Global Peace Services USA

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We are very pleased to focus this issue of the Newsletter of Global Peace Services USA on issues of violent conflict and mental health, both in developing countries and in schools in the United States. The first article, "Mental Health Disabilities and Post-Conflict Economic and Social Recovery," is by Dr. Robert J. Muscat, an expert on conflict and development and a GPS USA Board Member. The article deals with consequences of conflicts and trauma in developing countries. The second article, "Preventing Violence by Utilizing Schools and Violence Prevention Programs," is by Mr. Brian Stefanovic, a special education teacher working on his ED.S degree in School Psychology at the University of Missouri-Columbia. The article deals with reducing violence in U.S. schools and the author's experience at the Young America Works Public Charter School in Washington, DC. Announcements of recent and upcoming events in which GPS USA is either participating or sponsoring are found at the end of the issue. Dr. Robert Muscat is the guest editor of this Newsletter issue and can be contacted for further information with respect to the two articles at: rjmuscat@hotmail.com.

Mental Health Disabilities and Post-Conflict Economic and Social Recovery

by Robert J. Muscat

Economic losses from ill health - for an individual and for an economy - have been well established and measured in the health economics literature. They include a) costs of medical treatment; b) costs imposed on family care-givers; c) loss of human capital; d) income foregone during periods of lost work or due to disabilities; e) the costs of welfare support of the ill and disabled.

In developing countries, health status is typically poorer than in wealthy countries. Resources available for health maintenance are very inadequate. The World Health Organization found that economic losses from ill health in developing countries have been large. For example, in sub-Saharan Africa losses due to HIV/AIDS are estimated to be at least 12% of annual GNP. WHO estimated that economic benefits from recommended health investments could amount to six times the costs.

In recent years, there has been protracted violence (some genocidal) in over 40 developing countries. In these cases, problems of physical ill health are greatly compounded due to: a) vast numbers of land mines claiming new victims; b) collapsed health infra-structure; c) suspensions of inoculation programs; d) large numbers of widow-headed households with nutritional and other health exposures; e) slow economic recovery; f) degraded cultural and social capital.

The mental health effects on societal recovery and economic behavior - e.g. on labor force participation, individual productivity, production-related collective or cooperative action, investment and savings behavior, school educability - are much less studied. They are seldom taken into account by non-health professionals designing recovery programs in agriculture, education, and other areas. These effects can be significant where large fractions of a population have known displace-ment, deprivation, torture, and emotional trauma. The scale of these consequences moves the problem of functional impairment due to mental health beyond the confines of the health system per se.

Mental health problems can be extensive even in peaceful societies. For the European Union countries as a whole, an estimated 20% of the work force has some type of mental health disorder at any given time.

In the US more than 40 million people are estimated to have some mental illness. Economic consequences can include lost income, treatment costs, work errors and accidents, work days lost, and conflicts with fellow workers. In the US, mental/emotional disabilities have been cited as causing 200 million lost work days each year.

If studies were available for post-conflict developing countries, one would expect high incidence, but different profiles, of mental disorder and behavioral effects. In refugee populations the incidence of acute clinical depression and post-trauma stress disorder can range between 40-70%. Many in a post-conflict population will adapt and cope well over time, if the environment is secure, supportive, and experiencing economic recovery, which is often not the case. But sizable fractions will remain suffering from disabling psychiatric illness or severe psychological effects from their trauma.

The large scale of mental illness in post-conflict developing countries derives from the widespread physical and emotional trauma, fear, destruction of communities and institutions, betrayals and loss of trust, and social and cultural degradation that characterize many of these conflicts. Persons with mental health problems in developed countries can benefit from mental health institutions, cadres of mental health professionals, easily accessed medication, and specialized training and employment opportunities. In post-conflict developing countries, health providers of any kind may be scarce, mental health professionals are few in number, and few governments have a mental health policy framework that can serve as a basis for systematic attention.

Fortunately, lessons on low-cost, large-scale intervention methods, using primary health care systems, traditional healers, and NGOs, have been learned in recent years. At a conference in Rome in December 2004, health ministers, international health organizations, and mental health professionals launched an action plan to promote adoption of effective post-conflict intervention programs. Economic recovery may be difficult for families now short of adult male heads of household. Destruction of farm tools, irrigation channels, seed stocks, etc., creates anxiety over rural living standards, if not over sheer survival. Urban areas typically have high post-conflict unemployment. Returning refugees and displaced persons are likely to have high incidence of mental health disorders. Traditional communal and religious support networks have frequently been degraded. Social breakdown may result from mass ethnic conflict, causing a loosening of traditional restraints on criminal activity and domestic violence. In short, the environment is not enhancing for those afflicted with mental health problems.

