge within their field of activity on the international level as well (we believe that IAN is one of such organisations). Unpleasant experiences fade away and the memory remains of many exceptionally courageous and committed people who, coming from various sides to this country, have risked and given plenty in order to mitigate the predicaments. Their efforts have by far surpassed any professional interest, while the contact with them and sometimes the everyday work in difficult circumstances have inspired us and kept us from losing our faith in some of the basic principles of humanity.

PSYCHOLOGICAL TRAUMA – THEORETICAL MODELS AND PRACTICAL IMPLICATIONS

Psychologocal assistance in emergencies is ofter based on certain assumptions common to all models. These assumptions are the following: 1) catastrophic events such as war lead to psychologocal and psychiatric consequences; 2) psychological and/or psychiatric disorders originating in war are caused primarily by traumatic events; 3) majority of people exposed to traumatic events need assistance; 4) assistance is best provided quickly and immediately following trauma; 5) there are various types of psychological and psychiatric assistance that could be provided to those afflicted.

Consequences

Psychologicala nd psychiatric consequences of disasters, especially wars, are significant, massive and potentially disabling. These consequences are not always denoted by same terms or nosological categories. Depending on context, various words are used such as stress disorders, trauma / traumatic disorders, traumatic stress, post-traumatic stress disorder (PTSD), "war-related disorders", etc. Differences can be viewed as a consequence of a conflict between the 'hosological (top-down) and empirically based (bottom-up) approaches to assessment and taxonomy of psychopathology" (Achenbach, 2001). In the choice of terminology an important role is given to avoiding medicalisation and/or

pscyhiatrisation, often tantamount to stigmatisation, which is "combined with a prevailing trend to consider all refugees as emotionally distressed sufferers in need of non-medically oriented psychosocial rehabilitation" (Mollica, Cui, McInnes & Massagli, 2002). However, pragmatic resons, such as programme and operational aims (e.g. choice of target group or choice of particular type of intervention) also play an important role. On the other hand, it is clear that PTSD, as defined according to the criteria of psychiatric classficiations ICD-10 and DSM-IV, is not the only disorder that could be developed after traumatic experiences in disasters.

Causes

Stress-related disorders are in most cases described as "normal reactions to abnormal circumstances". This implies that the traumatic event is the cause of a pathological change. Changes are most ofter described in terms of the "economic model" (stressor of too string intensity disrupts the balance / possibility of adaptation / defence mechanisms / coping mechanisms, which leads to disorder). This model actually belongs to the psychoanalytical tradition (Bohleber, 2002). "Abnormal circumstances" encompass almost everything that has happened to the population of this country during the past ten or more years and this term is certainly insufficient for any distinction. Psychiatric classifications offer somewhat improved definitions of stressors: exposure to an event "involving actual or imminent death or serious injury or threat to own physical integrity or the integrity of others" (American Psychiatric Association, 1994), or "to a stressful event or situation (whether short-term or long-term) of an extremely theratering or catastrophic nature, that can cause comprehensive suffering of almost any person" (World Health Organization, 1993). These are definitions of stressors in the diagnostic criteria for PTSD. A simplified formula that a stressor "of the sufficienly high intensity" causes the disorder, has been advanced by an "epidemiological triad": agent (trauma) + host (personal characteristics of the refugee) + environmental conditions (social support, material deprivation, etc.) [7]. Complicated process of reducing psychological disorders to medical models has not been of great help in practical work. Adherents of the social constructivism oppose to the reductionist biological model an equaly unacceptable position that PTSD is an "entity constructed as much from socio-political ideas as from psychiatric ones" (Summerfield, 2001).

Who needs assistance?

Definition of the target group in need of psychosocial assistance is often based on a theoretical position. If the criterion is set very low (e.g. exposure to stressors), we get huge numbers of people at risk, accounting for tenths of percents of the exposed groups. Uncritical application of various instruments for assessing the post-traumatic pathology by which attempts are made to determine the "objective state", generates overestimated numbers of people who need assistance. Prevalence of "serious mental health problems" is estimated at 50% within the refugee population (de Jong, Scholte, Koeter & Hart, 2000),

PTSD at 65% (Weine et al., 1995), or even up to 70% (Kinzie et al., 1990). When examining the general population in post-conflict undeveloped countries, the prevalence rate remains between 15.8% and 37.4% (de-Jong et al., 2001). The division is frequently made between "those with severe psychological reactions to trauma and the majority who are able to adapt once peace and order are restored", when counting also persons with chronic mental disorders developed prior to war, who are particularly at risk and most often completely neglected during armed conflicts (Silove, Ekblad & Mollica, 2000). Finally the question remains - is treating the psychological suffering of persons who have survived a traumatic experience as a disease tantamount to "applying a paradigm that transforms the social into the biopsychomedical" (Summerfield, 2000).

Why do professionals often recognise problems in persons who do not seek help? The explanation is not simple, but this phenomenon has been observed in various groups. Isolation and avoidance of contact (in order to avoid remembering) may be only a part of the anwer. With the view of better understaning this important phenomenon, IAN became involved in a multi-centric project STOP ("Treatment Seeking and Treatment Outcomes in People Suffering from Posttraumatic Stress Following War and Migration in the Balkans") coordinated by the Unit for Social and Community Psychiatry, Barts and The London School of Medicine, Queen Mary, University of London UK. One of the aims of the research within this project is to understand why the refugees either come or do not come to seek psychological assistance (Priebe et al., 2002).

When and how?

Priority in emergencies is the provision of basic living conditions, e.g. food, drinking water, shelter and sanitation; mental health usually comes into play later. The idea to prevent subsequent consequences by earlier response or at least by simultaneous planning of psychosocial programmes, has been supported in some projects during the nineties (de Jong, Ford & Kleber 1999). It was suggested that "psychosocial care must become an integral part of emergency response and of the public health-care system" (Brundtland 2000). However, the concept of "debriefing" ("critical incident stress debriefing or CISD) as a structured psychological intervention temporaly placed immediately after trauma has proven to be highly controversial (Raphael, Meldrum & McFarlane, 1995; Deahl, 2000) . The idea to move the line of first aid more quickly towards the line of impact is as old as the contemplating a mental healt protection in wars, and the "doctrine" has changed depending on situations (Shephard, 2001). Shifting towards the frst line in case of refugee population most often implies working in refugee collective centres, which in turn requires special adaptation to circumstances, and the population, as well as an assessment of risk and protection factors (Mollica, Cui, McInnes & Massagli, 2002).

What kind of assistance?

Psychotrerapy

Proliferation of research on psychological trauma has led to the establishment of new forms of psychotherapy, some of which are specially designed for working with traumatised people. Some of the examples include the Eye Movement Desenzitization and Reprocessing (EMDR) or "testimony psychotherapy" (Cienfuegos & Monelli, 1983), as two paradigms. First psychotherapy is based on cognitive-behavioural tradition and its foundation is the assumed, very much controversial (Muris & Merckelbach, 1999), neurophysiological process. Since in this tradition symtpoms are explained by the general conditioning mechanism, the application of this technique is not limited only to stress-related disorders, but it is also used in other anxiety disorders or other psychiatric disordes generally. On the contrary, testimony is almost entirely based on explanations resting on social mechanisms, and the collective traumatisation is considered almost as equal as the individual one. Testimony is said to work through "narration of individuals' personal experiencing of collective traumatization in a new social context in which their remembrances can be used to develop new collective understandings of history and communal identity that can better support peace and social trust" (Weine, Kulenovic, Pavkovic & Gibbons, 1998). "Re-framing" as the foundation of testimony is one of the family therapy techniques, a concept developed by the so-called Palo Alto group. While the EMDR works in a clinical setting, testimony requires a "psychosocial space" (Agger & Jensen, 1996). These two approaches serve as examples of two divergent theoretical viewpoints determined more by the wider areas of discourse rather than by the empirical verification of the true effectiveness of therapies. Psychotherapy with torture victims includes other modalities as well - it can be said that inside each theoretical framework a space has been opened for working with trauma (Foy, Eriksson &, Trice, 2001; Vesti & Kastrup, 1992; Keane, Albano & Blake, 1992). However, some authors consider that the primary needs of refugees, especially torture victims, depend more on the personality of the therapist than they do on specific techniques (Kinzie, 2001).