Examples of behavior that is dysfunctional for socioeconomic recovery perspective can be drawn from experience in Cambodia, Rwanda, Guatemala, and elsewhere. First, the traumatized may have a highly foreshortened view of the future. In economic terms, they apply a high discount rate to the present value of future income or benefits. They are unwilling to forego short-term benefits in exchange for the possibility that longer-term benefits will thereby be higher. In Cambodia in the wake of the Khmer Rouge years, widowed heads of households resisted UNICEF project workers' advice that they turn some land from rice to fruit tree cultivation. The trees would take 2-3 years to bear the first fruit crop, too long for them to forego immediate rice for higher, but even moderately delayed, fruit income. They would not make an investment in larger future consumption. In Rwanda, 10 years after the genocidal conflict, some lasting dysfunctional patterns - e.g. high-risk sexual behavior and neglect of terrace maintenance - may reflect similar high time discount, or disregard for long-term consequences of present actions.

Second, effects on educability of children have been seen in Rwanda. Young children who experienced the genocide and its aftermath, now teenagers, are reported to express rage and act violently in school. In the primary schools there are also behavior problems that may reflect inter-generational effects of lingering psychological dysfunction within families. In Burundi, poor school attendance has been associated with "distress" of the household heads.

Third, trauma survivors may be unable to work individually, or to participate in economically relevant collective action. Traumatized communities may have been rendered incapable of internally generated social and economic recovery. In one Guatemalan village where lives had been "shattered," "resignation and passivity as a strategy for survival is a heavy albatross that chokes the

possibility of recovery. Everyone in this ethnic Mayan village [San Andres] experienced a tremendous sense of guilt, fear, depression, loss, abandonment, despair, humiliation, anger, and solitude. For some the blow was so devastating that it shattered their faith in God."

Although communities that have revived vigorously have also been observed, lingering communal torpor appears to have been more common. The nature of anthropological observation - close, but one community at a time - makes it difficult to draw generalizations about scale. Thus, some observers in Cambodia have described general psycho-social collapse, an inability to reconstitute the community as a functioning, economically cooperating entity. Others have described vigorous revival of social and economic life, despite mental health disabilities lingering 20 years after the end of the Khmer Rouge regime.

The effects of lingering psychological disability are subtle and difficult to separate from the complex of circumstances that shape human behavior. Nevertheless, the literature shows behavioral disabilities persisting long after the cessation of the period of trauma and injuriously affecting work capacity and the rebuilding of communities.

Conclusions

The interactions between mental health and socioeconomic functioning are complex. Much remains to be learned. Causation runs both ways. Post-conflict mental health disabilities affecting the economic, social, and learning behavior of significant numbers of people can have deleterious effects on socioeconomic recovery. Community dynamics and economic conditions, good or bad, feed back on the prospects for individuals' mental health recovery.

We need to: (1) advance the state of knowledge on psychosocial recovery after violent conflicts, and (2) ensure that problems of post-conflict psychosocial effects are taken into account by the general recovery planning authorities, and that potential complementarities between psychosocial recovery and economic recovery are identified and acted upon.

(1) Advancing Knowledge: The need for, and increasing availability of, effective (and cost-effective) mental health interventions, is becoming more widely recognized. Knowledge of the interactions between mental health and socioeconomic recovery, and the scale of these problems, could be enhanced if post-conflict research such as that supported by the World Bank - in Living Standards Measurement Surveys, and poverty assessments - included gathering the relevant data. Where such surveys indicate that mental health consequences are of a serious magnitude, the Bank and WHO should undertake in-depth research on consequences and economic interactions. Greater understanding would be very useful for both the health authorities and the planners of general recovery.

(2) Psychosocial and Economic Complementarities: Greater dialogue between national authorities responsible for mental health and those responsible for overall socioeconomic recovery should serve to strengthen professional understanding and the whole array of recovery intervention options. Mental health professionals should be included in the planning of service and reconstruction programs at the community level, especially programs involving populations that have experienced violence, fear, economic devastation and other war trauma, such as widow-headed households, child soldiers, and refugees and internally displaced persons. Stronger dialogue and coordination between health authorities and general planning authorities would benefit both sides. Planning authorities would gain greater understanding of how conflict's psychosocial legacies may be affecting general recovery. They would gain a heightened understanding of the need for allocating resources to address these legacies. Working together, they could identify policies and programs that could complement the therapeutic interventions of mental health professionals. Examples could include job training, job creation and food-for-work programs, community development, human rights workshops, agriculture extension, sports and physical education, adult education and literacy, and preparation for demobilization and reintegration of adult and child ex-combatants.

Preventing Violence by Utilizing Schools and Violence Prevention Programs

by Brian Stefanovic

Young America Works Public Charter School
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Many of us probably have had the sobering experience of taking a wrong turn and driving through a bad neighborhood and than feeling relieved after leaving what seemed to be a dangerous environment. Now imagine walking through several of such scary neighborhoods twice everyday. Unfortunately, many young people in major cities in America and around the world endure this feeling of uncertainty and fear of being harmed on a daily basis. Everyday, on their way to school, my students are fearful of being randomly jumped, robbed, and humiliated.