Psychoanalysis

The use of psychotherapy (and psychoanalytical psychotherapy) in working with torture victims is a vast topic, with year-long history and significant shifts (Baranger, Baranger & Mom, 1988). After two great wars in the twentieth century, psychoanalysis as a theory emerged quite strengthened; after the WW I by way of offering an alternative explanation instead of an organicistic idea of "shell shock" as a consequence of an organic injury (Freud, 1966; Abraham, 1955), and after WW II when the psychoanalysts offered an explanation for various destructive phenomena, which were difficult even to contemplate, and provided assistance to a great number of survivors in the worst of all pogroms, Shoah and their second generation (primarily people such as Kardiner, Krystal, Lifton, Fromm, Frankl, Niederland, Kestenberg, etc.). Contemporary psychotherapy currently offers many

theoretical frameworks and technical achievements that could help in understanding trauma (Varvin, 1998). With the view of opening up additional possibilities for a dialogue among psychoanalysts, IAN has organised the first meeting of the Trauma Research Group of the European Psychoanalytic Federation in Belgrade 2001, which has resulted in a collection of theoretical papers (Varvin, & Štajner-Popovic T, 2002) and in establishing continuity in the group's work. However, to analyse the positions of modern psychoanalysis on treating trauma and torture victims by far exceeds the scope of this monograph.

Psychosocial programmes

This term may denote various things. Sometimes it is used simply for some types of psychotherapy (Davidson, 2001). Attempts to define this term give different results (Agger , Buus Jensen &, Jacobs, 1995). Most often it is used to denote projects that apart from psychosocial assistance in the form of counselling, psychotherapy or psychiatric treatment, include some other types of assistance providing: 1. employment, income generation, economic self-reliance or simple material aid; 2. medical assistance treatment or drug distribution; 3. living conditions and basic necessities (food, water, hygiene items, clothing and footwear); 4. legal aid, protection, in-court representation or advocacy; 5. education, skills training or vocational training, job qualification training; 6. interventions in the community – cupport clubs, self-help groups, support to beneficiary associations. Defining the real role in rehabilitation of such programmes is of crucial importance (Mollica, Cui, McInnes & Massagli, 2002; Lucca &, Allen, 2001), since the lack of project evaluation results often leads to confusion and arbitrary decisions. The possibility of evaluation is further complicated by the process of implementation, which is frequently done in emergencies, i.e. in war or post-war situations, as well as by the complexity of methodology that is closer to the concept of community-based interventions than to a clinical, clearly defined setting that could serve for experiemental design (Hohmann & Shear, 2002). Centres that organise rehabilitation for torture victims often develop multi-disciplinary, comprehensive assistance programmes (Brjholm & Vesti, 1992; Larson, Eng & Stein, 1998) , which most frequently include most of the above-mentioned activities.

Psychiatric assistance

Psychiatric assistance often implies some form of clinical treatment, as well as introduction of pharmacotherapy into this treatment. The analysis of cost-effectiveness shows that long-term hospitalisation does not necessarily mean better treatment and that priroty should be given to short-term stay in specialised wards (Fontana & Rosenheck, 1997; Johnson et al., 1996) . PTSD pharmacoptherapy is not a topic that could be covered in this article; an overview of this type of assictance can be found in other sections of this monograph.

Unlike the studies on effectiveness of medication or residential hospital treatment, it is much more difficult to define the type of therapeutic relationship between the patient and psychiatrist, although this relationship is of crucial importance in the overall treatment (McGuire, McCabe & Priebe 2001; McFarlane & Yehuda, 2000). McGuire and associates

have defined six categories of therapeutic relationship in psychiatry: role theory, psychoanalysis, social constructionism, systems theory, social psychology and cognitive behaviourism. In a randomised controlled trial testing of the efficacy of pharmacotherapy for depression, it was found that the therapeutic alliance accounted for between 21 and 56% of the variance in outcome (McGuire, McCabe & Priebe 2001; Weiss et al 1997).

OUR EXPERIENCE

Since the beginning of its work, IAN has changed several times the area of operation, beneficiary groups and types of assistance, as well as its organisationa structure. This was primarily the consequence of a series of unpredictable external circumstances: from the beginning of the war in Kosovo and NATO airs strikes against Serbia in 1999, to the political changes and the fall of the previous regime in late 2000. For the sake of clarity, we shall represent the work of IAN by programme sections. This division is only conditional, since the programmes have over time been integrated into various functional units that emerged and changed in various periods of time.

TRAUMA CENTRE

Phase One: December 1997 - March 1999

Since the beginning of work until September 2000 (slightly less than three years in total), the work in Trauma Centre has been characterised by the following:

1. Assistance is free of charge, anonimous and without administrative procedures (doctor's recommendations, medical documentation, social insurance, health or refugee card), provided in an uninstitutional setting of which particular care is taken, including the possibility of assistance through the SOS phone line, open for the widest population in need of assistance.
2. The assistance consisted of: a) counselling (see under item 4.); b) deciding on other forms of treatment and ensuring admission into other institutions; c) providing information about other types of assistance, be it medical, legal or humanitarian; d) data collection, entry and analysis.
3. At the beginning, psychological assistance was provided by students at the final year of psychology studies, who were completing their education alongside working in IAN, and were previously trained in working with traumatised people. Staff development and education continued in various forms throughout the work of the Centre.
4. Psychological assistance during education and working with clients was based on the principles of Roger's client oriented therapy (Kondic & Popovic, 1988), with

elements of psychoanalytical counselling (Patton, Meara & Robbins, 1992). The model of work was developed and improved during three years by J. Cvetkovic, V. Matovic, O. Vidojevic, S. Mackic and the author of this paper. Education in psychoanalytical counselling later continued based on the theoretical curriculum developed by T. Štajner and A. Vuco. Working with clients demanded adherance to the strict rules of setting, which included regular planning of sessions, regular timing and length of sessions, constant premises protected from any disturbance.

5. During the first year all students -counsellors were provided with daily supervision, while after this time a supervision group was established, meeting once a week for 1,5 hours. This type of supervision has been going on unchanged until today.

6. From the outset the criteria were defined for including clients into treatment, as well as the criteria for exclusion (acute psychotic conditions, substance abuse on a clinically significant level, and the like). These criteria have been modified over time. Ovi kriterijumi su vremenom modifikovani. Inclusion criteria also extended to domicile population (not only to refugees), primairly family violence victims, and this has remained one of the principles of work - although the target group changed over time.

7. As basic support to counselling we have developed a principle of networking with *individuals* (sic!) from state institutions and referred to them such clients fro whom adequate treatment was impossible to provide in the Centre. When appropriate, clients were also referred to other NGOs providing other types of assistance.

8. Data on all clients have been gathered by way of strandardised instruments and kept in electronic and hard copy form in the Centre, for the purpose of continual monitoring of work, target group and clients' needs.

9. From the very beginning we endevoured to introduce and empirical approach in gathering data on types of trauma, clinical picture of stress-related disorders and personality characteristics of clients, as well as introduce some, hopefully best, form of treatment evaluation.

Trauma Centre during and immediately after the NATO air strikes (March-September 1999)

During the NATO air strikes our work changed significantly. Trauma Centre was closed for only one week after the beginning of the air strikes; at the first joint meeting of staff we unanimously decided to continue working in somewhat changed circumstances: 1) we shifted working hours so that counsellors could get back home in the early afternoon hours; 2) we organised simultaneous work of several people in the Centre, with the presence of someone from the Board of Directors; 3) work in one centre was divided among five locations in Belgrade and one in Pancevo, in order to facilitate access for our

clients, since they often avoided traveling across town; 4) counsellors organised work during the night in shelters where civilians and children were located.

After the end of air strikes the work in Belgrade was again organised within one centre, while the centre in Pancevo remained opened as a branch.

Network of psychosocial assistance centres in Serbia (September 1999-August 2001)

Since September 1999, with the support of CRS (Catholic Relief Services) and CORDAID and based on the model of Belgrade Trauma Centre, we have managed to establish similar centres in five largest towns in Serbia: Cacak, Kragujevac, Novi Sad, Niš and Valjevo. Centres were operational for two years, using the same methodology adopted in Belgrade and providing assistance to a wide range of beneficiaries, including local population traumatised by the air strikes, as well as refugees and internally displaced persons. During the work centres did not only provide psychological and psychiatric assistance, but served also as a backbone of the network for collecting data on beneficiaries of other IAN projects, for distribution of humanitarian aid organised by the Emergency Unit, as well as for identifying beneficiary needs.