Violence among adolescents continues to be a concern in the US. For example, 41% of 6th, 8th, and 10th grade students in an urban public school system reported having seen at least one shooting or stabbing in the past year (Schwab-Stone et al., 1995). A recent Surgeon General's report described violence as the greatest threat to the lives of children and adolescents (U.S. Surgeon General's Office, 2001). Even more recently, the UN reported that despite increased economical development globally, conditions among women, children and the poor are worsening. Community violence in the US occurs at an alarming rate and the mental health of youth is particularly vulnerable to it.

Higher rates of emotional, behavioral, and cognitive problems among youth have been shown to result from exposure to community violence (Kuther, 1999). Other problems stemming from exposure to community violence include depression, posttraumatic stress symptoms, suicidal behavior, aggression, and negative biological and hormonal developmental problems (Latzman & Swisher, 2005). Ozer (2005) discusses two general types of psychosocial protective factors for urban youth exposed to violence in their communities. The quality of support and communication in family, peer, and/or school domains and the relative safety of the home or school environments are argued to be influential on the development of young people.

Furthermore, the nature of students' perceived connection to school (belonging, safety, happiness) has been correlated with better educational and psychological outcomes (National Center for Education Statistics, 1997). Eccles & Gootman (2002) suggest that sup-portive relationships and physically safe environments are basic qualities of settings that influence healthier youth development. It is clear that schools have the challenging role of providing a safe, disciplined, and nurturing environment within which to educate students and socialize them for the adult roles of citizen, family member, and worker (Albert et al., 2003).

In recent years, the clinical field has endorsed utilizing evidence-based interventions to treat mental health problems. Clinicians have described efficacious interventions that have resulted in statistically significant behavior changes. Researchers and practitioners are striving to investigate and promote effective programs that help at-risk youth mental health development. For example, the Center for the Study and Prevention of Violence (CSPV) has identified 11 prevention and intervention programs that meet a strict scientific standard of program effectiveness. Common themes of effective programs often include adolescence skill building, critical analysis, conflict resolution, peer mediation, role playing, teacher awareness and training, student-teacher and parent-school relationships, promotion of structured and safe environments, academic development and school discipline. Considering how influential community violence is on adolescent mental health, it is apparent that successful schools and violence prevention programs are vital to promoting good mental health development among the youth. It is critical that policy makers, community support and service groups, and families, support healthy school environments as well as effective violence prevention programs as much as possible.

A program at Young America Works Public Charter School, in North East Washington DC, provides an example. Taking students on weekend outings has served as a therapeutic and positive experience for troubled students. In one case, the vice principal, counselor and special education teacher took a group of 9th and 10th grade boys out to a resort to go horseback riding and boating, and to play football and basketball. The goal was to give these students a much-needed opportunity of experiencing for 72 hours a positive, safe, and structured environment. The positive effects of this trip lasted for several weeks. Admittedly, continuation of such trips on a regular basis may be difficult due to funding and manpower. Ideally, it would be most effective if the students were able to take such therapeutic trips regularly. Young America Works also emphasizes providing information on vocational training, job internships and seeking high learning/college experiences. On a daily basis, students need to be reminded about their roots, opportunities for improving themselves, and the importance of work ethic, character, motivation, and responsibility.

In conclusion, prevention is a welcomed concept among mental health and medical professionals. Developing prevention activities takes time, effort and funding. Developing consensus among policy makers, community leaders, service providers and families to promote mental health prevention interventions remains challenging. Regardless, further cooperation among schools and related service professionals to address and lower community violence is vital.

Recent and Upcoming GPS Events

We on the GPS USA Board continue to hold to our central vision of helping to create a world of many women and men who transform violence into service to humankind. We believe that the major event we've sponsored recently and planned during 2006 have contributed to our core vision and mission.

- A Conference on Peace Service and the World's Great Religions. University of Mary Washington (UMW), Fredericksburg, VA, November 4-6, 2005. This convocation brought together experts from educational and religious institutions. The speakers and the audience helped us identify gaps which GPS USA could help fill.
- We plan to publish in early 2006 the proceedings of the Conference on *Peace Service in the Abrahamic Traditions*, co-sponsored by GPS USA and Marquette University in Milwaukee in October 2004.
- We are planning to give a seminar at the *Annual Nobel Peace Prize Forum*, to be held this year at Luther College in Decorah, IA, March 10-11.
- GPS USA will sponsor *Youngstown for Peace*, planned for the end of April 2006 in Youngstown, Ohio. This upcoming GPS-sponsored event will highlight initiatives underway in this industrial city to bring its diverse cultural and racial communities together to build bridges across existing social and economic divides. Youngstown's newly elected mayor, committed to implementing policies and programs fostering community-building and social inclusiveness, will be a featured speaker. Participants will include representatives from civic, religious, academic and governmental organizations.

The composition of the GPS USA Board has changed in 2005. We welcome Dr. Michael True as a new member. As always, we welcome your recommendations for nominations to the GPS Board and any suggestions you have for our future program of work.

John Eriksson, President

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GPS USA is incorporated in the District of Columbia and is tax-exempt. Current board members are:

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