Two years later the centres in Valjevo, Kragujevac and Cacak were closed. Centres in Niš and Novi Sad are still operational, but implementing activities under the repatriation programme.

CENTRE FOR REHABILITATION OF TORTURE AND TRAUMA VICTIMS (SEPTEMBER 2000 TO DATE): COMPREHENSIVE INTERDISCIPLINARY ASSISTANCE FOR VICTIMS OF TORTURE AND WAR-RELATED TRAUMA

Since September 2000, with the foundation of the Centre for Rehabilitation of Torture Victims, assistance provided in IAN gained additional characteristics:

1. The target group included as a priority those persons who had been captured, detained and tortured during wars in former Yugoslavia or by the then regime, or as victims of organised violence. This has led to strengthening of criteria for other groups of beneficiaries and practical exclusion of systematic work with domicile population that was not exposed to war-related sressors (victims of "civilian trauma" were reduced to under 5% of the total number of clients in the previous year – 2002).
2. Psychiatrists with an already extensive experience in working with traumatised people in their home institutions are involved in the work of the Centre on the basis pof part time contracts. This has led to introducing a variety of psychotherapeutic mehods (EMDR, psychodrama, behavioural techniques, systems family therapy) as well as the inclusion of pharmacotherapy treatment.

3. Systematic mobile team work began, covering large areas, initiating group work in refugee collective centres, as well as ensuring access for refugees settled in private accommodation, which is a hardly reachable group and therefore often left out in humanitarian projects.

4. Regular medical assistance began through systematic check-ups and continual treatment in the field of internal medicine, cardiology and neurology. Whenever possible, diagnostics and treatment were accompanied by free of charge basic medication.

At the time of writing this article, IAN Centre for Rehabilitation of Torture and Trauma Victims covers several areas of assistance: 1) psychological and psychiatric help; 2) legal aid; 3) medical assistance (with free of charge delivery of drugs); 4) forensic assistance; 5) assistance in the process of repatriation and 6) support in training and computer skills. Some of these activities will be described in other parts of this monograph. This article aims only at giving a general presentation, an overview of IAN services such as they were developed in a wider context.

EMERGENCY UNIT (SEPTEMBER 1999 – MAY 2001)

On the eve of the NATO air strikes in March 1999, many international humanitarian agencies have closed their offices in FR Yugoslavia and the living conditions became worse after the bombing campaign. The air strikes triggered a situation in which the number of clients in need of humanitarian emergency assistance was increasing. This required a very rapid response to procure basic assistance for the most vulnerable categories of population. Although primarily oriented towards psychosocial programmes, we decided to respond to the emergency situation and expand our work to direct humanitarian aid programmes, organising a distribution of humanitarian aid to those most at risk. Until May 2001 over 100.000 vulnerable people (internally displaced from Kosovo, refugees from Bosnia and Croatia, foster children, children and adults in social care institutions) received assistance. During this period we have implemented the following humanitarian aid programmes:

1. **Project:** Distribution of medical drugs to centres for mentally retarded children and children without parental care and institutes for chronic psychiatric patients; **beneficiaries**: mentally retarded children, children without parental care, institutions for chronic psychiatric patients (a total of 23 centres and social care institutions); **supported by**: CAFOD (Catholic Agency for Overseas Development).

2. **Project:** Distribution of basic provisions for children in homes for choldren withot parental care; **beneficiaries**: 2385 children in foster families; **supported by**: CAFOD.

3. **Project:** *Distribution of winter clothing and footwear for internally displaced people*; **beneficiaries**: 6478 internally displaced persons from Kosovo accommodated in 63 collective centres; **supported by**: DFID /CAFOD.

4. **Project:** Distribution of blankets, bed linen and hygiene items for mentally retarded and chronic psychiatric patients in residential institutions; **beneficiaries**: 8365 mentally retarded and chronic psychiatric patients in institutions; **supported by**: CAFOD.

5. **Project:** *Winter clothes and footwear for internally displaced persons, refugees and deprived local population*; **beneficiaries**: 14.000 internally displaced from Kosovo, refugees and deprived local population; **supported by**: DFID /CAFOD.

6. **Project:** *Distribution of clothes to deprived groups in Serbia*; **beneficiaries**: 41763 refugees, internally displaced persons, social cases and other deprived groups in Serbia; **supported by**: MCI (*Mercy Corps International*).

7. **Project:** *Distribution of family and hygiene parcels for refugees, internally displaced persons and socially deprived population*; **beneficiaries**: 8000 families and 2700 babies (refugees from Bosnia and Croatia, internally displaced from Kosovo and various categories of deprived local population - disabled, families with more than two children over 15, single parents, social welfare beneficiaries, persons over 65); **supported by**: CRS (*Catholic Relief Services*).

More detailed information about all projects can be obtained at http://www.ian.org.yu.

Basic principles of IAN programmes of humanitarian aid distribution were the following:

1. distribution of humanitarian aid was highly personalised. This means that each parcel of humanitarian aid was destined for a specific beneficiary, on the basis of previously collected information about this beneficiary;

2. aid was given directly to the beneficiary, or via local partner NGOs, wthe work of which was closely monitored;

3. IAN staff directly supervised all phases of project implementation;

4. data on our beneficiaries, were stored in a unified electronic data base on beneficiaries (this data base includes people of all above-mentioned categories, a total of about 100.000 individual beneficiaries of all programmes, or around 30.000 families).

5. distribution projects were accompanied with constant needs assessment of beneficiaries; findings of these assessments were shared with local and international NGOs [1].

In mid 2001, this unit discontinued its systematic work on humanitarian aid distribution and moved towards repatriation and return programmes for refugees and internally displaced persons.

REPATRIATION AND INTEGRATION UNIT

Repatriation programme has been going on since January 2001. It encompasses the provision of 1. informative, 2. legal and 3. psychological assistance to refugees and displaced persons in the process of decision-making on return to the country of origin or integration into local community of asylum. IAN centres in Belgrade, Nis and Novi Sad provide refugees and internally displaced with information, legal and psychological assistance, as well as the possibility to participate in social and educational activities organised in social clubs within each centre.

Informational assistance

The underlying assumption is that repatriation/return or integration must be based on the process of free decision-making of each individual and / or family, aimed at reaching a durable solution for their year-long exile and hardship. One of the most important factors influencing the final decision-making is the posession of accurate and relevant information related to the situation in the country of origin, possibilities and conditions under which return is possible. Therefore IAN programmes are oriented towards provision of the most comprehensive information, both indirectly through the media, public events and debates, as well as through individual tailor-made information for the people who come to seek assistance. During 2001 IAN began with a support programme for internally displaced persons from Kosovo within return-related assistance activities. Informational component is particularly important, through a web portal on which all relevant infromation about Kosovo can be found. Another form of informational assistance are the so-called "Go and See" visits to Croatia, which are a part of UNHCR programme, implemented since 2001 in co-operation with the Danish Refugee Council. These three-day journeys provide the refugees with an opportunity to visit their pre-war homes in the country of origin, and IAN ensures that they get proper psychological preparation prior to the visit as well as legal aid, especially in terms of personal document provision.

1 United Nations. Manual on the Effective Investigation and Documentation of Torture and Other Cruel, Inhuman or Degrading Treatment or Punishment. Istanbul Protocol. Geneva: United Nations, 2001.

Legal aid

The most frequent legal questions of our clients relate to exercising their basic citizen and human rights in the country of origin. In the scope of free legal aid provision for refugees, IAN mediates in obtaining their basic personal documents such as citizenship certificate, birth certificate, marriage certificate, death certificate, as well as documents necessary for exercising basic rights of refugees, both in Croatia and Serbia&Montenegro. Many people have no possibility to travel and personally establish contcts with individuals whom they could empower to act on their behalf in document provision and the only way for them to obtain documents is through the powers of attorney implemented through our partner organisations in Croatia. Provision of basic doduments for refugees through IAN offices is done free of charge. Document provisoon programme for refugees from Croatia is implemented in partnership with the Dalmatian Solidarity Committee in Split.

Psychological assistance

Psychological assistance for refugees and internally displaced persons in the process of decision-making about durable solutions is ensured through individual and group work. This part is based on the previously developed methodology for working with refugees in collective centres, with all its specific theoretical and practical implications.

Work in IAN social clubs involves video presentations, video conferences, lectures, education and training courses, group sessions with the group psychologist, public events, etc. Organising social activities, meetings, social games, TV and video performances, distribution of newspapers and magazines from Croatia are some of the "socialising elements" aimed at ensuring adequate approach to refugee families. These activities offer an opportunity to form support groups and potential psychologocal treatment of individuals with war-related stress disorders. All these activities aim at creating a "safe environment" in which refugees would not feel isolated, misunderstood or stressed. In such environment they could begin to talk about their fears and problems related to repatriation. Special attention is focused on children programmes (workshops, computer courses, etc.).

Cross-border cooperation

IAN is a member of various regional networks, including SEE-RAN (*"South East European Refugee Assistance Network"*) and the TRIANGLE initiative in the scope of FRESTA programme ("Secretariat for Peace and Stability in the Danish Ministry of Foreign Affairs"), as well as the ECRE Focus Group on South-East Europe. SEE-RAN was established in 2000, with a Secretariat based in Sarajevo (http://www.see-ran.org/). This network currently gathers 24 organisations from Bosnia, Croatia, Kosovo, Albania and Serbia&Montenegro.

SELF RELIANCE AND SKILLS DEVELOPMENT PROGRAMMES

Economic self-reliance programmes have been implemented in Serbia during the past several years in various forms, ranging from grants and loans to income generating and skills development programmes, re-training, etc. In IAN these programmes have only partly been brought to life through the Vocational Training Centre and only in a direct link with pscyhological assistance for clients who take part in other projects. This centre runs training in sewing, screen-printing and computer literacy (basic training and web-design) and the activities are contextually determined and evaluated as psychosocial projects, which includes an evaluation of pscyhologocal benefit from participation in the project. Benefit for the clients was not expected only from learning new skills and expected economic self-reliance, but also from the group work, strengthening their social network and communication skills in the process of learning and later on the running of some segments of the rpogramme, as well as benefit from other types of assistance provided in IAN.

MEDICAL ASSISTANCE

Medical assistance programme has been running since January 2001. Key aims of this programme are the following: 1. provision of timely and modern diagnostic and therapeutic services in the field of internal medicine - especially cardiology and neurology, which were usually not accessible for our clients in the public health system; 2. motivating clients for timely treatment of physical discomforts related to psychosomatic states; 3. continual follow-up of clients' condition and treatment; 4. gathering and analysing data related to somatic status of persons who have been exposed to violence and torture; 5. collecting donations and distributing free of charge medication to socially deprived clients. Beneficiary group is identical and encompasses torture victims and refugees. All procedures have been done according to internally set guidelines and documents determining the mechanism of referrals, registration, drug distribution and the like. Patients were included in the project on the basis of an internal referral form from the IAN Centre for Rehabilitation of Torture Victims, as well as from fieldwork in refugee collective centres.

All patients involved in the programme have undergone basic internist and / or neurological examination. If the first examination concluded that it would be necessary to perform additional diagnostic search (ultrasound, physical burdening test, Holter electro-cardiographic monitoring, electroencephalogram) patients were subsequently referred to additional examinations. Detailed overview of medical programme activities has been given in another part of this book.

FORENSIC EXPERTISE

Forensic expertise makes it possible to determine and document physical consequences of torture. As a rule, torture victims tend to approach various organisations

for human rights protection, combating torture, provision of psychological assistance, etc. or emigrate from the country where they have survived torture, usually ending up in countries of western Europe and USA. Information about the torture one has experienced, corroborated with certain valid documentation, sometimes facilitates obtaining the immigration permits or certain benefits in the country, although this is often overrated among our clients. Sometimes people venture into collecting medical documentation of suspicious credibility and are occasionally subjected to various manipulations in the process. The position we have taken from the beginning of work in CRTV was that the clients should, whenever possible and justified, be provided with forensic expertise based on certain international standards and protocols, in order to avoid abuse and at the same time ensure adequate support for clients in exercising their rights.

Although victims of torture, in these organisations or before the authorities of the country they wish to emigrate to, explain in detail the circumstances under which they have survived torture, as well as the types of torture applied against them, it is necessary to render these allegations objective by way of medical examinations and to perform an adequate forensic expertise. Physical examinations of victims are usually done after some time has elapsed from the torture incident, sometimes only months later, but occasionally it could be years, even decades later. It is understandable that the physical examination immediately after torture, only a few days or weeks later, could serve to document almost all bodily injuries and explain the mechanism of their infliction. However, not even the long period of time that has elapsed since torture should discourage and compromise the physical examination of torture victims. A multidisciplinary approach, after reviewing all collected anamnestic data about survived torture, allows the development of an appropriate expertise plan, which apart from the immediate physical examination can include various additional examinations: xray, ultra-sound, skin biopsy, various functional examinations, e.g. of hearing and the like. In practice a number of protocols have been developed for working with torture victims and documenting the consequences of the experienced torture. Among available protocols a prominent place is given to the Istanbul Protocol [51] that has a comprehensively developed scheme for working with torture victims, from taking anamnestic data, physical examination, psychiatric and psychological exploration, use of necessary additional diagnostic procedures, to the conclusions on the case. Finally, it should be mentioned that a negative finding of physical examination in some cases of torture does not necessarily eliminate the possibility that the victim has indeed survived what he/she claims by giving the anamnestic data. A positive finding, however, of the physical examination and forensic expertise of torture victims, findings that are consistent with collected anamnestic data (e.g. finding corresponding shapes of scars after having sustained cigarette burns) strongly corroborate the allegations about torture the victim had survived.

CONCLUSION

Writing the article for this monograph in the third year of specialised assistance provision for torture vistims and after six years of IAN work is a good occasion to take

stock of what has been acomplished and what has not. In the circumstances in which the system of service delivery has been developed in IAN centre there was no room for serious strategic planning; the need to redefine our role in various contexts was aimed at ensuring survival of the organisation, but did not distract us to the extent to abandon princuples defined at the outset and stipulated in the statute and by-laws of our NGO.

IAN services currently have over a thousand clients per year and several thousand various interventions that could be classified as psychosocial interventions within humanitarian programmes. During the reported period there have been 25 psychologists and 15 psychiatrists engaged in IAN, working directly with clients as counsellors (the number of professionals involved in some psychosocial projects was much higher, here we have counted only those with at least two-year continual contracts). Currently there are 21 psychologists and 8 psychiatrists empoyled to work with clients, but this number increses when we count psychologis ts and psychiatrists who also take part in the management of programmes. IAN remains outside the health care and social care systems funded by the state, but cooperation with government institutions is active and constantly improving. Communication with similar centres outside the country as well as the professional and expert exchange strengthen our belief that the level of knowledge and organisational development we have attained could be representative and set a motivating challenge for others as well.

Could we conclude from all this that we are successful or that we could do even better? IAN assistance provision is highly professional and accessible to a large number of beneficiraries they are meant for, services are flexible and capable of adaptation, yet based on models of assistance determined beforehand and developed according to needs assessed in advance. Nevertheless, a significant issues of continual evaluation of all services remains to be resolved by imrpoving the adequate methodology and a more detailed elaboration of all existing procedures. Development of therapeutic skills, regardless of the type of technique used, must strive to a better understanding of the specific features of traumatic experience, and the individual approach to client must be improved through more adequate case management. Beneficiary participation, which has been very significant so far, should be institutionalised, so that the support to associations of beneficiaries would remain the obligation of IAN henceforth, while the decisions taken by beneficiaries woould be formally binding and incorporated in the strategic planning for future.

Finally, a few words at the end: constant verification of how good we are does not only serve the purpose of improving the quality of work. In this type of assistance provision one needs to be aware of the survivor's guilt that always arises while working with people who have suffered as much as our clients have. We should not forget that this is not just an ordinary job as any other, or any other in the scope of mental health protection: therefore without a genuine desire to assist those who have been hurt, no other compensation apart from occasional gratitude or visible benefit for the clients would be enough and each effort would become exhausting and futile during time.

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